Retiree Benefits

OPEN ENROLLMENT

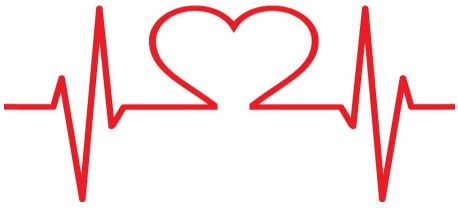
Health Insurance Notification

2017—2018

August 1, 2017—August 31, 2017

LEON COUNTY SCHOOLS

Welcome to Open Enrollment for your Benefits!



Elections you make during open enrollment will become effective October 1, 2017

Capital Health Plan (CHP) and **Florida Blue** will continue to provide health care coverage to Leon County Schools (LCS) for the 2017-2018 plan year, which begins October 1, 2017 and ends on September 30, 2018.

What's New?

Florida Blue will offer a new plan for the 2017-2018 enrollment:

Florida Blue Options 5172/ 5173

- **A new Non-Medicare option**
- **Higher Deductible Plans**
- **Can be combined with a Medicare 03559 plan**
- **10/50/80 RX plan**

***See Rate Sheet and Benefit Summary for additional coverage information**

Frequently Asked Questions

Q. If I am not making any changes to my retiree health coverage, do I need to contact Retiree Benefits?

A. No action or phone call is necessary if you are not making any changes. Your current retiree coverage will continue.

Q. What is Open Enrollment for Retirees?

A. Open enrollment is a period of time when retirees can change healthcare plans or providers.

Q. As a retiree, how many months out of the year do I pay premiums?

A. As a retiree, premiums are paid on a 12-month basis.

Q. How do I make plan or provider changes during Open Enrollment?

A. Contact the LCS Retiree Benefits Office for an appointment during the Open Enrollment Period. Contact information is located on the last page of this booklet.

Q. If I fail to pay my insurance premiums, will I be able to continue coverage?

A. No. Failure to pay for any insurance benefit **will result** in termination of benefits.

Q. Can I add dependents to my retiree coverage during Open Enrollment?

A. No. Dependents for retirees can only be added within thirty days of a Qualifying Event.

Q. What is a Qualifying Event?

A. The marriage or divorce of the retiree.

The death of the retiree's spouse or a dependent.

The birth or adoption of a child by the retiree

Q. Who qualifies as a dependent?

A. 1) A retiree's natural child, step-child, or legally adopted child.

2.) Retiree's legal spouse.

3.) A child for whom the retiree has established legal guardianship.

Eligibility for a dependent child ceases at the end of the calendar year the child turns 26 years old for Capital Health Plan and 30 years old for Florida Blue. **If your child no longer qualifies as a dependent, it is your responsibility to notify Retiree Benefits within the 30 calendar day window.**

Capital Health Plan provides an option for dependents to continue coverage until age 30 by completing an application and paying an additional premium. Contact Retiree Benefits for further details.

The requirements for an overage dependent are different than under 26. At the beginning of the calendar year the dependent turns 26, the child must be:

1. Unmarried and have no dependents of their own **and**
2. A resident of Florida **and**
3. Has no other coverage **and**
4. Is not eligible for Medicare.

Capital Health Plan (CHP) is a Health Maintenance Organization (HMO) and is available only to those retirees who live in the HMO service area. There is no option to use non-network physicians or providers. CHP offers the Capital Selection Plan for retirees under the age of 65 who are not Medicare eligible. CHP also offers the Retiree Advantage Plan for retirees who are Medicare eligible. Refer to the table below to find the rate structure that meets your needs: ****All Rates are based on 12 months.**

NON-MEDICARE PLAN

TYPE OF COVERAGE	PREMIUM
Single	583.92
Two Person	1197.12
Family	1693.51
Overage Dependent	642.31

MEDICARE PLANS

TYPE OF COVERAGE	PREMIUM
Single—Medicare	268.07
Two Person—One Medicare	851.99
Two Person—Two Medicare	536.14
Family—One Medicare	1377.66
Family—Two Medicare	1377.66

For assistance from Capital Health Plan, call 850-383-3311.

CAPITAL HEALTH PLAN

CAPITAL SELECTION (NON-MEDICARE PLAN)

SUMMARY OF BENEFITS

Capital Health PLAN **Capital Selection $15/$30/$50 Rx** Coverage Period: Plans beginning on or after 1/1/2017

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Employee or Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.capitalhealth.com/sbc. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-850-383-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $2,000 single coverage / $4,500 family coverage Pharmacy: $4,600 single coverage / $8,700 family coverage	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription drug brand additional charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers.	Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not Covered	————none————
	Specialist visit	$40 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$100 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	If a generic drug is available, and a more expensive brand name drug is dispensed at the request of the member or the prescriber, the member must pay the copayment amount for the brand name drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug. This additional cost does not count towards your out-of-pocket limit. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 2 drugs	$30/30-day supply $60/60-day supply $90/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 3 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.

