CITY OF GAINESVILLE BENEFIT SUMMARY 2013

CITY OF GAINESVILLE - SELF-INSURED PPO PLAN **BENEFIT PERIOD: 1/1/2013 to 12/31/2013**

WHAT THE PLAN COVERS & WHAT IT COSTS **COVERAGE-BCBS BLUEOPTIONS PLAN TYPE - PPO**

THIS IS NOT A POLICY (Summary Plan Description) - A policy has more detail about how to use the plan and about what you and your insurer must do. It also has more detail about coverage. To obtain a copy go to the City internet web site at: http://www.cityofgainesville.org/GOVERNMENT/CityDepartmentsNZ/RiskManagmentDepartment/BenefitForms/tabid/657/Default.aspx

IMPORTANT QUESTIONS	ANSWERS	WHY THIS MATTERS
What is the premium for full-time employees?	Employee only - $18.74/pp Emp./Spouse - $160.91/pp Emp./Child - $99.02/pp Family - $194.91/pp	The premium is the amount paid each pay period for health insurance. Premiums are "tiered" based on the member's selected coverage.
What is the overall deductible (DED)?	$500/year/covered person $1,500/year for a family Copayments don't apply	The amount you pay for health care expenses before reimbursement of covered health care expenses begin. After the annual deduction is met the member pays a a co-insurance amount based on in or out-of-network services.
Are there other deductibles for specific services?	$50/person/month for medical pharmacy	You must pay for medical pharmacy expenses even after meeting the overall calendar year deductible. These are certain medications administered in a physican's office
Is there an out-of-pocket limit on my expenses?	$3,000 per individual $6,000 per family In-network limits	The maximum amount a member must pay out-of-pocket during the benefit period. After the maximum is met the insurer covers all expenses. This limit helps you plan for health care expenses. "Out-of-network" limits are higher
What is not included in the out-of-pocket limit?	Pharmacy Co-pays, premiums, balance billed charges, and non-covered services	Even though you pay for these expenses they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the insurer pays?	No There is no overall annual limit	A complete list of covered services may be found in the policy An abbreviated list of covered services can be found on page 5 of this document
Does this plan use a network of providers?	Yes For a list of in-network providers go to www.BCBSFL.com	To maximize cost savings the City has an agreement with Blue Cross and Blue Shield to provide an affiliation with physicians, hospitals, and other providers who provide health care services at substantial savings to plan members.
Do I need a referral to see a specialist?	No You do not need a referral	The City's PPO plan allows members to use any specialist they select without pre-approval by a primary care physician. A member will see substantial savings if they use specialists in the "network".
Are there services this plan doesn't cover?	Yes	A complete list of non-covered services may be found in the policy An abbreviated list of non-covered services can be found on page 5 of this document

CITY OF GAINESVILLE SELF-INSURED PPO PLAN — BENEFIT PERIOD JANUARY 1, 2013 TO DECEMBER 31, 2103

SUMMARY OF COVERAGE: WHAT PLAN COVERS AND COSTS — COVERAGE-BCBS BLUEOPTIONS PLAN TYPE PPO

COVERED SERVICES, COST SHARING, LIMITATIONS and EXCEPTIONS

- Copayments are a predetermined (flat) fee that you pay for health care services. (annual deductible does not apply)
- Co-insurance, represented by a percentage, is the sharing of the bill for any covered services and begins after you have met the annual deductible. A member's in-network co-insurance is 20% for covered services after they have met the annual deductible.
- The plan's payment for covered services is based on the "allowed amount" which is the maximum amount a provider contracted with BCBS has agreed to accept as payment. Out-of-network providers may request payment exceeding "allowed amounts". When this happens you will be responsible for the difference between the allowed amount and the charge by the out-of-network provider called "balance billing". You will always receive the best prices for service by remaining in-network.

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS AND EXCEPTIONS
Visit to health care provider or clinic	Family Care Physicians	$15 Co-pay	$500 DED then 40% co-insurance *	* balance billing may apply
	Specialists and other practitioner visits	$500 DED then 20% coinsurance	$500 DED then 40% co-insurance *	* balance billing may apply
	Preventative care screenings & immunizations	100% of allowed amount	100% of allowed amount	
If you have a test	Diagnostic Service - Xray	$50 Copay per visit	$500 DED then 40% co-insurance Balanced billing may apply	Co-pay at approved independent facility only
	Diagnostic test - lab services	100% of allowed amount	$500 DED then 40% co-insurance Balanced billing may apply	100% only at approved independent lab
	Advanced Imaging Services: CT/CAT scans, MRA, MRI, PET scan & nuclear cardiology	$125 Co-pay per visit	$500 DED then 40% co-insurance Balanced billing may apply	Co-pay at approved independent facility only
	Mammograms	100% of allowed amount	100% of allowed amount *	*balance billing may apply
	Routine Colonoscopies for age 50+	100% of allowed amount	100% of allowed amount *	Diagnostic tests require copays or coinsurance

