Florida Blue
In the pursuit of health

Marion County School Board - 2019 Health Plan Overview – Actives

Employee Per Paycheck Insurance Deductions	BlueOptions Basic Plan 1	BlueOptions Basic Plan 2 Health Savings Account (HSA) Compatible		BlueOptions Mid-Plan 3	BlueOptions High Plan 4
Individual Single Coverage	**$0.00**	**$19.18**	**N/A**	**$54.43**	**$127.96**
Family Coverage	**$300.86**	**N/A**	**$266.09**	**$484.67**	**$671.65**
Family - Spouse also employed at MCSB	**$122.20**	**N/A**	**$87.13**	**$260.42**	**$447.41**
Important Plan Financial Features - Amount Member Pays					
Calendar Year Deductible (CYD) Per Person/Family Aggregate		Single Deductible	Family Deductible		
• In-Network	$2,500 / $5,000	$1,350	$2,700	$1,500 / $4,500	$500 / $1,000
• Out-of-Network	Combined w/In-Network	$2,500	$5,000	Combined w/In-Network	Combined w/In-Network
Coinsurance % of covered services paid by you after CYD					
• In-Network	20%	20%/25% (Option 2 hospitals)		20%	20%
• Out-of-Network	40%	40%		40%	40%
Physician Office Visits *					
• In-Network Family Physician	$25 Copay	CYD + 20%		$25 Copay	$20 Copay
• In-Network Specialist	CYD + 20%	CYD + 20%		CYD + 20%	CYD + 20%
• Out-of-Network Provider	CYD + 40%	CYD + 40%		CYD + 40%	CYD + 40%
Urgent Care Centers					
• In-Network	$35 Copay	CYD + 20%		$35 Copay	$35 Copay
• Out-of-Network	OON Ded + $35 Copay	OON Ded + 20%		OON Ded + $35 Copay	OON Ded + $35 Copay
Independent Clinical Lab Services					
• Quest Diagnostics (*Exclusive* In-Network Provider) *1-866-697-8378*	$0 Member Cost	CYD + 20%		$0 Member Cost	$0 Member Cost
• Out-of-Network Lab Providers	CYD + 40%	CYD + 40%		CYD + 40%	CYD + 40%
Out of Pocket Maximum					
Per Person/Family Aggregate	Includes CYD, Coinsurance, Copays and Rx	Includes CYD, Coinsurance, Copays and RX		Includes CYD, Coinsurance, Copays and Rx	Includes CYD, Coinsurance, Copays and Rx
In-Network	$6,350 / $12,700	$5,000		$3,000 / $6,000	$2,500 / $5,000
Out-of-Network	$7,350 / $13,700	$10,000		$5,000 / $10,000	$5,000 / $10,000
Lifetime Maximum					
Lifetime Maximum per person	Unlimited	Unlimited		Unlimited	Unlimited
Preventive Healthcare (Wellness)					
Annual Adult Wellness (CYM) – In Network	Unlimited	Unlimited		Unlimited	Unlimited
Routine Adult Physical Exams and Immunizations					
• In-Network Family	$0 Member Cost	$0 Member Cost		$0 Member Cost	$0 Member Cost
• In-Network Specialist	$0 Member Cost	$0 Member Cost		$0 Member Cost	$0 Member Cost
• Out-of-Network (unlimited)	40% (No CYD)	40% (No CYD)		40% (No CYD)	40% (No CYD)
Mammograms (Member cost In and Out-of-Network)	$0 Member Cost	$0 Member Cost		$0 Member Cost	$0 Member Cost
Routine Colonoscopy (Members 50+ In and Out-of-Network)	$0 Member Cost	$0 Member Cost		$0 Member Cost	$0 Member Cost
Well Child Care Services					
• In-Network Family Physician	$0 Member Cost	$0 Member Cost		$0 Member Cost	$0 Member Cost
• In-Network Specialist	$0 Member Cost	$0 Member Cost		$0 Member Cost	$0 Member Cost
• Out-of-Network	40% (No CYD)	40% (No CYD)		40% (No CYD)	40% (No CYD)

*Note: Physician Office Visits: Separate, additional 20% member cost share for Physician Administered Drugs** administered at an In-Network physician's office. Maximum member out of pocket is $200 per month. Separate, additional 50% member cost share for Physician Administered Drugs** administered at an Out of -Network physician's office. No cap on member monthly maximum Out of Pocket for out of Network. **Physician-administered drug - an FDA-approved Prescription Drug that requires administration by a Physician. This does not include allergy injections or immunizations.

CYD= Calendar Year Deductible. CYM=Calendar Year Maximum. OON = Out of Network. INN = In-Network, Family Physician= Family Practice, General Practice, Internal Medicine, Pediatrician. HSA= Health Savings Account. Out of Network Providers are reimbursed based on an allowance. Members may be balanced billed by an out of network provider for amounts above the allowance even for services reimbursed at 100%. In-Network Providers accept the BCBSF allowance and are not permitted to balance bill.