	Specialty drugs	$50 /30-day supply	Not Covered	Limited to 30 day supply and may be limited to certain pharmacies. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $100 / visit Hospital: $250 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$40 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$250 / visit	$250 / visit	Copayment is waived if inpatient admission occurs; however if moved to observation status an additional copayment may apply based on services rendered.
	Emergency medical transportation	$100 / transport	$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care: $25 / visit Telehealth :$15 / visit	Urgent care: $25 / visit Telehealth :$15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission $250 / observation	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Physician/surgeon fees	No Charge if admitted. $40 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / visit	Not Covered	————none————
	Inpatient services	$250 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you are pregnant	Office visits	$40 / visit	Not Covered	————none————
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$250 / admission	Not Covered	Prior authorization required. Your benefits/services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/services may be denied.
	Rehabilitation services	$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	Not Covered	Not Covered	————none————

	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-383-3311, 1-877-247-6512.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$250
Other *copayment*	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$13,400**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$250
Other *copayment*	$15

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,155**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$250
Other *copayment*	$0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,200**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination and Accessibility Notice (ACA §1557)

Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Capital Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Capital Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact: Member Services 1-850-383-3311 or 1-877-247-6512, TTY/TDD- 850-383-3534 or 1-877-870-8943.

If you believe that Capital Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943, Fax 850-523-7419, Email memberservices@chp.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–868–1019, 800–537–7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Have a disability? Speak a language other than English? Call to get help for free.
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

Vous souffrez d'un handicap ? Vous parlez une autre langue que l'anglais ? Appelez pour obtenir une aide gratuite. 850 383 3311, 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

هل تعاني من إعاقة؟ هل تتحدث لغة غير اللغة الإنجليزية؟ اتصل للحصول على المساعدة المجانية.
850-383-3311 أو 1-877-247-6512 أو TTY الهاتف النصي/TDD جهاز الاتصال الهاتفي للصم 850-383-3534 أو 1-877-870-8943

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos

Unterstützung zu erhalten. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

ناتوانی خاصی دارید؟ به زبانی بجز انگلیسی صحبت می کنید؟ برای دریافت کمک رایگان با این شماره ها تماس بگیرید. 850-383-3311، 1-877-247-6512، TTY/TDD 850-383-3534 یا 1-877-870-8943

અપંગતા છે? ઇંગલિશ કરતાં અન્ય ભાષા બોલો છો? નિશુલ્ક મદદ મેળવવા કૉલ કરો.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 અથવા 1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis?
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 lub
1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是残障人士吗？您不会说英语吗？请拨打电话以免费获取帮助。电话号码：850-383-3311、 1-877-247-6512；TTY/TDD（听障人士）：850-383-3534 或 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 850-383-3311, 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士? 您是否不會講英語? 請撥打電話以取得免費協助。 850-383-3311、
1-877-247-6512，聽障者請使用 TTY/TDD 850-383-3534 或 1-877-870-8943

พิการหรือเปล่า? พูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษหรือเปล่า? โทรเพื่อขอความช่วยเหลือฟรี
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 หรือ 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 hoặc 1-877-870-8943

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8 am – 5 pm at 850-383-3311 or 1-877-247-6512. State of Florida members can reach Member Services at 1-877-392-1532 from 7 am – 7 pm Monday-Friday. Medicare members please call Capital Health Plan Member Services Department at 850-523-7441 or 1-877-247-6512; October 1 – February 14: 8:00 a.m. – 8:00 p.m., seven days a week; February 15 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday. TTY/TDD (Telecommunication Device for the Deaf) users should call 850-383-3534 or 1-877-870-8943.

Capital Health Plan contact information is located on our website: http://www.capitalhealth.com/Capital-Health-Plan/Contact-Us

Approved by Compliance Committee: 8/23/16

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Capital Selection 15/30/50 Retiree Advantage (HMO)

Schedule of Copayments

Covered Service	Unit	Your Cost (Copayment)
Physician Services (including maternity care)		
Primary Care: Office visit for services provided by your primary care physician during regular office hours	Per Visit	$15
Specialty Care: Office visit for services provided by a participating provider when authorized by your primary care physician	Per Visit	$40
Urgent Care: Office Visit – Urgent care services provided by your primary care physician, or other Capital Health Plan personnel or participating providers including after regular office hours Telehealth – Urgent care services provided by network physicians through remote access technology including the web and other mobile devices	Per Visit Per Visit	$25 $15
Preventive services covered under Original Medicare	Per Visit	$0
Chiropractic Care	Per Visit	$20
Mental health and Substance Use Disorder outpatient care when medically necessary and authorized by the primary care physician	Per Visit	$40
Outpatient procedures, surgical services, and other medical care provided by the primary care physician or by a participating provider when authorized by primary care physician	Per Visit	$40
Hospital Services (including maternity care)		
Room and board in a semiprivate room, or private when medically necessary, and all services covered under this agreement	Per Admission	$250
Outpatient procedures performed in a hospital	Per Visit	$250
Mental health inpatient hospital care	Per Admission	$250
Emergency Services		
Emergency room visit	Per Visit	$100 (waived if admitted)
Medically necessary ambulance service	Per Transport	$100

