



FCCRMC 2010 HEALTH SCHEDULE OF BENEFITS

*****New*****

Blue Options 3565 Plan

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. 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

Benefit Description	In-Network	Out-of-Network
Individual Calendar Year Deductible (CYD) (CYD is the amount the member is responsible for before BCBSF pays) Per Individual per Calendar Year	\$1,000 Per Person	
Coinsurance (The percentage of the Allowed Amount you pay for Covered Services)	25%	50%
Out-of-Pocket Maximums Per Individual per Calendar Year	\$5,000	
Per Family per Calendar Year	\$10,000	

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

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.

Benefit Description	In-Network	Out-of-Network
Office visits rendered by		
Family Physicians	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialists)	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Allergy Injections rendered by		
Family Physicians	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialists)	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
E-Visits 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
Maternity Initial Visit rendered by		
Other health care professionals licensed to perform such Services (Specialist)	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services	\$500 Benefit Maximum	
Family Physicians	25% of the Allowed Amount	50% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialists)	25% of the Allowed Amount	50% of the Allowed Amount
Adult Well Woman Services		
Family Physicians	25% of the Allowed Amount	50% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialists)	25% of the Allowed Amount	50% of the Allowed Amount
Child Health Supervision Services rendered by		
Family Physicians	25% of the Allowed Amount	50% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialists)	25% of the Allowed Amount	50% of the Allowed Amount
Routine Colonoscopy (one time routine colonoscopy of rages 50+)	100% of the Allowed Amount	100% of the Allowed Amount

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services	No Benefit Maximum	
Mammograms	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*	
Inpatient			
Facility Services (per admission)	25% of the Allowed Amount after CYD	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Physician and other health care professional Services	25% of the Allowed Amount after CYD	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Outpatient			
Facility	25% of the Allowed Amount after CYD	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Physician and other health care professional Services	25% of the Allowed Amount after CYD	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Therapy Services	25% of the Allowed Amount after CYD	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Emergency Room Visits			
Facility (Waived if admitted)	25% of the Allowed Amount after CYD		50% of the Allowed Amount after CYD
Physician and other health care professional Services	25% 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
Ambulance Services	25% of the Allowed Amount after CYD	
Urgent Care Center	25% 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
Ambulatory Surgical Center Facility	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	25% of the Allowed Amount after CYD	50% of the Allowed Amount after CYD
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	25% 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	25% 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