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Prescription Drug Benefits	BlueOptions Basic Plan 1	BlueOptions Basic Plan 2 HSA–Compatible	BlueOptions Mid-Plan 3	BlueOptions High Plan 4
Which plan features the pharmacy benefits that are best for you? **Consider the overview features at the right and review the detailed descriptions of each plan below.**	**Generic Choice Rx Plan** **No coverage for Brand** ****Not a Creditable RX Plan for Medicare or Medicaid** **No Mail Order**	**Covers Generic and Brand Drugs** **Integrated RX Plan. Pharmacy expenses apply to your Medical Plan CYD** **Once you satisfy your CYD you pay a % percentage for each prescription** **No Mail Order**	**Covers Generic and Brand Drugs** **$500 Brand Deductible** **Annual Cap on Specialty Drug Costs** **Mail Order Included**	**Covers Generic and Brand Drugs** **No Brand Deductible** **Annual Cap on Specialty Drug Costs** **Mail Order Included**
Local Retail Pharmacy • **Generic** • **Brand RX Deductible** **Preferred Brand / Non-Preferred**	No Deductible You pay 20% NA **Not Covered*** (refer to Generic Choice RX Guide) ***Exceptions include** Federal Mandated Brand Vaccines, Women's Preventive Services, HIV and Cancer. **Covered HIV and Cancer Brands at 20% with Min $50 – Max $200 member cost share** **Eligible Diabetic Supplies and Insulin are covered at the generic cost share**	Generic & Brand Drugs Subject to Medical Plan CYD, then you pay **20% Generic / 30% Preferred Brand/ 50% Non-Preferred**	No Deductible You pay 20% $500 Deductible per person, then you pay **40% / 50%**	No Deductible You pay 20% No RX Deductible you pay, **40% / 50%**
Self- Administered Specialty Drugs*** **Must be purchased through CVS Specialty CareMark the In-network pharmacy to be covered. Contact number is 1-866-278-5108**	Not Covered Medical Plan may cover some drugs used in treatment of diabetes, cancer or conditions requiring immediate stabilization.	Same as Above	50% **Specialty***** Drugs (Maximum Member Cost per year for Specialty Drugs $2,000)	50% **Specialty*****Drugs (Maximum Member Cost per year for Specialty Drugs $2,000)
Mail Order Pharmacy 90 Day Supply **Generic / Preferred Brand / Non-Preferred** **Must be purchased through Prime Therapeutics. Contact number is 1-888-723-7451**	Mail Order Not Included with this Plan	Mail Order Not Included with this Plan	No Deductible **Co-pays $20/$80/$140**	No Deductible **Co-pays $20/$80/$140**

****Non-creditable RX** coverage is not expected to pay out as much as standard Medicare drug coverage pays. This may result in paying a penalty if you do not join a Medicare drug plan when first eligible.
*****Specialty Drug** - We have identified certain drugs as specialty drugs due to requirements such as special handling, storage, training, distribution, and management of the therapy. These drugs are listed as a 'Specialty Drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a Specialty Pharmacy. These pharmacies are different than the retail pharmacies and are identified in both the Provider Directory and the Medication Guide. Using an in-network Specialty Pharmacy to provide these Specialty Drugs lowers the amount you pay for these medications. (Self-administered Drug - An FDA-approved Prescription Drug that you may administer to yourself, as recommended by a Physician. Covered self-administered injectable drugs are denoted with a symbol (SI) in the Medication Guide.) *** Please refer to your plans Medication Guide at www.FloridaBlue.com for additional pharmacy details.**

PLAN 1 GENERIC CHOICE Medication Guide: http://www.bcbsfl.com/DocumentLibrary/Providers/Content/GenericChoicesMedGuide.pdf?_ga=1.213301521.489616663.1440184171

PLAN 2, 3 & 4 Medication Guide: http://www.bcbsfl.com/DocumentLibrary/Providers/Content/MedGuide.pdf?_ga=1.216871187.489616663.1440184171

