

# Lake-Sumter County Medical Society Health Plan Comparison

## Effective January 1, 2012– Physician Plans



**BlueCross BlueShield of Florida**  
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### Physician Plan D BlueChoice PPO

### Physician Plan E BlueOptions®

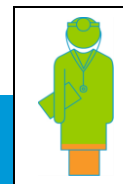
### Physician Plan F – HSA Plan BlueOptions

Provider Network	PPO	Provider Network	NetworkBlue	Provider Network	NetworkBlue
<b>Calendar Year Deductible (CYD)</b> <i>(2x per family)</i> <b>(Amount you pay)</b>	Individual \$2,500 Family \$5,000 In Network and Out of Network Combined	<b>Calendar Year Deductible (CYD)</b> <i>(3x per family)</i> <b>(Amount you pay)</b>	Single \$1,000 Family \$3,000 In Network and Out of Network Combined	<b>Calendar Year Deductible (CYD)</b> <i>Per Individual/Per Family</i> <b>(Amount you pay)</b>	Individual In Network \$2,500 Out of Network \$5,000 Family In Network \$5,000 Out of Network \$10,000
<b>Coinsurance</b> <b>(Amount you pay)</b>	In Network 20% Out Of Network 50%	<b>Coinsurance</b> <b>(Amount you pay)</b>	In Network 20% Out Of Network 30%	<b>Coinsurance</b> <b>(Amount you pay)</b>	In Network 20% Out Of Network 40%
<b>Annual Maximum Out-of-Pocket per Calendar Year</b> <b>(Amount you pay)</b>  <i>Includes Coinsurance, and RX, does not include CYD</i>	Individual \$2,500 Family \$5,000 In Network and Out of Network Combined	<b>Annual Maximum Out-of-Pocket per Calendar Year</b> <b>(Amount you pay)</b>  <i>Includes Deductible, co-pays &amp; Coinsurance (Excludes RX)</i>	Individual \$2,000 Family \$6,000 In Network and Out of Network Combined	<b>Annual Maximum Out-of-Pocket per Calendar Year</b> <b>(Amount you pay)</b>  <i>Includes Deductible, Coinsurance &amp; RX</i>	Individual In Network \$5,000 Out of Network \$10,000 Family In Network \$10,000 Out of Network \$20,000
<b>Lifetime Maximum</b> Per covered member	Unlimited	<b>Lifetime Maximum</b> Per covered member	Unlimited	<b>Lifetime Maximum</b> Per covered member	Unlimited
<b>Office Visits</b> <b>(Amount you pay)</b>	In-Network, CYD, then 20% coinsurance Out of Network CYD, then 50% coinsurance	<b>Office Visits In-Network</b> <b>(Amount you pay)</b>	In-Network, CYD, then 20% Coinsurance, Out of Network CYD, then 30% coinsurance	<b>Office Visits In-Network</b> <b>(Amount you pay)</b>	In-Network, CYD, then 20% Coinsurance, Out of Network CYD, then 40% coinsurance
<b>In Office Physician Administered Medications: Amount you Pay In-Network. In-Network:</b> 20% coinsurance up to member maximum monthly out of pocket \$200. Exception: HSA plan CYD applies. <b>Out of Network:</b> CYD, then 50% coinsurance (no monthly member maximum out of network pocket)					
<b>Urgent Care Centers</b> <b>(Amount you pay)</b>	In-Network CYD, then 20% coinsurance Out of Network CYD, then 50% Coinsurance	<b>Urgent Care Centers</b> <b>(Amount you pay)</b>	In-Network CYD, then 20% coinsurance Out of Network CYD, then 30% Coinsurance	<b>Urgent Care Centers</b> <b>(Amount you pay)</b>	In-Network CYD, then 20% coinsurance Out of Network CYD, then 40% Coinsurance

Note: Out of Network providers can balance bill for amount above BCBSF allowance. In Network Providers not permitted to balance bill.

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<b>Radiology Services at Physician Office: (MRI, MRA, PET, CT, Nuclear Medicine) (Amount you pay)</b> <i>Subject to Prior Authorization</i>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 50% coinsurance	<b>Radiology Services at Physician Office: (MRI, MRA, PET, CT, Nuclear Medicine) (Amount you pay)</b> <i>Subject to Prior Authorization</i>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 30% coinsurance	<b>Radiology Services at Physician Office: (MRI, MRA, PET, CT, Nuclear Medicine) (Amount you pay)</b> <i>Subject to Prior Authorization</i>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 40% coinsurance
<b>Hospital Facility In Patient and Outpatient (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 50% coinsurance	<b>Hospital Facility In Patient and Outpatient (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 30% coinsurance	<b>Hospital Facility In Patient and Outpatient (Amount you pay)</b>	In-Network CYD, then 20%/25* coinsurance  Out of Network CYD, then 40% coinsurance
<b>Hospital Emergency Room Facility (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 20% coinsurance	<b>Hospital Emergency Room Facility (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 20% coinsurance	<b>Hospital Emergency Room Facility (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 20% coinsurance
<b>Physician Services in Hospital &amp; Emergency Room Facility (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 20% coinsurance	<b>Physician Services Network Hospital &amp; Emergency Room Facility (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 20% coinsurance	<b>Physician Services In-Network Hospital &amp; Emergency Room Facility (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 20% coinsurance
<b>Ambulatory Surgical Center (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 50% coinsurance	<b>Ambulatory Surgical Center (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 30% coinsurance	<b>Ambulatory Surgical Center (Amount you pay)</b>	In-Network CYD, then 20% coinsurance  Out of Network CYD, then 40% coinsurance


\* 25% Option 2 Hospital Facility In-Patient or Out Patient. See BCBSF Provider Directory for hospital facility tier status.

