



# FCCRM 2010 HEALTH SCHEDULE OF BENEFITS

**\*\*\*\*\*NEW DEP ONLY\*\*\*\*\***

## **Blue Options Plan 3361**

Important things to keep in mind as you review this Schedule of Benefits:

- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider’s participation status prior to receiving Health Care Services. To verify a Provider’s specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at [www.bcbsfl.com](http://www.bcbsfl.com). If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Calendar Year Deductible are abbreviated as “CYD”.

### **Deductible, Coinsurance and Out-of-Pocket Maximum**

<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Individual Calendar Year Deductible (CYD)</b> (CYD is the amount the member is responsible for before BCBSF pays) Per Individual per Calendar Year	\$5,000 Per Person	
<b>Coinsurance</b> (The percentage of the Allowed Amount <b>you pay</b> for Covered Services)	30%	50%
<b>Out-of-Pocket Maximums</b> Per Individual per Calendar Year	\$10,000 Per Person	

What <b>applies</b> to out-of-pocket maximums?	<ul style="list-style-type: none"> <li>• CYD</li> <li>• Coinsurance</li> <li>• Copayments (Except RX)</li> </ul>
What <b>does not apply</b> to out-of-pocket maximums?	<ul style="list-style-type: none"> <li>• Non-covered charges</li> <li>• Any benefit penalty reductions</li> <li>• Charges in excess of the Allowed Amount</li> <li>• Any Prescription Drug Cost Share amounts</li> </ul>

## Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

<b>Benefit Description</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Office visits</b> rendered by  Family Physicians	\$20 Copayment	50% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialists)	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
<b>Allergy Injections</b> rendered by  Family Physicians	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialists)	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
<b>E-Visits</b> rendered by		
Family Physicians	\$10	50% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialist)	\$10	50% of the Allowed Amount after CYD
<b>Maternity Initial Visit</b> rendered by		
Other health care professionals licensed to perform such Services (Specialist)	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD

## Preventive Health Services

Benefit Description	In-Network	Out-of-Network
<b>Adult Wellness Services</b>	<b>\$500 Benefit Maximum</b>	
Family Physicians	30% of the Allowed Amount	50% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialists)	30% of the Allowed Amount	50% of the Allowed Amount
<b>Adult Well Woman Services</b>		
Family Physicians	30% of the Allowed Amount	50% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialists)	30% of the Allowed Amount	50% of the Allowed Amount
<b>Child Health Supervision Services</b> rendered by		
Family Physicians	30% of the Allowed Amount	50% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialists)	30% of the Allowed Amount	50% of the Allowed Amount
<b>Routine Colonoscopy</b> (one time routine colonoscopy for ages 50+)	100% of the Allowed Amount	100% of the Allowed Amount

Benefit Description	In-Network	Out-of-Network
	<b>No Benefit Maximum</b>	
<b>Mammograms</b>	100% of the Allowed Amount	100% of the Allowed Amount

### Preventive Adult (17 years of age or older) Wellness Services include:

1. annual physical and/or gynecological exam [including family planning/contraceptive Services]; and
2. related wellness Services including, but not limited to, pap smears, Prostate Specific Antigen (PSA), x-rays, laboratory Services, and immunizations. Routine vision and hearing examinations and screenings are not covered.

## Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2*	
<b>Inpatient</b>			
Facility Services ( per admission)	30% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Physician and other health care professional Services	30% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
<b>Outpatient</b>			
Facility	30% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Physician and other health care professional Services	30% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Therapy Services	30% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
<b>Emergency Room Visits</b>			
Facility (Waived if admitted)	30% of the Allowed Amount after CYD		50% of the Allowed Amount after CYD
Physician and other health care professional Services	30% of the Allowed Amount after CYD		50% of the Allowed Amount after CYD

## Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
<b>Ambulance Services</b>	30% of the Allowed Amount after CYD	
<b>Urgent Care Center</b>	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD

### **Important:**

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room physicians. We will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. If such Covered Services were rendered by a Physician who is not In-Network, or a Physician who is not participating in our Traditional Program, you will be responsible for the difference between what we pay and the Physician's charge. Claims paid in accordance with this note will be applied to the In-Network CYD and Out-of-Pocket Maximums.

\*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

## Surgical Services

Benefit Description	In-Network	Out-of-Network
<b>Ambulatory Surgical Center</b>  Facility	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD

## Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
<b>Independent Clinical Lab</b>	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
<b>Independent Diagnostic Testing Facility</b> Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD

## Prescription Drug Program\*

Benefit Description	Retail 30 day supply	Mail Order 90 day supply
Preferred Generic	\$15	\$30
Preferred Brand Name	\$40	\$80
Non-Preferred Prescription	\$60	\$120

**\*If a Brand Name Prescription Drug is purchased when a Generic Prescription Drug is available and the Physician has not indicated that a Brand Name Prescription Drug is Medically Necessary, you will be required to pay the difference between the cost of the Brand Name and Generic Prescription Drug. This does not apply for Insulin.**

## Other Special Services

Benefit Description	In-Network	Out-of-Network
Durable Medical Equipment Home Health Care Hospice Skilled Nursing Facility	30% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD

## Benefit Maximums

Unless specifically noted otherwise, benefit maximums apply per-person and accumulate either on a per-Benefit Period or per-lifetime basis, as indicated below.

**Ambulance Services** Per Day Maximum ..... \$400/ground and \$4,000/air & water

**Note:** In addition to the Cost Share listed in this Schedule of Benefits you are responsible for any additional amounts that exceed the per Person per Day maximum.

### Autism Spectrum Disorder Services

Per Calendar Year ..... \$36,000

Per Lifetime ..... \$200,000

**Home Health Care** per Calendar Year..... \$2,500

### Hospice (Combined Inpatient, Outpatient and Home)

per Lifetime ..... \$7,500

**Inpatient Rehabilitation** Days per Calendar Year ..... 21

**Outpatient Therapies and Spinal Manipulations** per Calendar Year ..... \$2,500

### Preventive Adult Wellness

In-Network and Out-of-Network Provider per Calendar Year ..... \$500

**Skilled Nursing Facility** Days per Calendar Year..... 60

Total Lifetime Maximum Benefit..... \$5,000,000