FCSRMC 2018 HEALTH SCHEDULE OF BENEFITS

BlueOptions Plan 03900

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)		
Per Person per Benefit Period	$1,500	$4,500
Per Family per Benefit Period	Not Applicable	Not Applicable
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	50%	50%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$6,350	$20,000
Per Family per Benefit Period	$12,700	$20,000

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 Deductible and Out-of-Pocket Maximum amounts.

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.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

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 and Services not otherwise outlined in this table rendered by		
Family Physicians	$35	DED + 50%
Other health care professionals licensed to perform such Services	$50	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	$200	DED + 50%
Other health care professionals licensed to perform such Services	$200	DED + 50%
Allergy Injections rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
E-Visits rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 50%	DED + 50%
Telemedicine	$10	Not Covered
Convenient Care Centers	$35	DED + 50%

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by: Family Physicians	20%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	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 Rendered by Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Adult Well Woman Services Rendered by Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Child Health Supervision Services rendered by Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Mammograms	$0	$0
Non-Routine Colonoscopy	$0	DED + 50%
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 50%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$200	DED + 50%
All other diagnostic Services (e.g., X-rays)	DED + 50%	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 50%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 50%	DED + 50%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Facility (per visit)	DED + 50%	DED + 50%
Radiologists, Anesthesiologists, and Pathologists	DED + 50%	In-Network DED + 50%
Other health care professional Services rendered by all other Providers	DED + 50%	DED + 50%
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)	$1,500	$2,500	DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Outpatient			
Facility (per visit)	$300	$400	DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Therapy Services	$45	$60	DED + 50%
Emergency Room Visits			
Facility	DED + 50%		DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%

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

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 DED and Out-of-Pocket Maximums.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at:		
Emergency Room	$0	$0
Hospital	$0	50%
Physician Services at Hospital and ER	$0	$0
Physician and other health care professionals licensed to perform such Services		
Family Physician office	$0	50%
Specialist office	$0	50%
All other locations	$0	50%
Inpatient		
Facility Services	$0	50%
Physician and other health care professionals licensed to perform such Services	$0	$0

Prescription Drug Program

Benefit Description	Retail 30-Day supply	Mail-Order 90-Day supply
Preferred Generic	$10	$25

Benefit Maximums

Home Health Care Visits per Benefit Period..... 10

Inpatient Rehabilitation days per Benefit Period..... 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... 25
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.

Prescription Drug Program
Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.