



FCCRMC 2010 HEALTH SCHEDULE OF BENEFITS

BlueCare Plan 10

With this plan the Member's financial responsibilities, including any applicable Copayments, will vary depending upon the medical service the Member receives, the setting of the services and the Provider the Member chooses to see.

All Copayments, if applicable, are subject to the Maximum Out-of-Pocket limitations described in the Member Handbook. 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 Member Handbook.

Calendar Year Deductible and Out-of-Pocket

Benefit Description	Cost to Member
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	Cost to Member
Primary Care Physician (PCP):	\$20 Copayment
• Routine health exam and immunizations	
• Pediatric and well-baby care	
Specialist	\$35 Copayment
In-office Surgery	Subject to PCP or Specialist Copayment, whichever is applicable
Allergy Injection	\$10 Copayment
Allergy Testing	\$0 Copayment
Annual Contracting Gynecologist	\$35 Copayment

Benefit Description	Cost to Member
Maternity – initial obstetrician visit only	\$35 Copayment

Inpatient Services

Benefit Description	Cost to Member
Inpatient Hospital	\$150 Per Day/5 Day Max Charge
Inpatient Physician	\$0 Copayment
Inpatient Rehabilitation Services (e.g., Physical, Speech, Cardiac, or Occupational)	\$0 Copayment

Outpatient Services

Benefit Description	Cost to Member
Surgical - Outpatient Hospital Surgical	\$200 Copayment
Surgical - Ambulatory Surgical Center	\$200 Copayment
Dialysis	\$0 Copayment
Diagnostic Lab	\$0 Copayment
Diagnostic Testing	Applicable Provider Copayment
X-Ray/Imaging	\$0 Copayment
Birth Center	\$0 Copayment

Emergency Services and Care (*Copayment waived if admitted)

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

Behavioral Health Services

Benefit Description	Cost to Member
Mental Health Outpatient – rendered by: PCP Specialist	\$20 Copayment/visit \$35 Copayment/visit
Inpatient	\$150 Copayment per Day
Partial Hospitalization	\$0 Copayment
Substance Dependency Outpatient – rendered by: PCP Specialist	\$20 Copayment/visit \$35 Copayment/visit
Inpatient (Detoxification Only)	\$150 Copayment per Day

Special Services

Benefit Description	Cost to Member
Autism Spectrum Disorder Services \$36,000 Calendar Year Maximum \$200,000 Lifetime Maximum	
Physician Services rendered by: PCP Specialist	\$20 Copayment \$35 Copayment
All Other Services	Applicable Provider Copayment
Mammograms Based on doctor's recommendation.	\$0 Copay
Durable Medical Equipment	\$0 Copayment
Home Health Care	\$0 Copayment
Hospice Care	\$0 Copayment
Prosthetic & Orthotic Devices	\$0 Copayment
Rehabilitation Services (e.g., Outpatient Physical, Speech, Cardiac, or Occupational)	\$25 Copayment/visit
Skilled Nursing Facility	\$0 Copayment per day

Benefit Description	Cost to Member
90 Days/Calendar Year	
Second Medical Opinion	
Services rendered by a Contracting Provider	\$35 Copayment
Services rendered by a Non-Contracting Provider	40% of Allowance

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.**