

Attachment D
School Board of Polk County
2010 MEDICAL PLAN SCHEDULE OF BENEFITS
COMPARISON

Medical Benefit	3160/3161		3566 Plan		704 (Current) Plan	
<i>Lifetime Maximum</i>						
\$5,000,000 - Cumulative for all plans						
	In-Network / YOU PAY	Out-of-Network*/ YOU PAY	In-Network / YOU PAY	Out-of- Network*/ YOU PAY	In-Network / YOU PAY	Out-of-Network*/ YOU PAY
<i>Calendar Year Deductible (CYD)</i>						
<i>Individual</i>	\$1,250	\$2,500	\$750	\$1,500	\$250	\$1,000
<i>Family</i>	\$2,500	\$5,000	\$1,500	\$3,000	\$500	\$2,000
<i>Calendar Year Out-of-Pocket Maximum</i>	<i>Includes CYD & Coinsurance</i> \$5,000 \$5,000* <i>The Individual & Family out-of- pocket maximum is the same.</i>	<i>Includes CYD & Coinsurance</i> \$10,000 \$10,000 * <i>The Individual & Family out-of- pocket maximum is the same.</i>	<i>Includes CYD & Coinsurance</i> \$5,000 \$10,000	Unlimited	<i>Includes only Coinsurance</i> \$2,500 \$5,000	Unlimited
<i>Individual Family</i>						
<i>Hospital Services Inpatient or Outpatient</i>	Option 1 - CYD +20% Coinsurance Option 2 –CYD + 15% Coins.	CYD + 40% Coinsurance	CYD +20% Coinsurance	CYD + 25% Coinsurance	CYD +20% Coinsurance	CYD + 40% Coinsurance
<i>Emergency Room (Copay waived if admitted)</i>	CYD +20% Coinsurance	CYD + 40% Coinsurance	CYD + 20% Coinsurance	CYD + 40% Coinsurance	CYD + 20% Coinsurance	CYD + 40% Coinsurance
<i>Urgent Care</i>	CYD +20% Coinsurance	CYD + 40% Coinsurance	CYD + 20% Coinsurance	CYD + 40% Coinsurance	\$20 Copay	CYD + 40% Coinsurance
<i>Outpatient Surgery Ambulatory Surgical Center Facility Services</i>	CYD +20% Coinsurance	CYD + 40% Coinsurance	CYD + 20% Coinsurance	CYD + 40% Coinsurance		
<i>Hospital Facility Services</i>	Option 1 - CYD + 20% Coinsurance Option 2 – CYD + 15% Coinsurance	CYD + 40% Coinsurance	Option 1 - CYD + 20% Coinsurance Option 2 – CYD + 25% Coinsurance	CYD + 40% Coinsurance	CYD + 20% Coinsurance	CYD + 40% Coinsurance
<i>Family Physician Office Visit (Includes General Practice, Family Practice, Internal Medicine & Pediatrics)</i>	CYD +20% Coinsurance	CYD + 40% Coinsurance	\$25 Copay	CYD + 40% Coinsurance	\$20 Copay	CYD + 40% Coinsurance
<i>Specialist Physician Office Visit (Includes all other physician specialties)</i>	CYD + 20% Coinsurance	CYD + 40% Coinsurance	\$50 Copay	CYD + 40% Coinsurance	\$30 Copay	CYD + 40% Coinsurance

Outpatient Therapy (Includes Cardiac, Occupational, Physical, Speech & Massage Therapies and Chiropractic Visits)	Option 1 - CYD + 20% Coinsurance Option 2 – CYD + 15% Coinsurance	CYD + 40% Coinsurance	Option 1 - CYD + 20% Coinsurance Option 2 – CYD + 25% Coinsurance	CYD + 40% Coinsurance	\$30 Copay for Office Visit Services (Plan pays up to \$5000 maximum benefit per calendar year)	CYD + 40% Coinsurance (Plan pays up to \$5000 maximum benefit per calendar year)
Independent Clinical Lab (outside the office visit setting)	CYD + 20% Coinsurance	CYD + 40% Coinsurance	CYD	CYD + 40% Coinsurance	20% Coinsurance (CYD is waived)	40% Coinsurance (CYD is waived)
Independent Diagnostic Testing Facility (IDTF) <i>(includes physician services)</i> Advanced Imaging (MRI, MRA, PET, CT, Nuclear Medicine)	CYD + 20% Coinsurance	CYD + 40% Coinsurance	CYD + 20% Coinsurance	CYD + 40% Coinsurance	Determined by Place of Service	Determined by Place of Service
Routine Preventive Health & Screening Services (includes well-woman exam) Family Physician/PCP or Specialist	No Maximum 20% Coinsurance (NO DEDUCTIBLE)	\$150 40% Coinsurance (NO DEDUCTIBLE)	No Maximum \$25 FP \$50 SP (NO DEDUCTIBLE)	\$150 40% Coinsurance (NO DEDUCTIBLE)	\$30 Copay for office visit services 20% Coinsurance outside office visit setting CYD is waived for these services only when they are preventive (not diagnostic) Up to \$250 maximum benefit per calendar year.	40% Coinsurance CYD is waived for these services only when they are preventive (not diagnostic) Up to \$250 maximum benefit per calendar year.
Preventive or Diagnostic Mammogram	\$0	\$0	\$0	\$0	\$0	\$0

Prescription Drugs			
	Generic	Preferred Brand	Non-Preferred Brand
Retail 30	\$8	\$30 + 10% (max \$60)	\$50 + 10% (max \$100)
Retail 90	\$8	\$90 + 10% (max \$180)	\$150 + 10% (max \$300)
Mail 90	\$8	\$75	\$125

This information is produced by the Risk Management and Insurance Department of the Polk County School Board. Any errors or omissions are not intentional. The provisions of the actual insurance policies and plan documents determine the covered benefits.