Covered Service	Unit	Your Cost (Copayment)
Other Benefits		
Home health services	Per Occurrence	$0
Hospice care	Per Occurrence	$0
Skilled nursing facility services limited to 100 days of confinement per benefit period	Per Confinement	$0
Outpatient procedures performed in an ambulatory surgical center	Per Visit	$100
Durable medical equipment	Per Device	$0
Orthotic and Prosthetic medical appliances	Per Appliance	$0
Diagnostic Imaging including MRI, PET, CT, and Thallium Scans	Per Visit	$100
Routine eye exams (one every 12 months)	Per Visit	$15
Visits for physical therapy, occupational therapy, and speech language therapy	Per Visit	$40
Visits for cardiac and intensive cardiac rehabilitation services	Per Visit	$40
Visits for pulmonary rehabilitation services	Per Visit	$25
Part B Drugs	Of the Cost	$0

Outpatient Prescription Drugs				
		30 day supply	60 day supply	90 day supply
Retail	Tier 1	$15	$30	$45
	Tier 2	$15	$30	$45
	Tier 3	$30	$60	$90
	Tier 4	$50	$100	$150
	Tier 5	$50	N/A	N/A
Mail order	Tier 1	$15	$30	$37.50
	Tier 2	$15	$30	$37.50
	Tier 3	$30	$60	$75
	Tier 4	$50	$100	$125
	Tier 5	N/A	N/A	N/A

Exclusions

Services not specifically listed in the Evidence of Coverage; service, which in our opinion was, or is, not medically necessary; hearing aids and devices; cosmetic surgery; nonprescription drugs and vitamins; and custodial care.

- You are responsible for the payment of charges for health care services that are not covered and for the payment of charges in excess of any maximum benefit limitation set forth in the Evidence of Coverage or Schedule of Copayments.
- Your maximum out-of-pocket amount for medical services in the calendar year is $3,400 per member, excluding your costs for covered Part D prescription drugs. After reaching your maximum out-of-pocket amount you generally pay nothing for covered Medicare Part A and Part B services for the remainder of the calendar year.
- Covered prescription drugs must be medically necessary, and prescribed by a qualified medical professional acting within the scope of his/her license, and dispensed by a pharmacist. Supplies other than 30, 60, or 90 days are available.
- See the Capital Health Plan Retiree Advantage Evidence of Coverage or the Capital Health Plan Retiree Advantage Summary of Benefits for additional information.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Florida Blue is a Preferred Provider Organization (PPO). A PPO is a managed care organization of medical doctors, hospitals, and other health care providers who have agreed with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's administration. PPO plans give you flexibility without requiring a primary care physician. You can go to any health care professional you want without a referral; inside or outside of your network.

Staying inside your network means smaller copays and full coverage. If you choose to go outside your network, you will have higher out-of-pocket costs, and not all services may be covered.

Blue Medicare is offered to cover retirees and dependents who are Medicare eligible

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

Florida Blue offers 2 plans with Medicare and Non-Medicare plan choices:

Option 1:

Non-Medicare—Blue Options (03559)

Medicare - BlueMedicare (03559)

- BlueMedicare PPO1 RX1 (03559)
- BlueMedicare PPO2 RX2 (03559)

Option 2: DEDUCTIBLE PLANS ****NEW****

Non-Medicare—Blue Options 5172/ 5173

- Option 2 Non-Medicare plan can be combined with a BlueMedicare (03559) plan
- BlueMedicare PPO1 RX1 (Plan 03559)
- BlueMedicare PPO2 RX2 (Plan 03559)

The Blue Options Plan may be used in conjunction with either BlueMedicare PPO1, RX1 or PPO2, RX2 to cover dependents who are not Medicare eligible. Refer to the table on the next page to find the rate structure that meets your needs.

OPTION 1

Florida Blue
An Independent Licensee of the
Blue Cross and Blue Shield Association

NON-MEDICARE PLANS

TYPE OF COVERAGE	FLORIDA BLUE BLUE OPTIONS 03559
SINGLE	809.19
TWO PERSON	1925.88
FAMILY	2524.66
OVERAGE DEPENDENT	N/A

MEDICARE PLANS

TPYE OF COVERAGE	BlueMedicare PPO1 RX1 Blue Options 03559	BlueMedicare PPO2 RX2 Blue Options 03559
SINGLE- Medicare	339.10	289.26
TWO PERSON - One Medicare	1455.79	1405.95
TWO PERSON - Two Medicare	678.20	578.52
FAMILY (Two BlueMedicare/ Single Blue Options)	1794.89	1695.21
FAMILY - One Medicare	2054.57	2004.73
FAMILY - Two Medicare	2393.67	2293.99

OPTION 2

Florida Blue
An Independent Licensee of the
Blue Cross and Blue Shield Association

NON-MEDICARE PLANS

TYPE OF COVERAGE	FLORIDA BLUE BLUE OPTIONS 5172/ 5173
SINGLE	489.30
TWO PERSON	1164.55
FAMILY	1526.62
OVERAGE DEPENDENT	N/A

MEDICARE PLANS

TPYE OF COVERAGE	BlueMedicare PPO1 RX1 Blue Options 03559	BlueMedicare PPO2 RX2 Blue Options 03559
SINGLE- Medicare	339.10	289.26
TWO PERSON - One Medicare	1014.35	964.51
TWO PERSON - Two Medicare	678.20	578.52
FAMILY (Two BlueMedicare/ Single BlueOptions)	1353.45	1253.77
FAMILY - One Medicare	1376.42	1326.58
FAMILY - Two Medicare	1715.52	1615.84

See benefit summary for additional plan information.

