



FAQ's



Q. Is Blue Cross Blue Shield of Florida (BCBSFL) my insurance plan?

A. No, the School Board of Polk County is a self-funded plan. Blue Cross Blue Shield of Florida (BCBSFL) administers the benefits for the school board as the Third Party Administrator. The services that BCBSFL provides to our members include access to its provider network, claims administration, customer service, and various utilization and disease management programs.

Q. What is covered under my plan?

A. Covered medical expenses or any medically necessary treatments, services, or supplies that are not specifically excluded for coverage are generally covered under the plan. As long as you use participating providers claims are paid at the higher benefit level. Remember: Just because your physician says a treatment is medically necessary does not mean it is covered under the plan. It's a good idea to have your provider verify coverage before you begin a treatment.

Q. Do I have to select a Primary Care Physician (PCP)?

A. No. Under the PCSB health benefit plan, you are free to see **any** Participating Physician in the network.

Q. Do I have to utilize a Specialist in the same group/clinic as my Primary Care Provider (PCP)?

A. No, you do not have to utilize a Specialist in the same group/clinic as your PCP. Most groups/clinics will direct you to physicians within the group/clinic; however, you may use any participating specialist with the School Board of Polk County Network.

Q. How do I find a doctor or hospital that accepts my insurance?

A. Use BCBSFL online provider search capability to determine if a provider is participating in your plan options network. Simply log on to www.bcbsfl.com. You can access the provider directory right from the home page. The network for the 3160/3161 & the 3566 Plan Options is NetworkBlue; the network for the 704 Plan Option is BlueChoice (Preferred Patient Care PPO). You may also call the number on your ID card and speak to a Customer Service Representative

Q. Why is the ambulance company billing me directly? Are these bills covered by my insurance?

A. At this time, there are no participating or contracted air or ground emergency transport services. Because the BCBS of Florida network does not have a participating provider for these services, allowable claims will be processed at 80% of the eligible and approved billed charges. The emergency service provider may balance bill you. Keep in mind if an ambulance is called and the patient is NOT transported, the charge is NOT covered.

****This information does not guarantee benefits or coverage.** Every effort has been made to report information accurately. However, all information, including the amount of any benefit and employee eligibility for benefits, is subject to and governed by the terms and conditions of the applicable contract, policy or plan document. In all cases where any of the information provided in this guide differs from the amount of benefit actually provided, the terms of the legal documents will control. Employees are encouraged to check their December check to ensure any payroll deductions reflect the enrollment decisions you have made for the 2011 Plan Year. Please notify PCSB Benefits Department immediately if anything appears to be incorrect.



FAQ's



- Q.** **Do I have coverage if I go to an Out-of-network provider?**
A. Yes you do, however, there will be a difference in the amount that you are responsible to pay. This includes but is not limited to; an increase in the deductible and coinsurance as well as the difference between the provider's fee and the plan allowance.
- HELPFUL HINTS WHEN USING AN OUT-OF-NETWORK PROVIDER**
If you are unable to locate a network provider and need to use the services of an out-of-network provider when traveling or residing outside of Florida, you should:
- Have an alternative method of payment available;
 - Keep all receipts in order to file a claim with BCBS of Florida for reimbursement;
 - Contact BCBS of FL for information to receive the appropriate forms in order to file an out-of-network claim.
- Q.** **Is there any way to reduce or eliminate the Pre-existing Condition exclusion from my policy?**
A. You may be able to reduce or even eliminate the Pre-existing Conditions exclusionary period if you have prior Creditable Coverage. If you are enrolling when you are first eligible for coverage and you have no more than a 63 day break in Creditable Coverage as of your Effective Date under this plan, your Pre-existing Conditions exclusionary period will be reduced by the amount of prior Creditable Coverage you have. Effective January 1, 2011 the pre-existing conditions exclusionary period has been eliminated for children up to the age of 19.
- Q.** **What is considered creditable coverage?**
A. Creditable Coverage is health care coverage that includes any of the following:
1. A group health insurance plan;
 2. Individual health insurance;
 3. Medicare Part A and Part B;
 4. Medicaid;
 5. Benefits to members and certain former members of the uniformed services and their dependents;
 6. A medical care program of the Indian Health Service or of a tribal organization;
 7. State Children's Health Insurance Program (SCHIP);
 8. Public health plans established by the federal government.
- Q.** **How do I prove my creditable coverage?**
A. You may provide a Prior/Concurrent Coverage affidavit or Certification of Creditable Coverage to the Employee Benefits Department to prove the amount of time you were covered under Creditable Coverage. Prior health insurers and/or group health plans are required to provide a certification of Creditable Coverage to you upon termination of your coverage and at any time upon request up to 24 months after termination of your prior health coverage.

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