2013 HDHP/HSA RENEWAL COMPARED TO CURRENT PLANS - CHANGES IN RED

Cost Sharing - Member's Responsibility					
	2012	2013		2012	2013
	05180/81 High Option H.S.A.	05192/93 High Option H.S.A.		05192/93 Low Option H.S.A.	05192/93 Low Option H.S.A.
	RX Co-pays	RX Co-pays		RX Co-pays	RX CYD & Coinsurance
Deductible (DED) (Per Person/Family Aggregate)					
In-Network	$1,500 (Single)	$2,500 (Single)		$2,500 (Single)	$2,500 (Single)
	$3,000 (Family)	$5,000 (Family)		$5,000 (Family)	$5,000 (Family)
Coinsurance (BCBSF pays / Member pays)					
In-Network	80% / 20%	80% / 20%		80% / 20%	80% / 20%
Out of Pocket Maximum (Per Person/Family Aggregate)	Includes DED, Coinsurance, & Copays	Includes DED, Coinsurance, & Copays		Includes DED, Coinsurance, & Copays	Includes DED, Coinsurance, & Copays
In-Network	$4,500 (Single)	$5,000 (Single)		$5,000 (Single)	$5,000 (Single)
	$6,000 (Family)	$10,000 (Family)		$10,000 (Family)	$10,000 (Family)
Professional Provider Services (e.g., Physician) (BCBSF pays / Member pays) - Per provider, per date of service					
E-Office Visit Services					
In-Network Family Physician	DED + 20%	DED + 20%		DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Office Services					
In-Network Family Physician	DED + 20%	DED + 20%		DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Allergy Injections					
In-Network Family Physician	DED + 20%	DED + 20%		DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Medical Pharmacy ($200 monthly OOP Max)	Calendar OOP Maximum does not apply until the DED is met.	Calendar OOP Maximum does not apply until the DED is met.		Calendar OOP Maximum does not apply until the DED is met.	Calendar OOP Maximum does not apply until the DED is met.
In-Network	DED + 20% Coinsurance	DED + 20% Coinsurance		DED + 20% Coinsurance	DED + 20% Coinsurance
Provider Services at Hospital and ER					
In-Network Family Physician	DED + 20%	DED + 20%		DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Provider Services at Locations other than Hospital and ER					
In-Network Family Physician	DED + 20%	DED + 20%		DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%		DED + 20%	DED + 20%

Radiology, Pathology and Anesthesiology Provider Services at Hospital or ASC					
In-Network Specialist	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Preventive Services (BCBSF Pays/Member Pays) Per Provider, Per Date of Service					
Adult Wellness Office Services					
In-Network Family Physician	$0	$0		$0	$0
In-Network Specialist	$0	$0		$0	$0
Well Child Office Visits (No PBP Max)					
In-Network Family Physician	$0	$0		$0	$0
In-Network Specialist	$0	$0		$0	$0
Facilities (Hospital/Surgical/Emergency/IDTFs)					
Ambulatory Surgical Center (ASC)					
In-Network Facility	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Inpatient Hospital Facility Services (per admit)					
In-Network Facility		Option 2 - DED + 20%		Option 2 - DED + 20%	Option 2 - DED + 20%
Outpatient Hospital Facility Services (per visit)	Option 1 - DED + 20% Option 2 - DED + 20%				
In-Network Facility	Option 2 - DED + 20%	Option 2 - DED + 20%		Option 2 - DED + 20%	Option 2 - DED + 20%
Therapy at an outpatient hospital setting					
In-Network	Option 2 - DED + 20%	Option 2 - DED + 20%		Option 2 - DED + 20%	Option 2 - DED + 20%
Emergency Room Facility Services (per visit; copayment waived if admitted)					
In-Network	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Out-of-Network	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Independent Clinical Lab					
In-Network	Deductible then 100%	Deductible then 100%		Deductible then 100%	Deductible then 100%
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)					
Independent Diagnostic Testing Facilities (IDTF)	**X-rays and Advanced Imaging**				
In-Network (Advanced Imaging Services)	DED + 20%	DED + 20%		DED + 20%	DED + 20%
In-Network (Other Diagnostic Services)	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Outpatient Hospital Facilities					
In-Network Facility	Option 2 - DED + 20%	Option 2 - DED + 20%		Option 2 - DED + 20%	Option 2 - DED + 20%
Mental Health / Substance Dependency					
Inpatient Hospitalization					
In-Network	Option 2 - DED + 20%	Option 2 - DED + 20%		Option 2 - DED + 20%	Option 2 - DED + 20%

Outpatient Hospitalization					
In-Network	Option 2 - DED + 20%	Option 2 - DED + 20%		Option 2 - DED + 20%	Option 2 - DED + 20%