Florida Blue
In the pursuit of health

BLUE OPTIONS 03559

(NON-MEDICARE PLAN)

BlueOptions
For Large Groups
Predictable Cost Health Benefit Plan 03559

Florida Blue

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue pays)	$500 per person $1,500 per family	$750 per person $2,250 per family
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$2,500 per person $5,000 per family	$5,000 per person $10,000 per family
Office Services		
Physician Office Services Primary Care Physician Specialist Convenient Care e-Office Visit	 $20 Copay $40 Copay $20 Copay $10 Copay	 40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	 $20 Copay $40 Copay	 40% after Deductible 40% after Deductible
Allergy Injections (per visit) Primary Care Physician Specialist	 $10 Copay $10 Copay	 40% after Deductible 40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$150 Copay	40% after Deductible
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum[3] Provider	 $200 20%	 50% after Deductible
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical* benefit. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	40%
Mammograms	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	$0
Emergency Medical Care		
Urgent Care Centers	$45 Copay	$45 Copay after Deductible
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$100 Copay	$100 Copay[4]
Ambulance Services	20% after Deductible	20% after In-Network Deductible

[1] DED = Deductible
[2] PBP = Per Benefit Period
[3] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.
[4] If admitted as an Inpatient from the Emergency Room member pays Out-of-Network DED and In-Network Emergency Room Copay.
Note: Out-of-Network services may be subject to balance billing.

Florida Blue
In the pursuit of health®

BlueOptions

For Large Groups
Predictable Cost Health Benefit Plan 03559

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$50 Copay	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$150 Copay	40% after Deductible
Independent Clinical Lab (e.g., Blood Work)	$0	40% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)		
Option 1	$200 Copay	40% after Deductible
Option 2	$300 Copay	40% after Deductible
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$100 Copay	40% after Deductible
Outpatient Hospital Facility Services (per visit)		
Therapy Services Option 1	$45 Copay	40% after Deductible
Option 2	$60 Copay	40% after Deductible
All other Services Option 1	$200 Copay	40% after Deductible
Option 2	$300 Copay	40% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit)		
Option 1	$600 Copay	40% after Deductible[4]
Option 2	$1,000 Copay	40% after Deductible[4]
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)		
Option 1 and Option 2	$0	40%[4]
Outpatient Hospitalization Facility Service (per visit)		
Option 1 and Option 2	$0	40%
Emergency Room Facility Services (per visit)	$0	$0
Provider Services at Hospital and ER		
Primary Care Physician / Specialist	$0	$0
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	$0	40%
Outpatient Office Visit		
Primary Care Physician / Specialist	$0	40%
Other Provider Services		
Provider Services at Hospital and ER	20% after Deductible	20% after In-Network Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	20% after Deductible	20% after In-Network Deductible
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician	20% after Deductible	40% after Deductible
Specialist	20% after Deductible	40% after Deductible
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$40 Copay	40% after Deductible
Outpatient Hospital Facility Services (per visit) Option 1	$45 Copay	40% after Deductible
Option 2	$60 Copay	40% after Deductible
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	40% after Deductible

Blue Options 5172/ 5173

(NON-MEDICARE PLAN)

BlueOptions
For Large Groups
Health Benefit Plans 05172 and 05173

Florida Blue

Summary of Benefits for Covered Services

	Amount Member Pays			
	HSA-Compatible			
	Plan 05172 (Single)	Plan 05173 (Family)	Plan 05172 (Single)	Plan 05173 (Family)
Financial Features	In-Network		Out-of-Network	
Deductible (EM DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue pays)	$3,000 per person	$3,000 per person $6,000 per family[1]	$10,000 per person	$20,000 per person $20,000 per family
Coinsurance (Coinsurance is the percentage the member pays for services)	10% of the allowed amount		20% of the allowed amount	
Out-of-Pocket Maximum (EM OOP[3]) (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$6,550 per person	$6,850 per person $13,100 per family[3]	$10,000 per person	$20,000 per person $20,000 per family
Office Services				
Physician Office Services Primary Care Physician Specialist Convenient Care e-Office Visit	10% after Deductible 10% after Deductible 10% after Deductible 10% after Deductible		20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible	
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	10% after Deductible 10% after Deductible		20% after Deductible 20% after Deductible	
Allergy Injections (per visit) Primary Care Physician Specialist	10% after Deductible 10% after Deductible		20% after Deductible 20% after Deductible	
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	10% after Deductible		20% after Deductible	
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum[4] Provider	$200 10% after Deductible		50% after Deductible	
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**				
Preventive Care				
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0		20%	
Mammograms	$0		$0	

[1] EM DED = Deductible is Embedded: A covered member's family deductible costs are capped at the individual deductible amount on the family plan.
[2] PBP = Per Benefit Period
[3] EM OOP = Out-of-Pocket Maximum is Embedded: A covered family member's out-of-pocket costs are capped at the individual out-of-pocket maximum amount on the family plan.
[4] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

Note: Out-of-Network services may be subject to balance billing.

