BlueOptions

Schedule of Benefits – Plan 03768

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.
- UF Health is the panel of Providers designated as In-Network Tier 1 for your plan. NetworkBlue is the panel of Providers designated as In-Network Tier 2 for your plan. Tier 3 is the panel of Providers designated as Out-of-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 Tier 2 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	Tier 1 INN	Tier 2 INN	Tier 3 OON
Deductible (DED) Per Person per Benefit Period	$400	Not Applicable	Not Applicable
Per Family per Benefit Period	$800	Not Applicable	Not Applicable
Per Admission Deductible (PAD)	Not Applicable	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	20%	Not Applicable	Not Applicable
Out-of-Pocket Maximums Per Person per Benefit Period	$3,000	Not Applicable	Not Applicable
Per Family per Benefit Period	$6,000	Not Applicable	Not Applicable

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	Tier 1 INN	Tier 2 INN	Tier 3 OON
Office visits and Services not otherwise outlined in this table rendered by			
Primary Care Providers	$10	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	$30	Not Covered	Not Covered
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by			
Primary Care Providers	$30	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	$30	Not Covered	Not Covered
Allergy Injections rendered by			
Primary Care Providers	DED + 20%	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	DED + 20%	Not Covered	Not Covered
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 20%	DED + 20%	Not Covered
Convenient Care Centers	$10	Not Covered	Not Covered
Outpatient Therapy rendered by			
Primary Care Providers	$10	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	$35	Not Covered	Not Covered

Virtual Health

Benefit Description	Tier 1 INN	Tier 2 INN	Tier 3 OON
Virtual Visits rendered by a designated **Virtual Care** Provider			
General Medicine and Urgent Care	$10	Not Covered	Not Covered
Specialized Care	$30	Not Covered	Not Covered
Behavioral Health	$10	Not Covered	Not Covered
Virtual Visits rendered by a designated **Virtual Only** Provider			
General Medicine and Urgent Care	$10	Not Covered	Not Covered
Covered Dermatology Services	$10	Not Covered	Not Covered
Behavioral Health	$10	Not Covered	Not Covered

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

Medical Pharmacy

Benefit Description	Tier 1 INN	Tier 2 INN	Tier 3 OON
Prescription Drugs administered in the office by:			
Family Physicians	Not Applicable	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	Not Applicable	Not Covered	Not Covered
Out-of-Pocket Maximum per Person per Month	Not Applicable	Not Covered	Not Covered

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	Tier 1 INN	Tier 2 INN	Tier 3 OON
Adult Wellness Services Primary Care Providers	$0	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	$0	Not Covered	Not Covered
All other locations	$0	Not Covered	Not Covered
Adult Well Woman Services Primary Care Providers	$0	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	$0	Not Covered	Not Covered
All other locations	$0	Not Covered	Not Covered
Child Health Supervision Services Primary Care Providers	$0	Not Covered	Not Covered
Other health care professionals licensed to perform such Services	$0	Not Covered	Not Covered
All other locations	$0	Not Covered	Not Covered
Mammograms	$0	Not Covered	Not Covered
Routine Colonoscopy	$0	Not Covered	Not Covered

Outpatient Diagnostic Services

Benefit Description	Tier 1 INN	Tier 2 INN	Tier 3 OON
Independent Clinical Lab	$0	Not Covered	Not Covered
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$100	Not Covered	Not Covered
All other diagnostic Services (e.g., X-rays)	$30	Not Covered	Not Covered
Outpatient Hospital Facility	See **Hospital Services Outpatient**		

Emergency and Urgent Care Services

Benefit Description	Tier 1 INN	Tier 2 INN	Tier 3 OON
Ambulance Services	DED + 20%	DED + 20%	DED + 20%
Emergency Room Visits	See **Hospital Services Emergency Room Visits**		
Urgent Care Center	$25	$25	$25