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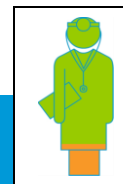


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Physician Plan D BlueChoice PPO		Physician Plan E BlueOptions®		Physician Plan F – HSA Plan BlueOptions	
<b>Independent Diagnostic Testing Facility Services</b> (Amount you pay)  <b>(MRI, MRA, PET, CT, Nuclear Medicine) – Subject to Prior Authorization</b>  <b>(Other Radiology Diagnostic Services)</b>	<b>Radiology Services</b> <b>Subject to Prior Authorization</b>  In-Network CYD, then 20% coinsurance  In-Network CYD, then 20% coinsurance  Out of Network Radiology CYD, then 50% coinsurance	<b>Independent Diagnostic Testing Facility Services</b> (Amount you pay)  <b>MRI, MRA, PET, CT, Nuclear Medicine) – Subject to Prior Approval</b>  <b>(Other Radiology Diagnostic Services)</b>	<b>Radiology Services</b> <b>Subject to Prior Authorization</b>  In-Network \$ 100 Co-payment  In-Network \$50 Co-payment  Out of Network Radiology CYD, then 30% Coinsurance	<b>Independent Diagnostic Testing Facility Services</b> (Amount you pay)  <b>MRI, MRA, PET, CT, Nuclear Medicine) – Subject to Prior Approval</b>  <b>(Other Radiology Diagnostic Services)</b>	<b>Radiology Services</b> <b>Subject to Prior Authorization</b>  In-Network CYD, then 20% coinsurance  In-Network CYD, then 20% coinsurance  Out of Network Radiology CYD, then 40% Coinsurance
<b>Independent Clinical Lab Services</b> (Amount you pay)	In-Network CYD, then 20% Coinsurance (Quest Diagnostics)  Out of Network CYD, then 50% Coinsurance	<b>Independent Clinical Lab Services</b> (Amount you pay)	\$ In-Network -0- Member cost (Quest Diagnostics)  Out of Network CYD, then 30% Coinsurance	<b>Independent Clinical Lab Services</b> (Amount you pay)	In-Network CYD, then 20% Coinsurance (Quest Diagnostics)  Out of Network CYD, then 40% Coinsurance
	Current In-Network Independent Clinical Lab Provider: Quest Diagnostics. Log-on to <a href="http://www.questdiagnostics.com">www.questdiagnostics.com</a> or call 1-800-377-8448 to find locations, schedule an appointment, receive reminders, visit on-line library, more.				

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## Routine Well Care

<b>Well Child Care Birth through Age 16</b>	Unlimited Annual Benefit  Waive Deductible, Paid at 100% In-Network, Coinsurance applies Out of Network	<b>Well Child Care Birth through Age 16</b>	Unlimited Annual Benefit  Waive Deductible, Paid at 100% In-Network, Coinsurance applies Out of Network	<b>Well Child Care Birth through Age 16</b>	Unlimited Annual Benefit  Waive Deductible, Paid at 100% In-Network, Coinsurance applies Out of Network
<b>Adult Routine Physical Exam</b>	Unlimited Annual Benefit  Waive Deductible, Paid at 100% In-Network, Coinsurance applies Out of Network	<b>Adult Routine Physical Exam</b>	Unlimited Annual Benefit  Waive Deductible, Paid at 100% In-Network, Coinsurance applies Out of Network	<b>Adult Routine Physical Exam</b>	Unlimited Annual Benefit  Waive Deductible, Paid at 100% In-Network, Coinsurance applies Out of Network
<b>Mammograms (Routine and Diagnostic)</b>	Waive Deductible, Paid at 100% of Allowance	<b>Mammograms (Routine and Diagnostic)</b>	Waive Deductible, Paid at 100% of Allowance	<b>Mammograms (Routine and Diagnostic)</b>	Waive Deductible, Paid at 100% of Allowance
<b>Colonoscopy (Routine for age 50+)</b>	Not Covered	<b>Colonoscopy (Routine for age 50+)</b>	Waive Deductible, Paid at 100% of Allowance	<b>Colonoscopy (Routine for age 50+)</b>	Waive Deductible, Paid at 100% of Allowance

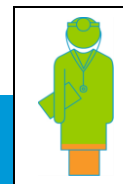


Adult Routine Wellness services include annual routine physicals, screenings, related blood work, family planning, and immunizations. Visit BCBSF website for information on wellness and services routinely performed for you based on your age, gender, and family history. [www.bcbsfl.com](http://www.bcbsfl.com)