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BlueOptions

For Large Groups
Health Benefit Plans 05172 and 05173

Summary of Benefits for Covered Services

	Amount Member Pays			
	HSA-Compatible			
	Plan 05172 (Single)	Plan 05173 (Family)	Plan 05172 (Single)	Plan 05173 (Family)
Preventive Care (continued)	In-Network		Out-of-Network	
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0		$0	
Emergency Medical Care				
Urgent Care Centers	10% after Deductible		20% after Deductible	
Emergency Room Facility Services (per visit)	10% after Deductible		10% after Deductible[5]	
Ambulance Services	10% after Deductible		10% after In-Network Deductible	
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	 10% after Deductible 10% after Deductible		 20% after Deductible 20% after Deductible	
Independent Clinical Lab (e.g., Blood Work)	Deductible		20% after Deductible	
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays) Option 1 and Option 2	 10% after Deductible		 20% after Deductible	
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	10% after Deductible		20% after Deductible	
Outpatient Hospital Facility Services (per visit) Therapy Services (Option 1 and Option 2) All other Services (Option 1 and Option 2)	 10% after Deductible 10% after Deductible		 20% after Deductible 20% after Deductible	
Inpatient Hospital Facility and Rehabilitation Services (per admit) Option 1 and Option 2	 10% after Deductible		 20% after Deductible[5]	
Mental Health / Substance Dependency				
Inpatient Hospitalization Facility Services (per admit) Option 1 and Option 2	 10% after Deductible		 20% after Deductible[5]	
Outpatient Hospitalization Facility Service (per visit) Option 1 and Option 2	 10% after Deductible		 20% after Deductible	
Emergency Room Facility Services (per visit)	10% after Deductible		10% after In-Network Deductible	
Provider Services at Hospital and ER Primary Care Physician / Specialist	 10% after Deductible		 10% after In-Network Deductible	
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	 10% after Deductible		 20% after Deductible	
Outpatient Office Visit Primary Care Physician / Specialist	 10% after Deductible		 20% after Deductible	
Other Provider Services				
Provider Services at Hospital and ER	10% after Deductible		10% after In-Network Deductible	
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	10% after Deductible		10% after In-Network Deductible	

[5] If admitted as an Inpatient from the Emergency Room member pays Out-of-Network DED and In-Network Emergency Room Coinsurance.

Florida Blue
In the pursuit of health

BlueOptions

For Large Groups
Predictable Cost Health Benefit Plan 03559

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Other Special Services (continued)		
Home Health Care	20% after Deductible	40% after Deductible
Skilled Nursing Facility	20% after Deductible	40% after Deductible
Hospice	20% after Deductible	40% after Deductible

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services you need to get an approval from Florida Blue before your service or you'll have to pay the entire cost for the service. Before an appointment, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

BlueScript Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them. Important Note: Your health plan may include prescription drug coverage that only provides coverage at Exclusive Pharmacies except for emergency situations.

Access to Our Strong Networks

NetworkBlue℠ is the Preferred Provider Network designated as "In-Network" for BlueOptions. While In-Network providers remain the best value, members are still **protected from balance billing** if they go Out-of-Network to someone who is part of our Traditional Provider Network. You may also receive **out-of-state coverage through the BlueCard®** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, Florida Blue does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician before you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at **floridablue.com**.

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

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BLUE MEDICARE 03559

PPO1 RX1

Florida Blue
In the pursuit of health

Leon County School District #78116
2017 BlueMedicare Group PPO (Employer PPO) Health Benefits

Benefits	BlueMedicare Group PPO Plan 1
Premium (per member, per month)	$339.10 for PPO1Rx1
Annual Deductible	$0 In-Network / $1,000 Out-of-Network
Out-of Pocket Maximum (based on plan year)	$1,000 In-Network / $3,000 Out-of-Network In-Network out-of-pocket maximum accumulates toward Out-of-Network out-of-pocket maximum
Physician Office	
Primary Care (per visit)	In-Network $10 Copayment Out-of-Network Deductible & 20% Coinsurance
Specialist Care (per visit)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance
e-Visit	In-Network $5 Copayment Out-of-Network Deductible & 20% Coinsurance
Convenient Care Center	In-Network / Out-of-Network $30 Copayment
Podiatry Services (per visit) (routine foot care up to 6 visits per year)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance
Chiropractic Services (per visit) For each Medicare-covered visit (manual manipulation of the spine to correct subluxation)	In-Network $20 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Mental Health Care (per visit) For individual or group therapy (including partial hospitalization)	In-Network $35 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Substance Abuse Care (per visit)	In-Network $35 Copayment Out-of-Network Deductible & 20% Coinsurance
Part B Drugs (including chemotherapy)	In-Network 20% Coinsurance Out-of-Network Deductible & 20% Coinsurance
Allergy Injections	In-Network $5 Copayment Out-of-Network Deductible & 20% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Other Services	
Outpatient Surgery	In-Network • $150 Copayment for each outpatient hospital facility visit • $100 Copayment for each visit to an ambulatory surgical center Out-of-Network Deductible & 20% Coinsurance In-Network / Out-of-Network • $0 Copayment for physician services
Diagnostic Tests, X-Rays Office	In-Network • PCP $10 Copayment • Specialist $30 Copayment Out-of-Network Deductible & 20% Coinsurance
IDTF	In-Network $50 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Hospital	In-Network $150 Copayment Out-of-Network Deductible & 20% Coinsurance
Lab Services Independent Clinical Lab Outpatient Hospital All Locations	In-Network $0 Copayment In-Network $15 Copayment Out-of-Network Deductible & 20% Coinsurance
Advanced Imaging (MRI, MRA, CT Scan, PET Scan and Nuclear Medicine): Office	In-Network $125 Copayment Out-of-Network Deductible & 20% Coinsurance
IDTF	In-Network $125 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Hospital	In-Network $150 Copayment Out-of-Network Deductible & 20% Coinsurance