Outpatient Surgical Services

Benefit Description	Tier 1 INN	Tier 2 INN	Tier 3 OON
Ambulatory Surgical Center Facility (per visit)	DED + 20%	Not Covered	Not Covered
Radiologists, Anesthesiologists, and Pathologists	$0	$0	$0
Other health care professional Services rendered by all other Providers	DED + 20%	Not Covered	Not Covered
Outpatient Hospital Facility	See **Hospital Services Outpatient**		

Hospital Services

Benefit Description	(Option 1 & 2) Tier 1 INN*	Tier 2 INN* and Out-of-State BlueCard® Participating	Tier 3 OON
Inpatient			
Facility Services (per admission)	DED + 20%	**Not Covered	**Not Covered
Physician and other health care professional Services	DED + 20%	Not Covered	Not Covered
Outpatient			
Facility (per visit)	DED + 20%	Not Covered	Not Covered
Physician and other health care professional Services	DED + 20%	Not Covered	Not Covered
Radiologists, Anesthesiologists, and Pathologists	$0	$0	$0
Therapy Services	DED + 20%	Not Covered	Not Covered
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$100	Not Covered	Not Covered
All other diagnostic Services (e.g., X-rays)	$30	Not Covered	Not Covered
Emergency Room Visits			
Facility	DED + 20%	DED + 20%	DED + 20%
Physician and other health care professional Services	DED + 20%	DED + 20%	DED + 20%

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 Tier 2 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. Baptist Wolfson is available at the In-Network Tier 1 benefit level for patients ages 18 and under.

**If you are admitted to an In-Network Tier 2 Hospital or Out-of-Network Tier 3 Hospital as an inpatient at the time of the emergency room visit to the same facility the In-Network Tier 1 inpatient Cost Share will apply to that admission.

Behavioral Health Services

Benefit Description	Tier 1 INN*	Tier 2 INN*	Tier 3 OON
Mental Health and Substance Dependency Treatment Services **Outpatient** Facility Services rendered at: Emergency Room	DED + 20%	DED + 20%	DED + 20%
Hospital	DED + 20%	Not Covered	Not Covered
Physician Services at Hospital	DED + 20%	Not Covered	Not Covered
Emergency Room Physicians	DED + 20%	DED + 20%	DED + 20%
Physician and other health care professionals licensed to perform such Services rendered at: Primary Care Provider office	$10	Not Covered	Not Covered
Specialist office	$10	Not Covered	Not Covered
All other locations	$10	Not Covered	Not Covered
Inpatient Facility Services	DED + 20%	**Not Covered	**Not Covered
Physicians and other health care professionals licensed to perform such Services	DED + 20%	Not Covered	Not Covered

*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 Tier 1 benefit level.

**If you are admitted to an In-Network Tier 2 Hospital or Out-of-Network Tier 3 Hospital as an inpatient at the time of the emergency room visit to the same facility the In-Network Tier 1 inpatient Cost Share will apply to that admission.

Other Services

Benefit Description	Tier 1 INN	Tier 2 INN	Tier 3 OON
Birthing Center	DED + 20%	Not Covered	Not Covered
Chiropractor	$35	$35	Not Covered
Contrast Materials	$0	$0	$0
Diabetic Supplies	$0	$0	Not Covered
Dialysis Center	DED + 20%	Not Covered	Not Covered
Enteral Formula	DED + 20%	DED + 20%	Not Covered
Home Health Care	DED + 20%	Not Covered	Not Covered
Hospice Care	DED + 20%	Not Covered	Not Covered
Medical Pharmacy (Home Health)	20%	Not Covered	Not Covered
Motorized Wheelchairs	DED + 20%	DED + 20%	Not Covered
Nurse Practitioner	$10	Not Covered	Not Covered
Routine Eye Exam (with Refraction)	$0	Not Covered	Not Covered
Routine Hearing Exam	$0	Not Covered	Not Covered
Skilled Nursing Facility	DED + 20%	Not Covered	Not Covered

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 100

Inpatient Rehabilitation days per Benefit Period 100

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 100

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.