BlueCare

Schedule of Benefits Plan 48

Important things to keep in mind while reviewing this Schedule of Benefits:

- This Schedule of Benefits is part of the Benefit Booklet, where more detailed information about benefits can be found.
- Copayments listed in this Schedule of Benefits appear as a dollar amount only and apply per visit.
- Your Cost Share will vary depending upon the medical Service you receive, the setting of the Services and the Provider you choose to see.
- References to Deductible are abbreviated as "**DED**" and references to Benefit Period are abbreviated as "**BP**".

Your Benefit Period (BP).....01/01/25 - 12/31/25

DEDUCTIBLE AND MAXIMUM OUT-OF-POCKET	YOU PAY
Deductible (DED) Per person per BP	$500
Per family per BP	$1,000
Per Admission Deductible (PAD)	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	30%
Maximum Out-of-Pocket Per person per BP	$3,000
Per family per BP	$6,000

What **applies** to the maximum out-of-pocket?

- Copayments
- Coinsurance (if applicable)
- DED (if applicable)
- PAD (if applicable)
- Prescription Drug Cost Share

What **does not apply** to the maximum out-of-pocket?

- Charges for non-covered Services

OFFICE SERVICES	YOU PAY	
	PCP	**Specialist**
Office Visit Cost Share	$25	$35
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$300	$300
All other diagnostic Services (e.g., x-rays)	$25	$35
Allergy Injections	$25	$35
Allergy Testing	$25	$35
Maternity (Copayment due at initial visit only)	$25	$35
Therapy and Spinal Manipulation (e.g., Physical, Speech, Cardiac or Occupational)	$25	$35

VIRTUAL HEALTH	YOU PAY
Virtual Visits rendered by a designated **Virtual Care** Provider	
General Medicine and Urgent Care	$25
Specialized Car	$35
Behavioral Health	$35
Virtual Visits rendered by a designated **Virtual Only** Provider	
General Medicine and Urgent Care	$15
Covered Dermatology Services	$15
Behavioral Health	$15

Please visit https://www.floridablue.com/docview/virtualhealth for more information on Virtual Visits.

MEDICAL PHARMACY	YOU PAY
Medication**	
Preferred Medications	Not Applicable
Non-Preferred Medications	Not Applicable
Maximum Out-of-Pocket per person per Month***	
Preferred Medications	Not Applicable
Non-Preferred Medications	Not Applicable

****Important** – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office visit 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. Refer to the most current Medication Guide at www.floridablue.com to determine whether the medication is a Preferred or Non-Preferred medication.

PREVENTIVE HEALTH SERVICES	YOU PAY
Adult Wellness Services Physician's office and all other locations	$0
Adult Well Woman Services Physician's office and all other locations	$0
Child Health Supervision Services Physician's office and all other locations	$0
Colonoscopies (Routine)	$0
Mammograms	$0

OUTPATIENT DIAGNOSTIC SERVICES	YOU PAY
Independent Clinical Lab	$0
Independent Diagnostic Testing Center Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$300
All other diagnostic Services (e.g., x-rays)	$30
Outpatient Hospital Facility	See **Hospital Services**

EMERGENCY AND URGENT CARE SERVICES	YOU PAY
Ambulance Services	$200
Emergency Room Visits	See **Hospital Services**
Urgent Care Center	$30

OUTPATIENT SURGICAL SERVICES	YOU PAY
Ambulatory Surgical Center Facility	DED + 30%
PCP	$25
Radiologists, Anesthesiologists, and Pathologists	$30
Other health care professional Services rendered by all other Providers	$35
Outpatient Hospital Facility	See **Hospital Services**

HOSPITAL SERVICES	YOU PAY
Inpatient	
Facility	DED + 30%
Physician and other health care professional Services	DED + 30%
Outpatient	
Facility	DED + 30%
Physician and other health care professional Services	DED + 30%
Therapies and Spinal Manipulation	$35
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$300
All other diagnostic Services (e.g., x-rays)	$30
Emergency Room Visits	
In-Network Hospital Facility	$300 + 30%
Out-of-Network Hospital Facility	$300 + 30%
Physician and other health care professional Services	30%

Note: If you are admitted to a Hospital as an inpatient at the time of an emergency room visit to the same facility the Cost Share applicable to inpatient Hospital will apply instead of the emergency room Cost Share.

SPECIAL SERVICES	YOU PAY
Birth Center	DED + 30%
Convenient Care Center	$25
Contrast Materials	$0
Diabetic Equipment	$0
Dialysis Center	DED + 30%
Durable Medical Equipment Motorized wheelchairs	$500
All other Durable Medical Equipment	$30
Enteral Formula	$0
Home Health Care	$20
Home Health Care – Medical Pharmacy Preferred Prescription Drugs	Not Applicable
Non-Preferred Prescription Drugs	Not Applicable
Hospice Services	$20
Outpatient Rehabilitation Facility	$35
Physician Services (rendered at locations not otherwise noted in this schedule) PCP	$25
Specialist	$35
Prosthetic and Orthotic Devices	$30
Routine Eye Exam (with Refraction)	$0
Routine Hearing Exam	$0
Second Medical Opinion In-Network Provider	$35
Out-of-Network Provider	40%
Skilled Nursing Facility	DED + 30%

BEHAVIORAL HEALTH SERVICES	YOU PAY
Mental Health and Substance Dependency Treatment Services	
Outpatient Facility	
Emergency Room	$300 + 30%
Hospital	$25
Physician Services at a Hospital and ER	
PCP	30%
Specialist	30%
Physician and other health care professionals licensed to perform such Services rendered at:	
PCP Office	$25
Specialist Office	$35
All other locations	
PCP	DED + 30%
Specialist	DED + 30%
Inpatient	
Facility	DED + 30%
Physician and other health care professional Services	30%

Note: Services at The Recovery Village Maryland LLC are covered at the negotiated rate for firefighters when not related to workers compensation. Services at Harbor Grace Recovery Center in Maryland are covered at the In-Network benefit level.

Note: If you are admitted to a Hospital as an inpatient at the time of an emergency room visit to the same facility the Cost Share applicable to inpatient Hospital will apply instead of the emergency room Cost Share.

BENEFIT MAXIMUMS

Unless specifically noted otherwise, benefit maximums apply per person and accumulate on a Benefit Period basis.

Bariatric Weight Loss Surgery per Lifetime 1

Note: Refer to the Benefit Booklet for reimbursement guidelines.

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

Inpatient Rehabilitation days 30

Outpatient Therapies and Spinal Manipulation visits 60

Note: Spinal Manipulations are limited to 20 per Benefit Period and accumulate towards the Outpatient Therapies and Spinal Manipulation combined visit maximum.

Routine Eye Exam (with Refraction) every 24 months for adults..... 1

Note: Covered once every 12 months for children (ages 0-17).

Skilled Nursing Facility days ..... Unlimited

Benefit Maximum Carryover

If you or your Covered Dependent were covered under a prior group policy form issued to the Group by Blue Cross and Blue Shield of Florida, Inc., HOI or BeHealthy Florida, Inc. and changed to this plan under the same Group, amounts applied to your Benefit Period maximums under the prior Blue Cross and Blue Shield of Florida, Inc., HOI or BeHealthy Florida, Inc. policy will be applied toward your Benefit Period maximums under this plan.