Florida Blue

In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Outpatient Hospital Services (per visit): Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac and Pulmonary Rehab (including intensive cardiac rehab)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance $1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Radiation Therapy	In-Network $50 Copayment Out-of-Network Deductible & 20% Coinsurance
Dialysis	In-Network / Out-of-Network 20% Coinsurance
Lab Only	In-Network $15 Copayment Out-of-Network Deductible & 20% Coinsurance
All Other Diagnostic Tests, X-Rays, Advanced Imaging, etc.	In-Network $150 Copayment Out-of-Network Deductible & 20% Coinsurance
Urgently Needed Care (This is not emergency care, and in most cases is out-of-the-service area.)	In-Network / Out-of-Network $30 Copayment
Emergency Services (Including Worldwide Coverage)	In-Network / Out-of-Network $75 Copayment
Dental, Hearing and Vision (Medicare-Covered)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance
Home Health	In-Network / Out-of-Network $0 Copayment
Ambulance	In-Network / Out-of-Network $150 Copayment for Medicare-covered ambulance services

Florida Blue

In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Outpatient Medical Services and Supplies	
Durable Medical Equipment/Diabetic Supplies Diabetic Supplies (glucose meters, test strips and lancets) *Note: needles, syringes and insulin for self-injection are covered under your Part D benefit*	In-Network $0 Copayment Out-of-Network Deductible & 20% Coinsurance
Equipment: Plan-Approved Electric Customized Wheelchairs, Electric Scooters	In-Network 20% Coinsurance Out-of-Network Deductible & 20% Coinsurance
All Other Medicare-Covered Durable Medical Equipment	In-Network $0 Copayment Out-of-Network Deductible & 20% Coinsurance
Prosthetic Devices	In-Network $0 Copayment for Medicare-covered items Out-of-Network Deductible & 20% Coinsurance
Outpatient Rehabilitation Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac and Pulmonary Rehab (including intensive cardiac rehab)	$1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Office or Freestanding Facility Services	In-Network $30 Copayment for each visit Out-of-Network Deductible & 20% Coinsurance
Outpatient Hospital Services	In-Network $30 Copayment for each visit Out-of-Network Deductible & 20% Coinsurance
Dialysis	In-Network/Out-of-Network 20% Coinsurance
Inpatient Care	
Inpatient Hospital Care (including substance abuse treatment)	In-Network • $150 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • After the 7th day, the plan pays 100% of covered expenses per stay Out-of-Network Deductible & 20% Coinsurance

Florida Blue

In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Inpatient Mental Health Care	In-Network • $200 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • $0 Copayment each day for day(s) 8-90 for a Medicare-covered stay in a network hospital • 190-day lifetime limit in a psychiatric hospital Out-of-Network Deductible & 20% Coinsurance
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In-Network • $0 Copayment each day for days 1-20 per benefit period • $75 Copayment each day for days 21-100 per benefit period • There is a limit of 100 days for each benefit period • 3-day prior hospital stay is not required Out-of-Network Deductible & 20% Coinsurance
Hospice	Member must receive care from a Medicare-certified hospice
Preventive Services	
Annual Screening Mammograms (for women with Medicare, age 40 and older)	In-Network $0 Copayment for Medicare-covered screening mammograms Out-of-Network 20% Coinsurance
Pap Smears and Pelvic Exams (for women with Medicare)	In-Network • $0 Copayment per pap smear • $0 Copayment per pelvic exam Out-of-Network 20% Coinsurance
Bone Mass Measurement (for people with Medicare who are at risk)	In-Network $0 Copayment for each Medicare-covered bone mass measurement Out-of-Network 20% Coinsurance
Colorectal Screening Exams (for people with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered colorectal screening exams Out-of-Network 20% Coinsurance
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered prostate cancer screening exams Out-of-Network 20% Coinsurance

Florida Blue
In the pursuit of health®

Benefits	BlueMedicare Group PPO Plan 1
Vaccines (Medicare-covered)	In-Network • $0 Copayment for influenza vaccine • $0 Copayment for pneumococcal vaccine • $0 Copayment for hepatitis B vaccine Out-of-Network 20% Coinsurance
Health & Wellness Benefit	
Fitness	Free membership through SilverSneakers

BlueMedicare Group PPO out-of-pocket maximum includes all covered health services member cost share rendered in/out of network on a Plan Year basis. Supplemental services and Part D costs are not applied to out-of-pocket maximum.

