BlueOptions

Schedule of Benefits – Plan 05782

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- 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.floridablue.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 Deductible are abbreviated as "DED" and references to In-Network are abbreviated as "INN".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period.....01/01/25 - 12/31/25

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period	$1,000	$1,000
Per Family per Benefit Period	$2,000	$2,000
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	30%	50%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$6,500	$9,000
Per Family per Benefit Period	$13,000	$18,000

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

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.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

Office Services

A Primary Care Provider is a Provider whose primary specialty, according to our records, is one of the following: Family Practice, General Practice, Internal Medicine, or Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office visits and Services not otherwise outlined in this table rendered by		
Primary Care Providers	$30	DED + 50%
Other health care professionals licensed to perform such Services	$40	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Primary Care Providers	$300	DED + 50%
Other health care professionals licensed to perform such Services	$300	DED + 50%
Allergy Injections rendered by		
Primary Care Providers	$30	DED + 50%
Other health care professionals licensed to perform such Services	$40	DED + 50%
Durable Medical Equipment, Prosthetics, and Orthotics	$45	DED + 50%
Convenient Care Centers	$30	DED + 50%

Virtual Health

Benefit Description	In-Network	Out-of-Networ
Virtual Visits rendered by a designated **Virtual Care** Provider General Medicine and Urgent Care	$30	Not Covered
Specialized Care	$40	Not Covered
Behavioral Health	$40	Not Covered
Virtual Visits rendered by a designated **Virtual Only** Provider General Medicine and Urgent Care	$20	Not Covered
Covered Dermatology Services	$20	Not Covered
Behavioral Health	$20	Not Covered

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

Medical Pharmacy

Benefit Description	In-Network	Out-of-Networ
Prescription Drugs administered in the office by: Family Physicians	Not Applicable	Not Applicable
Other health care professionals licensed to perform such Services	Not Applicable	Not Applicable
Out-of-Pocket Maximum per Person per Month	Not Applicable	Not Applicable

Important – When applicable, the Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services 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.

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services		
Primary Care Providers	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Adult Well Woman Services		
Primary Care Providers	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Child Health Supervision Services		
Primary Care Providers	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 50%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$300	DED + 50%
All other diagnostic Services (e.g., X-rays)	$35	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	$200	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	$35	DED + $35

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Facility (per visit)	DED + 30%	DED + 50%
Radiologists, Anesthesiologists, and Pathologists	$35	$35
Other health care professional Services rendered by all other Providers	$40	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient Facility Services (per admission)	DED + 30%	DED + 30%	**DED + 50%
Physician and other health care professional Services	DED + 30%		INN DED + 30%
Outpatient Facility (per visit)	DED + 30%	DED + 30%	DED + 50%
Physician and other health care professional Services	DED + 30%		INN DED + 30%
Therapy Services	$40	$40	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$300	$300	DED + 50%
All other diagnostic Services (e.g., X-rays)	$35	$35	DED + 50%
Emergency Room Visits Facility	$300 + 30%		$300 + 30%
Physician and other health care professional Services	30%		30%

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. We 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. Claims paid in accordance with this note will be applied to the In-Network Deductible and Out-of-Pocket Maximums.

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

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the In-Network Option 1 inpatient Cost Share will apply to that admission.

Behavioral Health Services

Benefit Description	In-Network*	Out-of-Network
Mental Health and Substance Dependency Treatment Services		
Outpatient		
Facility Services rendered at:		
Emergency Room	$300 + 30%	$300 + 30%
Hospital	$30	DED + 50%
Physician Services at Hospital	30%	30%
Emergency Room Physicians	30%	30%
Physician and other health care professionals licensed to perform such Services rendered at:		
Primary Care Provider office	$30	DED + 50%
Specialist office	$40	DED + 50%
All other locations	$40	50%
Inpatient		
Facility Services	DED + 30%	**DED + 50%
Physicians and other health care professionals licensed to perform such Services	30%	30%

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

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility, the In-Network Option 1 inpatient Cost Share will apply to that admission.

Other Services

Benefit Description	In-Network	Out-of-Network
Birthing Center	DED + 30%	DED + 50%
Contrast Materials	$0	DED + 50%
Diabetic Equipment and Supplies	$0	DED + 50%
Dialysis Center	DED + 30%	DED + 50%
Enteral Formula	$0	DED + 50%
Home Health Care	$20	DED + 50%
Hospice Care	$20	DED + 50%
Motorized Wheelchairs	$500	DED + 50%
Routine Eye Exam (with Refraction)	$0	Not Covered
Routine Hearing Exam	$0	Not Covered
Second Medical Opinion	DED + 30%	DED + 50%
Skilled Nursing Facility	DED + 30%	DED + 50%

Benefit Maximums

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

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 per Benefit Period 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period 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 per Benefit Period..... Unlimited

Additional Benefits/Features

Benefit Maximum Carryover

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

Prescription Drug Program

Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.