FCSRMC 2018 HEALTH SCHEDULE OF BENEFITS
BlueOptions Plan 05191 Family Coverage
with Integrated Prescription Drug Coverage

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

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- 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.floridablue.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 Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period...**01/01 – 12/31**

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED) - Shared*		
Per Person per Benefit Period	$3,000	$6,000
Per Family per Benefit Period	$3,000	$6,000
Per Admission Deductible (PAD)	Not Applicable	$500
Coinsurance - The percentage of the Allowed Amount **you pay** for Covered Services	20%	40%
Out-of-Pocket Maximums - Embedded*		
Per Person per Benefit Period	$6,850	$18,000
Per Family per Benefit Period	$9,000	$18,000

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the DED and Out-of-Pocket Maximum amounts.

*Refer to the Understanding Your Share of Health Care Expenses section of your Benefit Booklet for information on how Embedded and Shared Deductibles and Embedded and Shared Out-Of-Pocket Maximums amounts are satisfied.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.

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	DED + 20%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Allergy Injections rendered by Family Physicians	DED + 20%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by Family Physicians	DED + 20%	DED + 40%
Other health care professionals licensed to perform such Services.	DED + 20%	DED + 40%
E-Visits rendered by Family Physicians	DED + 20%	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 20%	DED + 40%
Telemedicine	DED + 20%	Not Covered
Convenient Care Centers	DED + 20%	DED + 40%

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by:		
Family Physicians	DED + 20%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	DED + 20%	DED + 50%
Out-of-Pocket Maximum per Person per Month (applies only after DED is satisfied)	$200	Not Applicable
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Adult Well Woman Services		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Child Health Supervision Services		
Family Physicians	$0	40%
Other health care professionals licensed to perform such Service	$0	40%
All other locations	$0	40%
Mammograms	$0	$0
Routine Colonoscopies	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	DED	DED + 40%
Independent Diagnostic Testing Facility		
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	DED + 20%	DED + 40%
All other diagnostic Services (e.g., X-rays)	DED + 20%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 20%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 20%	DED + 20%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Facility (per visit)	DED + 20%	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	In-Network DED + 20%
Other health care professional Services rendered by all other Providers	DED + 20%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services** Outpatient	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	DED + 20%	DED + 25%	**PAD + DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Outpatient			
Facility (per visit)	DED + 20%	DED + 25%	DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Therapy Services	DED + 20%	DED + 25%	DED + 40%
Emergency Room Visits			
Facility	DED + 20%		DED + 20%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%

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

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the Out-of-Network Deductible and In-Network Coinsurance will apply to that admission.

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. This Plan 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. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

BlueScript® Pharmacy Program

All Covered Prescription Drugs, Covered Over-the-counter (OTC) Drugs and Covered Prescription Supplies purchased from a Pharmacy are subject to the **In-Network DED**, which must be satisfied by you before any payment will be made by us. To verify if a Pharmacy is a Participating Pharmacy, you may access a current pharmacy directory, refer to our website at www.floridablue.com, or call the customer service phone number on your Benefit Booklet or Identification Card.

Retail Pharmacy	*Participating Pharmacy	**Non-Participating Pharmacy
Preferred Generic Prescription Drugs and Covered OTC Drugs		
For up to a One-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies		
For up to a One-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies		
For up to a One-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance
Oral Chemotherapy Drugs	DED + $10	DED + 50% of the Non-Participating Pharmacy Allowance
Specialty Drugs	DED	DED + 50% of the Non-Participating Pharmacy Allowance

Mail Order Pharmacy	*Participating Pharmacy	**Non-Participating Pharmacy
Preferred Generic Prescription Drugs and Covered OTC Drugs		
For up to a Three-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies		
For up to a Three-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies		
For up to a Three-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance

Specialty Pharmacy	*Participating Pharmacy	**Non-Participating Pharmacy
Preferred Generic Prescription Drugs and Covered OTC Drugs		
For up to a One-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies		
For up to a One-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance
Non-Preferred Prescription Drugs or Supplies		
For up to a One-Month Supply	DED	DED + 50% of the Non-Participating Pharmacy Allowance

* Our payment for Covered Prescription Drugs is based on the **Participating Pharmacy Allowance**

** Our payment for Covered Prescription Drugs is based on the **Non-Participating Pharmacy Allowance** and may be less than the cost of the Drug or Supply. You are responsible for any charges in excess of the Non-Participating Pharmacy Allowance for purchases at Non-Participating Pharmacies.

Other Important information affecting what you will pay:

- The DED is waived for Value Based Generic and Preferred Brand Drugs listed in the Non-HSA Value Based Benefit Drug list, which may be subject to change without prior notification.
- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:
  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

     Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an “Exception Request Form” from the Insured’s Physician.

     The Insured can obtain an Exception Request Form on BCBSF’s website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured’s Identification Card and one will be mailed to the Insured upon request;
  2. Diaphragms indicated as covered in the Medication Guide; and
  3. Emergency contraceptives indicated as covered in the Medication Guide.
- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:
  1. the Cost Share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.
- The Specialty Pharmacies designated, solely by us, are the only “Participating Pharmacy” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us in the Medication Guide as a Specialty Pharmacy is considered a Non-Participating Pharmacy for payment purposes under this BlueScript Pharmacy Program.
- Some Specialty Drugs may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.
- You can get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy.

  This note does not apply to Specialty Drugs, which are covered only up to a One-Month Supply.

- Amounts incurred for Covered Prescription Drugs, Over-The-Counter Drugs and Covered Prescription Supplies will be applied to the In-Network Out-of-Pocket Maximum as indicated in this Schedule of Benefits.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health Services Outpatient Facility Services rendered at:		
Emergency Room	DED + 20%	In-Network DED + 20%
Hospital	DED + 20%	DED + 40%
Physician Services at Hospital and ER	DED + 20%	In-Network DED + 20%
Physician and other health care professionals licensed to perform such Services rendered at:		
Family Physician office	DED + 20%	DED + 40%
Specialist office	DED + 20%	DED + 40%
All other locations	DED + 20%	DED + 40%
Inpatient		
Facility Services	DED + 20%	In-Network DED + 20%
Physicians and other health care professionals licensed to perform such Services	DED + 20%	In-Network DED + 20%

Benefit Maximums

Home Health Care Visits per Benefit Period.. 20

Inpatient Rehabilitation days per Benefit Period.. 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period.......................... 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility Days per Benefit Period.. 60

Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.