Medicare Part B - the premium provided under this plan excludes the Medicare Part B premium payments. (Members must continue to pay the Medicare Part B premium unless paid by Medicaid or another third party.)

Florida Blue is a PPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Florida Blue
In the pursuit of health

Leon County School District #78116
2017 BlueMedicare Group Rx (Employer PDP)

Benefits	BlueMedicare Group Rx Option 1
Premium	Included in PPO1Rx1
Annual Deductible	$0
Retail	**31-day Supply**
Tier 1 - Preferred Generics	$10 Copayment
Tier 2 - Generics	$10 Copayment
Tier 3 - Preferred Brand	$40 Copayment
Tier 4 - Non-Preferred Brand	$70 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Mail Order	**90-day Supply with PRIME Mail Order**
Tier 1 - Preferred Generics	$0 Copayment
Tier 2 - Generics	$0 Copayment
Tier 3 - Preferred Brand	$80 Copayment
Tier 4 - Non-Preferred Brand	$140 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance (31-day supply only)
Gap	**31-day Supply**
Tier 1 - Preferred Generics	$10 Copayment
Tier 2 - Generics	$10 Copayment
Tier 3 - Preferred Brand	$40 Copayment
Tier 4 - Non-Preferred Brand	$70 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Catastrophic	$3.30 Copayment for generic drugs $8.25 Copayment for brand drugs

Florida Blue is an Rx (PDP) Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

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Part D Creditable Coverage – The enrolling member may incur late enrollment penalties as defined and set by CMS in accordance with Part D guidelines if prior creditable coverage cannot be proven.

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BLUE MEDICARE 03559

PPO2 RX2

Florida Blue
In the pursuit of health

Leon County School District #78116
2017 BlueMedicare Group PPO (Employer PPO) Health Benefits

Benefits	BlueMedicare Group PPO Plan 2
Premium (per member, per month)	$289.26 for PPO2Rx2
Annual Deductible	$0 In-Network / $2,000 Out-of-Network
Out-of Pocket Maximum (based on plan year)	$2,000 In-Network / $4,000 Out-of-Network In-Network out-of-pocket maximum accumulates toward Out-of-Network out-of-pocket maximum
Physician Office	
Primary Care (per visit)	In-Network $35 Copayment Out-of-Network Deductible & 40% Coinsurance
Specialist Care (per visit)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
e-Visit	In-Network $5 Copayment Out-of-Network Deductible & 40% Coinsurance
Convenient Care Center	In-Network / Out-of-Network $50 Copayment
Podiatry Services (per visit) (routine foot care up to 6 visits per year)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Chiropractic Services (per visit) For each Medicare-covered visit (manual manipulation of the spine to correct subluxation)	In-Network $20 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Mental Health Care (per visit) For individual or group therapy (including partial hospitalization)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Substance Abuse Care (per visit)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance
Part B drugs (including chemotherapy)	In-Network 20% coinsurance Out-of-Network Deductible & 40% Coinsurance
Allergy Injections	In-Network $10 Copayment Out-of-Network Deductible & 40% Coinsurance

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Benefits	BlueMedicare Group PPO Plan 2
Other Services	
Outpatient Surgery	In-Network • $250 Copayment for each outpatient hospital facility visit • $175 Copayment for each visit to an ambulatory surgical center Out-of-Network Deductible & 40% Coinsurance In-Network / Out-of-Network • $0 Copayment for physician services
Diagnostic Tests, X-Rays	
Office	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
IDTF	In-Network $100 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance
Lab Services	
Independent Clinical Lab	In-Network $0 Copayment
Outpatient Hospital	In-Network $30 Copayment
All Locations	Out-of-Network Deductible & 40% Coinsurance
Advanced Imaging (MRI, MRA, CT Scan, PET Scan and Nuclear Medicine):	
Office	In-Network $175 Copayment Out-of-Network Deductible & 40% Coinsurance
IDTF	In-Network $175 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance

Florida Blue

In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 2
Outpatient Hospital Services (per visit): Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac Rehab (including intensive cardiac rehab)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance $1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Pulmonary Rehab	In-Network $30 Copayment Out-of-Network Deductible & 40% Coinsurance
Radiation Therapy	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Dialysis	In-Network / Out-of-Network 20% Coinsurance
Lab Only	In-Network $30 Copayment Out-of-Network Deductible & 40% Coinsurance
All Other Diagnostic Tests, X-Rays, Advanced Imaging, etc.	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance
Urgently Needed Care (This is not emergency care, and in most cases is out-of-the-service area.)	In-Network / Out-of-Network $50 Copayment
Emergency Services (Including Worldwide Coverage)	In-Network / Out-of-Network $75 Copayment
Dental, Hearing and Vision (Medicare-Covered)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Home Health	In-Network / Out-of-Network $0 Copayment
Ambulance	In-Network / Out-of-Network $150 Copayment for Medicare-covered ambulance services