Other Special Services and Locations					
Urgent Care Centers					
In-Network	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Durable Medical Equipment, Prosthetics & Orthotics					
In-Network	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Home Health Care					
In-Network	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Skilled Nursing Facility					
In-Network	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Diabetic Equipment and Supplies					
In-Network	DED + 20%	DED + 20%		DED + 20%	DED + 20%
Additional Benefits and Maximums					
Lifetime Maximum	No Maximum	No Maximum		No Maximum	No Maximum
Ambulance Maximum (Ground/ Air/Water & Newborn per day max)	$5,000	$5,000		$5,000	$5,000
Hospice Maximum	No Maximum	No Maximum		No Maximum	No Maximum
Prescription Drugs					
Deductible:	Deductible	Deductible		Deductible	Deductible
Retail (30 days): Generic / Brand / Non-Preferred	$10 / $50 / $80**	$10 / $50 / $80**		$10 / $50 / $80**	20% Coinsurance up to Out of Pocket Maximum
Mail Order (90 days) / 2.5x Copay: Generic / Brand / Non-Preferred	$25 / $125 / $200	$25 / $125 / $200		$25 / $125 / $200	20% Coinsurance up to Out of Pocket Maximum

**HDHP HDHP 05192/93 - All pharmacy costs count toward CYD and all pharmacy co-pays count towards annual Out of Pocket Maximum

2013 PPO RENEWAL COMPARED TO CURRENT PLANS - CHANGES IN RED

	2012	2013		2012	2013
	5360 High Option PPO	5773 High Option PPO		5773 Low Option PPO	5301 Low Option PPO
	Std. RX with Co-pays	Std. RX with Co-pays		Std. RX with Co-pays	Generic Only RX
Cost Sharing - Member's Responsibility					
Deductible:					
In-Network	$1,500 / $4,500	$2,000/$6,000		$2,500/$7,500	$5,000 / $10,000
Out-of-Network	$3,000 / $9,000	$5,000/$10,000		$5,000/$15,000	$10,000 / $20,000
Coinsurance (BCBSF pays / Member pays)					
In-Network	90% / 10%	70% / 30%		70% / 30%	70% / 30%
Out-of-Network	60% / 40%	50% / 50%		50% / 50%	50% / 50%
Out of Pocket Maximum (Per Person/Family Aggregate)	Includes DED, Coinsurance, & Copays; excludes Rx	Includes DED, Coinsurance, & Copays; excludes Rx		Includes DED, Coinsurance, & Copays; excludes Rx	Includes DED, Coinsurance, & Copays; excludes Rx
In-Network	$4,000 / $8,000	$5,000/$10,000		$7,500 / $15,000	$7,500 / $15,000
Out-of-Network	$8,000 / $16,000	$10,000/$20,000		$13,000 / $26,000	$15,000 / $30,000
Per Admission Deductible (PAD)					
In-Network	Not Applicable	$500 Copayment		$300 Copayment	NA
Out-of-Network	Not Applicable	$500 Copayment		$500 Copayment	NA
Professional Provider Services (e.g., Physician) (BCBSF pays / Member pays) - Per provider, per date of service					
E-Office Visit Services					
In-Network Family Physician	$10 Copayment	$10 Copayment		$10 Copayment	$10 Copayment
In-Network Specialist	$10 Copayment	$10 Copayment		$10 Copayment	$10 Copayment
Office Services					
In-Network Family Physician	$30 Copayment	$35 Copayment		$35 Copayment	$25 Copayment**
In-Network Specialist	$50 Copayment	$65 Copayment		$85 Copayment	$45 Copayment**
Allergy Injections					
In-Network Family Physician	$10 Copayment	$10 Copayment		$10 Copayment	$10 Copayment
In-Network Specialist	$10 Copayment	$10 Copayment		$10 Copayment	$10 Copayment
Medical Pharmacy ($200 monthly OOP Max) In-Network	10% Coinsurance	30% Coinsurance		30% Coinsurance	30% Coinsurance
Provider Services at Hospital and ER					
In-Network Family Physician	DED + 10%	DED + 30%		DED + 30%	DED + 30%
In-Network Specialist	DED + 10%	DED + 30%		DED + 30%	DED + 30%
Provider Services at Locations other than Hospital and ER					
In-Network Family Physician	DED + 10%	DED + 30%		DED + 30%	DED + 30%
In-Network Specialist	DED + 10%	DED + 30%		DED + 30%	DED + 30%