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### Other Services, Provisions and Maximum Benefits

<b>Outpatient Rehabilitative Services</b>	Annual Maximum: 75 visits Subject to CYD & Coinsurance	<b>Outpatient Rehabilitative Services</b>	Annual Maximum: 75 visits Subject to CYD & Coinsurance	<b>Outpatient Rehabilitative Services</b>	Annual Maximum: 75 visits Subject to CYD & Coinsurance
<b>Outpatient Rehabilitative Services include:</b> Medically Necessary Chiropractic, Physical Therapy, Massage Therapy, Speech Therapy, and Occupational Therapy. Medical Policy Guidelines apply.					
<b>Hospice</b>	Unlimited Subject to CYD & Coinsurance	<b>Hospice</b>	Unlimited Subject to CYD & Coinsurance	<b>Hospice</b>	Unlimited Subject to CYD & Coinsurance
<b>Accidents</b>	Waive CYD Coinsurance Applies	<b>Accidents</b>	Waive CYD Coinsurance Applies	<b>Accidents</b>	Subject to CYD & Coinsurance
<b>Durable Medical Equipment</b>	Subject to CYD & Coinsurance	<b>Durable Medical Equipment</b>	Subject to CYD & Coinsurance	<b>Durable Medical Equipment</b>	Subject to CYD & Coinsurance
<b>Home Health Care</b>	Annual Maximum: 30 visits	<b>Home Health Care</b>	Annual Maximum: 30 Visits	<b>Home Health Care</b>	Annual Maximum: 30 Visit
<b>Mental and Nervous Services</b> <i>Prior Authorization applies</i>	<b>Subject to Prior Authorization</b> In compliance with Mental Health Parity Federal Mandate	<b>Mental and Nervous Services</b> <i>Prior Authorization applies</i>	<b>Subject to Prior Authorization</b> In compliance with Mental Health Parity Federal Mandate	<b>Mental and Nervous Services</b> <i>Prior Authorization applies</i>	<b>Subject to Prior Authorization</b> In compliance with Mental Health Parity Federal Mandate
<b>Substance Dependency Services</b> <i>Prior Authorization applies</i>	<b>Subject to Prior Authorization</b> In compliance with Mental Health Parity Federal Mandate	<b>Substance Dependency Services</b> <i>Prior Authorization applies</i>	<b>Subject to Prior Authorization</b> In compliance with Mental Health Parity Federal Mandate	<b>Substance Dependency Services</b> <i>Prior Authorization applies</i>	<b>Subject to Prior Authorization</b> In compliance with Mental Health Parity Federal Mandate

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## Pharmacy Benefits

Prescription Drugs Amount you Pay	Mediscript	Prescription Drugs Amount you Pay	Bluescript	Prescription Drugs Amount you Pay	Bluescript
<b>Retail = 30 Day Supply In-Network</b>	Calendar Year Deductible, then Member Pays	<b>Retail = 30 Day Supply In-Network</b>	No Pharmacy Deductible Member Pays	<b>Retail = 30 Day Supply In-Network</b>	Calendar Year Deductible, then Member pays
<b>Retail = 90 day Supply at In-Network Extended Supply Providers**</b>	Generic 50% Preferred Brand 50% Non Preferred Brand 50%	<b>Retail = 90 day Supply at In- Network Extended Supply Provider**</b>	Generic 20% Preferred Brand 30% Non Preferred Brand 40%	<b>Retail = 90 day Supply at In- Network Extended Supply Provider**</b>	Generic 20% Preferred Brand 30% Non-Preferred Brand 50%
	Member receives discount at point of sale, pays for prescription and files for reimbursement.		<b>Specialty Drugs*</b> <b>\$100 Co-payment per 30 day supply at CareMark.</b>		

- ✓ \*Pharmacy Medication Guide available at [www.bcbsfl.com](http://www.bcbsfl.com),
- ✓ CareMark is exclusive in-network specialty drug provider.
- ✓ All other providers (including Prime mail) are out of network providers for specialty drugs and subject to out of network pharmacy benefits.
- ✓ Out of Network Pharmacy services subject to pharmacy deductible (where applicable) and paid at 50% of allowance.
- ✓ Pharmacy Program includes Oral Contraceptives, diabetic supplies; self injected medications and specialty drugs.
- ✓ \*\*90 day supply available at select retail extended supply pharmacies. Visit BCBSF website provider directory for retail pharmacy provider details and participation status.
- ✓ Pharmacy Utilization Programs (e.g.) Responsible RX, Mandatory Generic Rx, Drug Exclusion, apply to all plans. See BCBSF Medication Guide for more details.

Mail Order Amount you Pay Prime Therapeutics = 90 day Supply	No-Mail Order		No-Mail Order
			
		Generic \$20 Preferred Brand \$80 Non-Preferred Brand \$140	

This is a summary of benefits and not a contract. All benefits are subject to the provisions, exclusions and limitations set forth in the master contract. To verify a provider's specialty or participation on status, the insured may contact the local BCBSF office, contact the provider's office, or review the most recent Provider Directory. It is the insured's sole responsibility to select and verify a provider's network participation status and the time services are rendered. 10/27/11 jg

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