CITY OF GAINESVILLE SELF-INSURED PPO PLAN BENEFIT PERIOD JANUARY 1, 2013 TO DECEMBER 31, 2103

SUMMARY OF COVERAGE: WHAT PLAN COVERS AND COSTS COVERAGE-BCBS BLUEOPTIONS PLAN TYPE PPO

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS AND EXCEPTIONS
If you need drugs to treat your illness or condition	Generic drugs	$10 co-pay retail and specialty drugs; $20 co-pay mail order	40% of non-participating pharmacy allowance	Covers up to a 30 day supply (retail) or 90 day supply (mail order)
	Preferred brand drugs	$30 co-pay retail and specialty drug; $60 co-pay mail order	40% of non-participating pharmacy allowance	Covers up to a 30 day supply (retail) or 90 day supply (mail order)
More pharmacy information may be found at www.BCBSFL.com	Non-preferred brand drugs	$50 co-pay retail and specialty drugs; $100 co-pay mail order	40% of non-participating pharmacy allowance	Covers up to a 30 day supply (retail) or 90 day supply (mail order)
If you have outpatient surgery	Ambulatory Surgical Center	$100 Co-pay per visit	$500 DED then 40% co-insurance *	* balance billing may apply
	Physician/Surgeon fees	$500 DED then 20% coinsurance	$500 DED then 40% co-insurance *	* balance billing may apply
If you need immediate medical attention	Emergency Room Services (Copay waived if admitted)	$100 co-pay per visit	$100 co-pay per visit	
	Emergency Medical Transportation	$500 DED then 20% coinsurance	$500 DED then 20% coinsurance	
	Urgent Care	$30 co-pay per visit	$500 DED then 40% co-insurance *	* balance billing may apply
If you have a hospital stay	Facility Fee	Option 1 - $750 Co-pay per admission Option 2 - $1,000 Co-Pay per admission	$500 DED then 40% co-insurance *	* balance billing may apply
	Physician/Surgeon fees	$500 DED then 20% coinsurance	$500 DED then 40% co-insurance *	* balance billing may apply

QUESTIONS: Visit the web site at www.bcbsfl.com or call (352) 334-5045

If you aren't clear about any of the terms on this form, see the Glossary at http://www.healthcare.gov/glossary/a/

CITY OF GAINESVILLE SELF-INSURED PPO PLAN BENEFIT PERIOD JANUARY 1, 2013 TO DECEMBER 31, 2103

SUMMARY OF COVERAGE: WHAT PLAN COVERS AND COSTS COVERAGE-BCBS BLUEOPTIONS PLAN TYPE PPO

COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS AND EXCEPTIONS
If you have mental health, behavioral health or substance abuse needs	Mental/behavioral health **out_patient** services	Licensed Family physician - $15 co-pay; Licensed Specialist $500 DED then 20% coinsurance;	$500 DED then 40% co-insurance *	* balance billing may apply
	Mental/behavioral health **inpatient** services	$750 co-pay per visit	$500 DED then 40% co-insurance *	* balance billing may apply
	Substance use disorder **outpatient** services	Licensed Family physician - $15 co-pay; Licensed Specialist $500 DED then 20% coinsurance;	$500 DED then 40% co-insurance *	* balance billing may apply
	Substance use disorder **inpatient** services	$750 co-pay per visit	$500 DED then 40% co-insurance *	* balance billing may apply
If you become pregnant	Prenatal & postnatal care	Primary care physician $15 Co-pay; Specialist or other practitioner $500 DED then 20% coinsurance	$500 DED then 40% co-insurance *	* balance billing may apply
	Delivery and all inpatient services	**Option I** - $750 Co-pay per admission **Option II** - $1,000 Co-pay per admission	$500 DED then 40% co-insurance *	* balance billing may apply

