JPOFFHIT
UF Health Plan

Florida Blue
Your local Blue Cross Blue Shield

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (EM DED)[1] (PBP)[2] (DED is the amount the member is responsible for before Florida Blue pays)	$750 per person $1,500 per family	NA NA
Inpatient Hospital Facility Services Per Admission Deductible (PAD)	$0	$0
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	NA
Out-of-Pocket Maximum (EM OOP)[3] (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$2,5000 per person $5,000 per family	NA NA
Office Services		
Virtual Visits[4] Primary Care Physician Specialist	 $10 Copay $30 Copay	 Not Covered Not Covered
Physician Office Services Primary Care Physician Specialist	 $10 Copay $30 Copay	 Not Covered Not Covered
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	 $10 Copay $10 Copay	 Not Covered Not Covered
Allergy Injections (per visit) Primary Care Physician Specialist	 $10 Copay $30 Copay	 Not Covered Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	DED + 20%	Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) **Monthly Out-of-Pocket (OOP) Maximum**[6] Preferred Non-Preferred	 20% Combined with Preferred OOP	Not Covered NA NA

Important Note: Physician-Administered Medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical benefit*. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.

[1]EM DED = Deductible is Embedded: A covered member's family deductible costs are capped at the individual deductible amount on the family plan. / [2]PBP = Per Benefit Period / [3]EM OOP = Out-of-Pocket Maximum is Embedded: A covered family member's out-of-pocket costs are capped at the individual out-of-pocket maximum amount on the family plan. / [4]Virtual Visit services are only covered for In-Network providers.. / [6]In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

Note: Out-of-Network services may be subject to balance billing.

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Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0 Copay	Not Covered
Mammograms	$0 Copay	Not Covered
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0 Copay	Not Covered
Emergency Medical Care		
Urgent Care Centers	$25 Copay	$25 Copay
Emergency Room Facility Services[7] (per visit) (cost share waived if admitted)	DED + 20%	INN DED + 20%
Ambulance Services	DED + 20%	INN DED + 20%
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	 DED + 20% DED + 20%	 Not Covered Not Covered
Independent Clinical Lab (e.g., Blood Work)	$0 Copay	Not Covered
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	DED + 20%	Not Covered
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	DED + 20%	Not Covered
Outpatient Hospital Facility Services (per visit) Therapy Services All other Services	 DED + 20% DED + 20%	 Not Covered Not Covered
Inpatient Hospital Facility and Rehabilitation Services[7] (per admit)	DED + 20%	Not Covered

Mental Health / Substance Dependency		
Virtual Visits[4] Primary Care Physician Specialist	 $10 Copay $10 Copay	 Not Covered Not Covered
Physician Office Services Primary Care Physician Specialist	 $10 Copay $10 Copay	 Not Covered Not Covered
Emergency Room Facility Services[7] (per visit) (cost share waived if admitted)	DED + 20%	$0 Copay
Outpatient Hospitalization Facility Service (per visit)	DED + 20%	Not Covered
Inpatient Hospitalization Facility Services[7] (per admit)	DED + 20%	Not Covered
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	 DED + 20% DED + 20%	 Not Covered Not Covered
Durable Medical Equipment, Prosthetics and Orthotics	DED + 20%	Not Covered
Home Health Care	DED + 20%	Not Covered
Skilled Nursing Facility	DED + 20%	Not Covered
Hospice	DED + 20%	Not Covered

[4]Virtual Visit services are only covered for In-Network providers. / [7]If admitted as an Inpatient from the Emergency Room member pays the Option 1 In-Network Hospital cost share.

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Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services **you need to get an approval** from Florida Blue before your service or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

Benefit Maximums	
Home Health Care	No Max
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	60 Visits PBP
Spinal Manipulations	20 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	No Max