CONSTRUCTION RECRUITERS AMERICA STAFFING INC. ®

BlueCross BlueShield

2020 Medical Benefits & Out-of-Pocket Expenses	FL Blue Options PPO 5903		FL Blue Options PPO 3768	
	National Network		National Network	
Calendar Year Deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
	Applies to items with no copay		Applies to items with no copay	
Individual	$5,500	$11,000	$250	$1,000
Family	$11,000	$22,000	$750	$3,000
Coinsurance	Applies to items with no copay		Applies to items with no copay	
In-Network	70%		0%	
Out-of-Network	50%		50%	
Max Out of Pocket	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$6,850	$20,000	$3,000	$6,000
Family	$13,700	$40,000	$6,000	$12,000
Deductible Included in OOP	Yes		Yes	
PCP Required	No		No	
Office Visits				
Primary Care	$50 Copay		$20 Copay	
Specialist	$75 Copay		$45 Copay	
Preventive Care	No Copay		No Copay	
Out-of-Network	50% After Deductible		50% After Deductible	
Inpatient Hospital				
In-Network	30% After Deductible		$700 per admit	
Out-of-Network	50% After Deductible		50% After Deductible	
Outpatient Surgery				
In-Network Hospital Based	30% After Deductible		$200 per admit	
Out-of-Network	50% After Deductible		50% After Deductible	
Emergency Room				
In-Network	$500 Copay		$200 Copay	
Out-of-Network	$500 Copay		$200 Copay	
Urgent Care				
In-Network	$80 Copay		$50 Copay	
Out-of-Network	Deductible + $80 Copay		Deductible + $50 Copay	
Mammogram-Preventive	No Copay		No Copay	
Other Preventive Opt. Diagnostics	No Copay		No Copay	
Independent Lab	No Copay for Quest		No Copay for Quest	
Outpatient X-Ray Minor Procedures	30% After Deductible		$50 Copay Independent	
Diagnostic X-Ray (MRI, CAT, PET)	30% After Deductible		$200 Copay Independent	
Out-of-Network for all other	50% After Deductible		50% After Deductible	
Pharmacy				
Tier 1 - Typically Generic	$10 Copay		$10 Copay	
Tier 2 - Typically Preferred Brand	20%		$50 Copay	
Tier 3 - Typically Non-preferred Brand	Not Covered		$80 Copay	
Tier 4 - Specialty	Not Covered		Subject to Cost Share	

IMPORTANT NOTE: *This is only a partial listing of the benefit provisions under the plans offered. Other copays and limitations may apply. See the Plan highlights brochure for each plan for specific information and out of network benefit coverage.*

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2020 Dental Benefits & Out-of-Pocket Expenses	Dental Low		Dental High	
Calendar Year Deductible	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Preventive Care	100% Deductible Waived		100% Deductible Waived	
Basic Care	80%	80%	80%	80%
Major Services	50%	50%	50%	50%
Annual Maximum	$1,000		$2,000	
Orthodontics	Not Covered		Not Covered	

2020 Vision Benefits & Out-of-Pocket Expenses	In-Network	Out-of-Network
Eye Exam Once every 12 months	100% after $10 copay	Up to $45 reimbursement
Eyeglass Lenses One pair every 12 months (Standard glass or plastic)	100% after $10 copay	Single Vision: Up to $30 reimbursement Bifocal: Up to $50 reimbursement Trifocal: Up to $65 reimbursement
Eyeglass Frames Once every 12 months	$70 Costco max+20% off balance OR $130 retail max	Up to $70 reimbursement
Contact Lenses Every 12 months	$130 allowance	Up to $105 reimbursement

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