FCSRMC 2013 HEALTH SCHEDULE OF BENEFITS
HRA
BlueOptions Plan 3359

HRA Funded Account for qualified Medical Expenses

Emp. 1 - $500

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 **you must pay** before the Plan pays) Per Individual per Calendar Year	$1,000	
Per Family per Calendar Year	$3,000	
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	20%	30%
Out-of-Pocket Maximums Per Individual per Calendar Year	$3,000	
Per Family per Calendar Year	$9,000	

What **applies** to out-of-pocket maximums?

- CYD
- Coinsurance
- Copayments (except Rx)

What **does not apply** to out-of-pocket maximums?

- Non-covered charges
- Any benefit penalty reductions
- Charges in excess of the Allowed Amount
- Any Prescription Drug Cost Share amounts

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	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialist)	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Office visits: Mental Health and Substance Abuse Family Physician Specialist	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by:	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Allergy Injections rendered by Family Physicians	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialist)	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
E-Visits rendered by Family Physicians	$10	30% of the Allowed Amount after CYD
Other health care professionals licensed to perform such Services (Specialist)	$10	30% of the Allowed Amount

Benefit Description	In-Network	Out-of-Network
		after CYD
Maternity Office Services	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services rendered by	**$500 Maximum per Calendar Year**	
Family Physicians	20% of the Allowed Amount	30% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialist)	20% of the Allowed Amount	30% of the Allowed Amount
Adult Well Woman Services rendered by		
Family Physicians	20% of the Allowed Amount	30% of the Allowed Amount
Other health care professionals licensed to perform such Services	20% of the Allowed Amount	30% of the Allowed Amount
Child Health Supervision Services rendered by		
Family Physicians	20% of the Allowed Amount	30% of the Allowed Amount
Other health care professionals licensed to perform such Services (Specialist)	20% of the Allowed Amount	30% of the Allowed Amount
Mammograms*	0% of the Allowed Amount	0% of the Allowed Amount
Routine Colonoscopy for ages 50+	0% of the Allowed Amount	0% 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;
2. one routine colonoscopy (per person per lifetime) for ages 50+; and
3. related wellness Services including, but not limited to, pap smears, Prostate Specific Antigen (PSA), colonoscopies, x-rays, laboratory Services, and immunizations. Routine vision and hearing examinations and screenings are not covered.

*****Expenses for Mammograms will not apply to the Preventive Adult Wellness Benefit Maximum.

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	0% of the Allowed Amount	30% of the Allowed Amount after CYD
Independent Diagnostic Testing Facility	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1* and Out-of-State BlueCard® Participating	**Option 2***	
Inpatient Facility Services (per admission)	20% of the Allowed Amount	25% of the Allowed Amount	30% of the Allowed Amount after CYD
Physician and other health care professional Services	20% of the Allowed Amount after CYD		30% of the Allowed Amount after CYD
Inpatient: Mental Health/Substance Abuse Facility Services (per admission)	20% of the Allowed Amount	20% of the Allowed Amount	30% of the Allowed Amount after CYD
Physician and other health care professional Services	20% of the Allowed Amount after CYD		20% of the Allowed Amount after CYD
Outpatient Facility	20% of the Allowed Amount	25% of the Allowed Amount	30% of the Allowed Amount after CYD
Physician and other health care professional Services	20% of the Allowed Amount after CYD		30% of the Allowed Amount after CYD
Therapy Services	20% of the Allowed Amount after CYD	25% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD

Benefit Description	In-Network		Out-of-Network
	Option 1* and Out-of-State BlueCard® Participating	**Option 2***	
Outpatient Therapy Services: Mental Health/Substance Abuse	20% of the Allowed Amount	20% of the Allowed Amount	30% of the Allowed Amount after CYD
Physician and other health care professional Services for Mental Health/Substance Abuse	20% of the Allowed Amount after CYD		20% of the Allowed Amount after CYD
Emergency Room Visits Facility	20% of the Allowed Amount after CYD		30% of the Allowed Amount after CYD
Physician and other health care professional Services	20% of the Allowed Amount after CYD		30% 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. The 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. 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 the Plan pays and the Physician's charge. Claims paid in accordance with this note will be applied to the In-Network CYD.

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

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	20% of the Allowed Amount after CYD	
Urgent Care Center	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD

Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Facility	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Family Physicians	20% of the Allowed Amount after CYD	20% of the Allowed Amount after CYD
Radiologists, Anesthesiologists, and Pathologists	20% of the Allowed Amount after CYD	
Other health care professional Services rendered by all other Providers	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

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 Pharmacy Program Schedule of Benefits and Endorsement for additional information regarding your Pharmacy coverage.

Other Special Services

Benefit Description	In-Network	Out-of-Network
Durable Medical Equipment **Home Health Care Services** **Hospice Services** **Skilled Nursing Facility Services**	20% of the Allowed Amount after CYD	30% of the Allowed Amount after CYD

Benefit Maximums

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

Ambulance Services Per Day Maximum ..... $400 ground and $10,000 air & water

Exception to per Day Maximum: Covered expenses for Ambulance Services are limited to a maximum of $1,000 per day when provided for a newborn child, as described in the Newborn Assessment provision of the "What Is Covered?" section of the Booklet.

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 ..... No Maximum

Per Lifetime ..... No Maximum

Enteral Formula per Calendar Year $2,500

Home Health Care per Calendar Year ..... 20 Visits

Hospice (Combined Inpatient, Outpatient and Home)
per Lifetime ..... No Maximum

Inpatient Rehabilitation Days per Calendar Year 21

Outpatient Therapies and Spinal Manipulations per Calendar Year ..... 35 Visits

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Preventive Adult Wellness
Per Calendar Year $500

Skilled Nursing Facility Days per Calendar Year 60

Total Lifetime Maximum Benefit ..... No Maximum