

# Summary of Health Plan Benefits

## GatorGradCare – August 16, 2014

	GatorCare Network Tier 1	NetworkBlue <sup>1</sup> (Blue Options) Tier 2	Out-of-Network <sup>2</sup> Tier 3
<b>Benefit Year Deductible (BYD)</b>			
The BYD met for Tier 3 will also accumulate to Tier 2.			
Individual Deductible	\$0	\$100	\$300
<b>Out-of-Pocket Maximum (OOP)</b>			
Includes Medical BYD, Coinsurance, Copays, and Per-Visit Deductibles. Does not include Pharmacy. The OOP Maximum values cross accumulate between all tiers.			
Individual Maximum	\$2,500	\$2,500	\$5,000
Family Maximum	\$5,000	\$5,000	\$10,000
<b>Coinsurance</b>			
Coinsurance (plan pays after CYD has been satisfied)	90%	80%	70%
Coinsurance (member pays after CYD has been satisfied)	10%	20%	30%
<b>Lifetime Maximum</b>			
Lifetime Maximum	Unlimited		
<b>Physician Office Services</b>			
Primary Office Visit	\$20 copay	20% after BYD	30% after BYD
Specialist Office Visit	\$30 copay	20% after BYD	30% after BYD
Urgent Care Center	\$30 copay	20% after BYD	30% after BYD
<b>Wellness and Preventive Care (Annual Physical and Related Labs)</b>			
Primary Office Visit	\$0 copay	\$0 copay	30% after BYD
Specialist Office Visit	\$0 copay	\$0 copay	30% after BYD
<b>Hospital Services (Pre-certification required for Inpatient Admissions)</b>			
Per-Admission Deductible	\$0	\$0	\$0
Inpatient Services	10%	20% after BYD	30% after BYD
Outpatient Services	10%	20% after BYD	30% after BYD
<b>Emergency Care</b>			
Per-Visit Deductible	\$150 Per-Visit Deductible; Waived if Admitted	\$250 Per-Visit Deductible; Waived if Admitted	\$250 Per-Visit Deductible; Waived if Admitted
Emergency Room Services	10%	10% after BYD	10% after BYD

<sup>1</sup>Outside the state of Florida, members will utilize the National Blue Card PPO network for Tier 2 services.

<sup>2</sup>Balance Billing may apply for out of network providers



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<b>Other Services</b>			
Skilled Nursing Facility	10%	20% after BYD	30% after BYD
	60-Day Limit Per Benefit Period*		
Home Health Care	10%	20% after BYD	30% after BYD
	30-Visit Limit Per Benefit Period*	20-Visit Limit Per Benefit Period*	
Hospice Facility	10%	20% after BYD	30% after BYD
Outpatient Therapies in Physician Office (Occupational, Physical, Speech, and Cardiac)	\$30 copay	20% after BYD	30% after BYD
Outpatient Therapies Facility	10%	20% after BYD	30% after BYD
Therapy maximum is inclusive of Chiropractic Services	Combined Therapy 75-Visit Limit Per Benefit Period*		
Chiropractic Services	\$30 copay	\$30 copay	30% after BYD
Chiropractic Limit is included in overall Therapy maximum	Chiropractic 26-Visit Limit Per Benefit Period*		
Ambulance	10%		
Durable Medical Equipment (Authorization required)	10%	20% after BYD	30% after BYD
Outpatient Diagnostic Lab and X-Ray	10%	20% after BYD	30% after BYD
<b>In-network Pharmacy Benefit administered by Magellan Pharmacy Solutions**</b>			
<b>Prescription – Retail (up to a 34-Day Supply) CYD does not apply</b>			
<i>You will pay the brand copay plus the difference in cost between the brand and generic if you choose a brand product when a generic equivalent is available.</i>			
Generic	25% Coinsurance with \$10 Min. up to \$20 Max.		N/A
Preferred Brands	25% Coinsurance with \$25 Min. to \$50 Max.		N/A
Preferred Specialty	25% Coinsurance with \$50 Min. to \$100 Max.		N/A
Non-Preferred Brands	40% Coinsurance with \$70 Min. to \$240 Max.		N/A
Non-Preferred Specialty	40% Coinsurance with \$70 Min. to \$240 Max.		N/A
<b>Prescription – 90 Day Supply** (Retail and Mail Order) CYD does not apply</b>			
Generic	25% Coinsurance with \$25 Min. up to \$50 Max.		N/A
Preferred Brands	25% Coinsurance with \$62.50 Min. to \$125 Max.		N/A
Preferred Specialty	N/A		
Non-Preferred Brands	40% Coinsurance with \$175 Min. to \$600 Max.		N/A
Non-Preferred Specialty	N/A		

<sup>1</sup>Outside the state of Florida, members will utilize the National Blue Card PPO network for Tier 2 services.

<sup>2</sup>Balance Billing may apply for out of network providers

\*Benefit Period is defined as August 16<sup>th</sup> through August 15<sup>th</sup>. Visit Limit is combined in-and out-of-network.

\*\* Applies to in-network pharmacies only.

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.