

PCSB Health Plan 2012 Plan Year



FLORIDA

An Independent Licensee of the
Blue Cross and Blue Shield Association

HEALTH INSURANCE

Risk Management Customer Service: 863-519-3858

BCBSF Customer Service: 800-664-5295

Website: <http://www.bcbsfl.com>



The Monthly Board Contribution per Employee is \$503.61.

Monthly Premium Deductions*	
TIER	3566 Plan
Employee Only	\$ 0.00
Spouse	\$418.00
1 Child	\$ 95.00
2 Children	\$190.00
3 or More Children	\$215.00



*These premiums include medical coverage through BCBSF and prescription coverage through Medco. Please make sure you have a card from both companies! If you are missing a card, please call the company directly to request one.

SCHEDULE OF BENEFITS

Medical Benefit	PCSB Health Plan	
Lifetime Maximum	Unlimited	
	In-Network / YOU PAY	Out-of-Network*/ YOU PAY
Calendar Year Deductible (CYD)		
<i>Individual</i>	\$750	\$1,500
<i>Family</i>	\$1,500	\$3,000
Calendar Year Out-of-Pocket Maximum	<i>Includes CYD, Copays & Coinsurance</i>	
<i>Individual</i>	\$5,000	
<i>Family</i>	\$9,000	Unlimited
Hospital Services		
Inpatient or Outpatient	Option 1 - CYD +20% Coinsurance Option 2 –CYD + 25% Coinsurance	CYD + 40% Coinsurance
Emergency Room	CYD + 20% Coinsurance	CYD + 20% Coinsurance
Urgent Care	\$40 Copay	CYD + 40% Coinsurance
Outpatient Surgery		
Ambulatory Surgical Center Facility Services	CYD + 20% Coinsurance	CYD + 40% Coinsurance
Hospital Facility Services	Option 1 - CYD + 20% Coinsurance Option 2 – CYD + 25% Coinsurance	CYD + 40% Coinsurance
Family Physician Office Visit <i>(Includes General Practice, Family Practice, Internal Medicine & Pediatrics)</i>	\$40 Copay	CYD + 40% Coinsurance
Specialist Physician Office Visit <i>(Includes all other physician specialties)</i>	\$40 Copay	CYD + 40% Coinsurance
Maternity Care		
OB Specialist	\$40 (Initial OB Visit Only)	
Hospital Services	Option 1 - CYD +20% Coinsurance Option 2 –CYD + 25% Coinsurance	CYD + 40% Coinsurance
Outpatient Therapy <i>(Includes Cardiac, Occupational, Physical, Speech & Massage Therapies and Chiropractic Visits)</i>	Option 1 - CYD + 20% Coinsurance Option 2 – CYD + 25% Coinsurance	CYD + 40% Coinsurance
Benefit Period Maximum	35 Visits <i>(Includes up to 26 Spinal Manipulations)</i>	35 Visits <i>(Includes up to 26 Spinal Manipulations)</i>
Independent Clinical Lab <i>(outside the office visit setting)</i>	CYD	CYD + 40% Coinsurance
Independent Diagnostic Testing Facility (IDTF) <i>(includes physician services)</i>		
Advanced Imaging <i>(MRI, MRA, PET, CT, Nuclear Medicine)</i>	CYD + 20% Coinsurance	CYD + 40% Coinsurance
Routine Preventive Health & Screening Services <i>(includes well-woman exam)</i>	No Maximum	No Maximum
Family Physician/PCP or Specialist	\$0	CYD + 40% Coinsurance

SCHEDULE OF BENEFITS

Medical Benefit	PCSB Health Plan	
Preventive or Diagnostic Mammogram	\$0	\$0
Colonoscopy (Routine)	\$0	CYD + 40% Coinsurance
Colonoscopy (Diagnostic) Ambulatory Surgical Center	\$0	CYD + 40% Coinsurance
Outpatient Hospital	Option 1 – 20% Coinsurance (CYD Waived) Option 2 – 25% Coinsurance (CYD Waived)	
Mental Health & Substance Abuse Inpatient/Outpatient	CYD + 20% Coinsurance	CYD + 40% Coinsurance
Provider Services at Hospital and ER	CYD + 20% Coinsurance	CYD + 20% Coinsurance
Skilled Nursing Facility	CYD + 20% Coinsurance	CYD + 40% Coinsurance
	Limited to 60 days per Benefit Period	Limited to 60 days per Benefit Period

* **Diabetic** Supplies are not covered as the Rx benefit is carved out. Diabetic Equipment (insulin pumps, tubing) are covered under the medical benefit.

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 your Health Plan. For a complete description of benefits and exclusions, please refer to the Summary Plan Description (SPD). The written terms of the SPD prevail.