Radiology, Pathology and Anesthesiology Provider Services at Hospital or ASC					
In-Network Specialist	DED + 10%	Hospital DED + 30% ASC $100 Co-pay		DED + 30%	DED + 30%
Preventive Services (BCBSF Pays/Member Pays) Per Provider, Per Date of Service					
Adult Wellness Office Services					
In-Network Family Physician	$0	$0		$0	$0
In-Network Specialist	$0	$0		$0	$0
Well Child Office Visits (No PBP Max)					
In-Network Family Physician	$0	$0		$0	$0
In-Network Specialist	$0	$0		$0	$0
Facilities (Hospital/Surgical/Emergency/IDTFs)					
Ambulatory Surgical Center (ASC)					
In-Network Facility	$200 Copayment	$350 Copayment		$300 Copayment	DED + 30%
Inpatient Hospital Facility Services (per admit)					
In-Network Facility	Option 1 or 2 - DED + 10%	Option 1 or 2 - $500 (PAD) + DED + 30%		Option 1 or 2 - $300 (PAD) + DED + 30%	Opton 1 or 2 - DED + 30%
Outpatient Hospital Facility Services (per visit)					
In-Network Facility	Option 1 or 2 - DED + 10%	Option 1 or 2 - DED + 30%		Option 1 or 2 - DED + 30%	Option 1 or 2 - DED + 30%
Therapy at an outpatient hospital setting					
In-Network	Option 1 - $45 Option 2 - $60	Option 1 - $75 Option 2 - $90		Option 1 - $85 Option 2 - $100	Option 1 - $65
Emergency Room Facility Services (per visit; copayment waived if admitted)					
In-Network	$250 Copayment	$400 Copayment		$350 Copayment	$300 copayment***
Out-of-Network	$250 Copayment	$400 Copayment		$350 Copayment	$300 copayment***
Independent Clinical Lab					
In-Network	$0 Quest	$0 Quest		$0 Quest	$0 Quest
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)					
Independent Diagnostic Testing Facilities (IDTF) **X-rays and Advanced Imaging**					
In-Network (Advanced Imaging Services)	$250 Copayment	$400 Copayment		$350 Copayment	DED + 30%

In-Network (Other Diagnostic Services)	$50 Copayment	$50 Copayment		$50 Copayment	DED + 30%

Outpatient Hospital Facilities					
In-Network Facility	Option 1 - $400 Option 2 - $500	Option 1 or 2 - DED + 30%		Option 1 or 2 - DED + 30%	Option 1 or 2 - DED + 30%
Mental Health / Substance Dependency					
Inpatient Hospitalization					
In-Network	Option 1 - $0 Option 2 - $0	Option 1 - $0 Option 2 - $0		Option 1 - $0 Option 2 - $0	Option 1 - $0 Option 2 - $0
Outpatient Hospitalization					
In-Network	Option 1 - $0 Option 2 -$0	Option 1 - $0 Option 2 -$0		Option 1 - $0 Option 2 -$0	Option 1 - $0 Option 2 -$0
Other Special Services and Locations					
Urgent Care Centers					
In-Network	$50 Copayment	$75 Copayment		$100 Copayment	$50 Copayment**
Durable Medical Equipment, Prosthetics & Orthotics					
In-Network	DED + 10%	DED + 30%		DED + 30%	DED + 30%
Home Health Care					
In-Network	DED + 10%	DED + 30%		DED + 30%	DED + 30%
Skilled Nursing Facility					
In-Network	DED + 10%	DED + 30%		DED + 30%	DED + 30%
Diabetic Equipment and Supplies					
In-Network	DED + 10%	DED + 30%		DED + 30%	DED + 30%
Additional Benefits and Maximums					
Lifetime Maximum	No Maximum	No Maximum		No Maximum	No Maximum
Ambulance Maximum (Ground/ Air/Water & Newborn per day max)	$5,000	$5,500		$5,000	$5,500
Prescription Drugs					
Deductible:	N/A	$100 Brand Only		NA	NA
Retail (30 days): Generic / Brand / Non-Preferred	$10 / $50 / $80	$5 / $60 / $100		$10 / $60 / $100	$10 Generic Only
Mail Order (90 days) / 2.5x Copay: Generic / Brand / Non-Preferred	$25 / $125 / $200	$13 / $150 / $250		$25 / $150 / $250	$25 Generic Only

**** Office/Urgent Care Services - First six visits combined are co-pay only. After six visits, DED + 30% coinsurance applies**

***** Emergency Room - First two visits are co-pay only. After two visits, DED + 30% coinsurance applies**

PPO 05773 - Pharmacy costs do not count toward DED but do count towards annual Out of Pocket Maximum

PPO 05301 - This is a GENERIC Only Pharmacy program. There is No RX coverage for brand or preferred medications.