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	BlueOptions Basic Plan 1	BlueOptions Basic Plan 2 HSA–Compatible	BlueOptions Mid-Plan 3	BlueOptions High Plan 4
Hospital Services				
Hospital Facility Services – Inpatient, Outpatient & Physical Therapy performed at a hospital				
• In-Network	CYD + 20%	Option 1 - CYD + 20% Option 2 - CYD + 25%	CYD + 20%	CYD + 20%
• Out-of-Network	CYD + 40%	CYD + 40%	CYD + 40%	CYD + 40%
Emergency Medical Care Services				
Emergency Room Facility Services				
• In-Network	CYD + 20%	CYD + 20%	CYD + 20%	$200 Copay
• Out-of-Network	OON Ded + 20%	OON Ded + 20%	OON Ded + 20%	$200 Copay (copay waived if admitted)
Ambulance - Ground/Air & Water	No Maximums	No Maximums	No Maximums	No Maximums
• In-Network & Out-of-Network	INN Ded + 20%	INN Ded + 20%	INN Ded + 20%	INN Ded + 20%
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility (IDTF) (includes physician services) In-Network				
• **Advanced Imaging Services** (MRI, MRA, PET, CT, Nuclear Medicine)	CYD + 20%	CYD + 20%	CYD + 20%	$125 Copay Also applicable at office location.
Note: Prior Authorization required for Advanced Imaging Services In-network or Out of Network at IDTF, Physician's Office or Outpatient Hospital *NIA Authorizations 1-866-326-6302*				
• **Other IDTF Diagnostic Services** (i.e. X-Ray, ultrasound) In-Network	CYD + 20%	CYD + 20%	CYD + 20%	$50 Copay
Out Of Network Diagnostic Services	CYD + 40%	CYD + 40%	CYD + 40%	CYD + 40%
****Mental Health and Substance Abuse Services**				
Office Visit				
• In-Network Family Physician	20%	CYD + 20%	20%	20%
• In-Network Specialist	CYD + 20%	CYD + 20%	CYD + 20%	CYD + 20%
• Out-of-Network	CYD + 40%	CYD + 40%	CYD + 40%	CYD + 40%
Inpatient/Outpatient Hospital Facility Services				
• In-Network	CYD + 20%	CYD + 20%(Option 1 & Option 2 hospitals)	CYD + 20%	CYD + 20%
• Out of Network	CYD + 40%	CYD + 40%	CYD + 40%	CYD + 40%
Emergency Room Facility Services				
• In-Network	CYD + 20%	CYD + 20%	CYD + 20%	$200 Copay
• Out of Network	OON Ded + 20%	OON Ded + 20%	OON Ded + 20%	$200 Copay (copay waived if admitted)
Provider Services at Hospital and Emergency Room				
• In-Network	CYD + 20%	CYD + 20%	CYD + 20%	$0
• Out of Network	INN Ded + 20%	INN Ded + 20%	INN Ded + 20%	$0

****Utilization Management/Prior Authorization programs are applicable for Mental Health and Substance Abuse Services. New Directions Behavioral Health at 1-866-287-9569.**

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Other Types of Facilities and Provider Services				
Ambulatory Surgical Center Facility Services • In-Network • Out-of-Network	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 $100 Copay CYD + 40%
Provider Services at Hospital, and ER • In-Network • Out-of-Network	 CYD + 20% INN Ded + 20%	 CYD + 20% INN Ded + 20%	 CYD + 20% INN Ded + 20%	 CYD + 20% INN Ded + 20%
Radiology, Pathology, Anesthesiology Provider Services at an Ambulatory Surgical Center • In-Network • Out-of-Network	 CYD + 20% INN Ded + 20%	 CYD + 20% INN Ded + 20%	 CYD + 20% INN Ded + 20%	 CYD + 20% INN Ded + 20%
Provider Services at Locations other than Office, Hospital and Emergency Room • In-Network Family Physician • In-Network Specialist • Out-of-Network	 CYD + 20% CYD + 20% CYD + 40%	 CYD + 20% CYD + 20% CYD + 40%	 CYD + 20% CYD + 20% CYD + 40%	 CYD + 20% CYD + 20% CYD + 40%
Home Health Care *Care Centrix 1-877-561-9910* • In-Network • Out-of-Network	CYM 30 visits CYD + 20% CYD + 40%	CYM 30 visits CYD + 20% CYD + 40%	CYM 30 visits CYD + 20% CYD + 40%	CYM 30 visits CYD + 20% CYD + 40%
Outpatient Therapy + Spinal Manipulations Cardiac Rehabilitation, Occupational Therapy, Speech Therapy, Physical Therapy, Massage Therapy & Spinal Manipulations • In-Network • Out-of-Network	CYM 75 visits (Includes up to 26 Spinal Manipulations) CYD + 20% CYD + 40%	CYM 75 visits (Includes up to 26 Spinal Manipulations) CYD + 20% CYD + 40%	CYM 75 visits (Includes up to 26 Spinal Manipulations) CYD + 20% CYD + 40%	CYM 75 visits (Includes up to 26 Spinal Manipulations) CYD + 20% CYD + 40%
Skilled Nursing Facility • In-Network • Out-of-Network	CYM 60 days CYD + 20% CYD + 40%	CYM 60 days CYD + 20% CYD + 40%	CYM 60 days CYD + 20% CYD + 40%	CYM 60 days CYD + 20% CYD + 40%
Hospice - Unlimited • In-Network • Out-of-Network	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%
Durable Medical Equipment (DME) & Prosthetics/Orthotics • In-Network • Out-of-Network *DME Prior Authorization: Care Centrix 1-877-561-9910*	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%
Maternity • In-Network Specialist • Out-of-Network	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%	 CYD + 20% CYD + 40%
Allergy Injections • In-Network Family Physician • In-Network Specialist • Out-of-Network	 $10 Copay CYD + 20% CYD + 40%	 CYD + 20% CYD + 20% CYD + 40%	 $10 Copay CYD + 20% CYD + 40%	 $10 Copay CYD + 20% CYD + 40%

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail. The information contained in benefit overview includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency.

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