Florida College System Risk Management Consortium
2012 HEALTH SCHEDULE OF BENEFITS
HMO BlueCare Plan 10 – No Changes From 2011

Brevard Community College	Northwest Florida State College	Pensacola State College	Seminole State College
Edison State College	Palm Beach State College	Polk State College	State College of Florida Manatee-Sarasota
Florida Gateway College	Pasco-Hernando Community College	Santa Fe College	

With this plan your financial responsibilities, including any applicable Copayments and/or Coinsurance responsibilities, will vary depending upon the medical Service you receive, the setting of the Services and the Provider you choose to see.

All Copayments, Coinsurance and Deductible, if applicable, are subject to the Maximum Out-of-Pocket limitations described in the Benefit Booklet. The following description of Services is not intended to create, and shall not create, any rights or obligations that differ from or are inconsistent with those set forth elsewhere in the Benefit Booklet.

Calendar Year Deductible and Out-of-Pocket

Benefit Description	Your Cost
Calendar Year Deductible (CYD)	
Single	Not Applicable
Family	Not Applicable
Maximum Out-of-Pocket (per Calendar Year) Includes CYD, Coinsurance and Copayments (including pharmacy) as applicable to your plan	
Single	$5,000
Family	$10,000

Physician Services

Benefit Description	Your Cost
Primary Care Physician (PCP)	$25 Copayment
Specialist	$40 Copayment
In-office Surgery	Subject to PCP or Specialist Copayment, whichever is applicable
Allergy Injection	$10 Copayment

Benefit Description	Your Cost
Allergy Testing	$0 Copayment
Annual Contracting Gynecologist	$40 Copayment
Maternity – initial obstetrician visit only	$40 Copayment

Inpatient Services

Benefit Description	Your Cost
Inpatient Hospital	$150 per day/ maximum $750/admission
Inpatient Physician	$0 Copayment
Inpatient Rehabilitation Services (e.g., Physical, Speech, Cardiac, or Occupational)	$0 Copayment

Outpatient Services

Benefit Description	Your Cost
Outpatient Hospital	$200 Copayment
Ambulatory Surgical Center (any services)	$200 Copayment
Dialysis (facility copay may apply)	$0 Copayment
Diagnostic Lab (facility copay may apply)	$0 Copayment
Diagnostic Testing (facility copay may apply)	Applicable Provider Copayment
X-Ray/Imaging (facility copay may apply)	$0 Copayment
Birthing Center (facility copay may apply)	$0 Copayment

Emergency and Urgent Care Services and Care (*Copayment waived if admitted)

Benefit Description	Your Cost
Emergency Room in a Contracting Hospital	$50 Copayment*
Emergency Room in a Non-Contracting Hospital	$50 Copayment*
Ambulance (Medically Necessary)	$0 Copayment

Urgent Care Center	$35 Copayment

Behavioral Health Services

Benefit Description	Your Cost
Mental Health Office Visits rendered by: PCP Specialist	 $25 Copayment/visit $25 Copayment/visit
Inpatient Hospital	$150 per day/ maximum $750/admission
Partial Hospitalization	$0 Copayment
Outpatient Hospital Therapy Services	$25 Copayment/visit
Provider Services at Hospital and ER	$0 Copayment
Substance Dependency Office Visits rendered by: PCP Specialist	 $25 Copayment/visit $25 Copayment/visit
Inpatient Hospital	$150 per day/ maximum $750/admission
Outpatient Hospital Therapy Services	$25 Copayment/visit
Provider Services at Hospital and ER	$0 Copayment

Special Services

Benefit Description	Your Cost
Autism Spectrum Disorder Services	No Maximum
Physician Services rendered by: PCP Specialist	 $25 Copayment $25 Copayment
All Other Services	Applicable Provider Copayment
Durable Medical Equipment	$0 Copayment
Home Health Care	$0 Copayment
Hospice Care	$0 Copayment
Prosthetic & Orthotic Devices	$0 Copayment

Benefit Description	Your Cost
Rehabilitation Services (e.g., Outpatient Physical, Speech, Cardiac, or Occupational)	No Maximum, authorization required
Skilled Nursing Facility 90 Days/Calendar Year	$0 Copayment
Second Medical Opinion Services rendered by a Contracting Provider Services rendered by a Non Contracting Provider	$40 Copayment 40% of Allowance

Prescription Drug Program

Benefit Description	Retail 30-Day supply	Mail-Order 90-Day supply
Preferred Generic	$15	$30
Preferred Brand Name*	$45	$90
Non-Preferred Prescription*	$65	$130

*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 note does not apply to insulin. Please refer to your BlueCare Rx Pharmacy Endorsement for additional information regarding your Pharmacy coverage.