Florida Blue
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Benefits	BlueMedicare Group PPO Plan 2
Outpatient Medical Services and Supplies	
Durable Medical Equipment/Diabetic Supplies Diabetic Supplies (glucose meters, test strips and lancets) *Note: needles, syringes and insulin for self-injection are covered under your Part D benefit*	In-Network $0 Copayment Out-of-Network Deductible & 40% Coinsurance
Equipment: Plan-Approved Electric Customized Wheelchairs, Electric Scooters	In-Network 20% Coinsurance Out-of-Network Deductible & 40% Coinsurance
All Other Medicare-Covered Durable Medical Equipment	In-Network $0 Copayment Out-of-Network Deductible & 40% Coinsurance
Prosthetic Devices	In-Network $0 Copayment for Medicare-covered items Out-of-Network Deductible & 40% Coinsurance
Outpatient Rehabilitation Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac Rehab (including intensive cardiac rehab)	$1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Office or Freestanding Facility Services	In-Network $40 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital Services	In-Network $40 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Pulmonary Rehab	In-Network $30 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Dialysis	In-Network/Out-of-Network 20% Coinsurance
Inpatient Care	
Inpatient Hospital Care (including substance abuse treatment)	In-Network • $250 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • After the 7th day, the plan pays 100% of covered expenses per stay Out-of-Network Deductible & 40% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 2
Inpatient Mental Health Care	In-Network • $250 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • $0 Copayment each day for day(s) 8-90 for a Medicare-covered stay in a network hospital • 190-day lifetime limit in a psychiatric hospital Out-of-Network Deductible & 40% Coinsurance
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In-Network • $0 Copayment each day for days 1-20 per benefit period • $100 Copayment each day for days 21-100 per benefit period • There is a limit of 100 days for each benefit period • 3-day prior hospital stay is not required Out-of-Network Deductible & 40% Coinsurance
Hospice	Member must receive care from a Medicare-certified hospice
Preventive Services	
Annual Screening Mammograms (for women with Medicare, age 40 and older)	In-Network $0 Copayment for Medicare-covered screening mammograms Out-of-Network 40% Coinsurance
Pap Smears and Pelvic Exams (for women with Medicare)	In-Network • $0 Copayment per pap smear • $0 Copayment per pelvic exam Out-of-Network 40% Coinsurance
Bone Mass Measurement (for people with Medicare who are at risk)	In-Network $0 Copayment for each Medicare-covered bone mass measurement Out-of-Network 40% Coinsurance
Colorectal Screening Exams (for people with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered colorectal screening exams Out-of-Network 40% Coinsurance
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered prostate cancer screening exams Out-of-Network 40% Coinsurance

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Benefits	BlueMedicare Group PPO Plan 2
Vaccines (Medicare-covered)	In-Network • $0 Copayment for influenza vaccine • $0 Copayment for pneumococcal vaccine • $0 Copayment for hepatitis B vaccine Out-of-Network 40% Coinsurance
Supplemental Benefit	
Fitness	Free membership through SilverSneakers

BlueMedicare Group PPO out-of-pocket maximum includes all covered health services member cost share rendered in/out of network on a Plan Year basis. Supplemental services and Part D costs are not applied to out-of-pocket maximum.

Medicare Part B - the premium provided under this plan excludes the Medicare Part B premium payments. (Members must continue to pay the Medicare Part B premium unless paid by Medicaid or another third party.)

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Florida Blue

In the pursuit of health®

Leon County School District #78116
2017 BlueMedicare Group Rx (Employer PDP)

Benefits	BlueMedicare Group Rx Option 2
Premium	Included in PPO2Rx2
Annual Deductible	$75 for Brand Drugs Only
Retail	**31-day Supply**
Tier 1 - Preferred Generics	$15 Copayment
Tier 2 - Generics	$15 Copayment
Tier 3 - Preferred Brand	$45 Copayment
Tier 4 - Non-Preferred Brand	$85 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Mail Order	**90-day Supply with PRIME Mail Order**
Tier 1 - Preferred Generics	$8 Copayment
Tier 2 - Generics	$8 Copayment
Tier 3 - Preferred Brand	$135 Copayment
Tier 4 - Non-Preferred Brand	$255 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance (31-day supply only)
Gap	**31-day Supply**
Tier 1 - Preferred Generics	$15 Copayment
Tier 2 - Generics	$15 Copayment
Tier 3 - Preferred Brand	$45 Copayment
Tier 4 - Non-Preferred Brand	$85 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Catastrophic	$3.30 Copayment for generic drugs $8.25 Copayment for brand drugs

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CONTACT INFORMATION

Questions regarding Open Enrollment for

LCS Retirees should be directed to:

Amy Howell

(850) 487-7383

howella@leonschools.net

Fax Number

(850) 414-5120

Please call to make an appointment if you would like to make any changes to your coverage.

LEON COUNTY SCHOOLS

LCS