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COMMON MEDICAL EVENT	SERVICES YOU MAY NEED	YOUR COST IF YOU USE AN IN-NETWORK PROVIDER	YOUR COST IF YOU USE AN OUT-OF-NETWORK PROVIDER	LIMITATIONS AND EXCEPTIONS
If you have a recovery or other health need	Home health care	30 visits/Benefit Period (BP)	$500 DED then 40% co-insurance *	
	Rehabilitation services	75 visits per BP		
	Skilled nursing care	120 days/BP		
	Durable medical equipment	$500 DED then 20% coinsurance	$500 DED then 40% co-insurance *	* balance billing may apply
	Hospice Services	Unlimited last 12 months of life		Recertification required every 6 mos.
If your child needs dental or eye care	Eye exam Glasses Dental check-up	NOT COVERED	NOT COVERED	Voluntary vision & dental plans are available to employee

EXCLUDED SERVICES & OTHER COVERED SERVICES

Services Your Plan Does Not Cover (This is not a complete list. Check the policy for others)

- Assisted Reproductive Therapy
- Autopsy
- Cosmetic Services
- Elective abortion
- Experimental or Investigational Services
- Private nursing care
- Genetic screening
- Gestational surrogate maternity services
- Hearing Aids
- Orthomolecular therapy
- Sexual reassignment or modification
- Weight control services

Other Covered Services (This is not a complete list. Check the policy for others)

- Acupuncture
- Allergy testing & treatment
- Autism Spectrum Disorder
- Breast reconstructive surgery
- Diabetes outpatient self management
- Dialysis services
- Maternity & newborn services
- Osteoporosis screening, diagnosis, and treatment
- Speech therapy
- Spinal manipulation
- Preventative adult and child services
- Prosthetic devices
- Transplant Services
- Substance dependency care & treatment

QUESTIONS: Visit the web site at www.bcbsfl.com or call (352) 334-5045

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COVERAGE INFORMATION

Your Right to Continue Coverage

You may keep your coverage as a eligible employee if you continue to pay your premiums unless:

- Fraud, material misrepresentation, omission in applying for coverage or benefits
- The knowing misrepresentation, omission or the giving of false information on Enrollment Forms or other forms completed by you or on your behalf
- The City ceases to offer health insurance coverage

COVERAGE INFORMATION - continued

Grievance and Appeal Rights

A grievance is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction or denial of coverage for claims under this health insurance. To file a complaint mail the complaint to :

BLUE CROSS AND BLUE SHIELD OF FLORIDA
ATTENTION: APPEALS AND DISPUTE DEPARTMENT
P.O. BOX 44197
JACKSONVILLE, FL
32231-4197

OR

RISK MANAGEMENT DEPARTMENT
CITY OF GAINESVILLE
P.O. BOX 490, STATION 60
GAINESVILLE, FL
32627-0490

An appeal is a request for your health insurer or plan to review a decision or a grievance again. For more information on the appeals process visit the Blue Cross Blue Shield web page at:

www.bcbsfl.com
select "sitemap" for members
select "frequently asked questions -Claims"

OR

Call (352)-334-5045 for a copy of BCBS's Appeal Procedures

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans

THIS IS NOT A COST ESTIMATOR

Don't use these examples to estimate your actual costs under this plan. The actual care you receive may be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

HAVING A BABY (Normal Delivery)	
•Amount owed to providers: $7,540	
•Plan pays: $5,902	
•Patient pays: $ 1,638	
Sample Care Costs: *	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventative	$40
Total	$7,540
Patient pays:	
Deductibles	$500
Co-pays	$770
Co-insurance	$368
Limits or exclusions	$0
Total	$1,638

* standards and guidelines provided by the Center for Consumer Information and Insurance Oversight(CCIIO)

MANAGING TYPE 2 DIABETES (Routine Maintenance of a Well-controlled Condition using S.W.E.E.T.S. Program)	
•Amount owed to providers: $4,100	
•Plan pays: $3920	
•Patient pays: $180	
Sample Care Costs: *	
Prescriptions	$1,500
Medical equipment and supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventative	$140
Total	$4,100
Patient pays:	
Deductibles	$120
Co-pays	$60
Co-insurance	$0
Limits or exclusions	$0
Total	$180

Note: These numbers assume the patient is participating in the City's diabetes management program. (S.W.E.E.T.'s) If you have diabetes and do not participate in the S.W.E.E.T.'s program, your costs will be higher.. For more information about the S.W.E.E.T.'s program contact Employee Health

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was an excluded or preexisting condition.
- All services and treatments start and ended in the same
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles , co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No, Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advise, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No, Coverage examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge and the reimbursement your plan allows.
and the reimbursement your plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller the number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FHAs) or health reimbursement accounts (HRAs) health