

2026 Benefits for:
St Johns River Water Management District

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions Plan 03160 HSA compatible (Single Coverage)	BlueOptions Plan 03161 HSA compatible (Family Coverage)
Deductible (DED) (Per Person/Family Agg)		
In-Network	\$1,700 / Not Applicable	\$3,400 / \$3,400
Out-of-Network	\$3,400 / Not Applicable	\$6,800 / \$6,800
Coinsurance (Member Responsibility)		
In-Network	20%	20%
Out-of-Network	40%	40%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins, Copays	Includes DED, Coins, Copays
In-Network	\$3,400 / Not Applicable	\$6,800 / \$6,800
Out-of-Network	\$6,800 / Not Applicable	\$13,600 / \$13,600
Lifetime Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Virtual Visit Services		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
BlueVirtualCare – 24 Hr Service	DED + 20%	DED + 20%
Office Services		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Medical Pharmacy Monthly In-Network OOP Max (Provider-Administered Rx)*	\$200 applies after DED	\$200 applies after DED
In-Network Family Physician and Specialist Out-of-Network	DED + 20% DED + 50%	DED + 20% DED + 50%
Provider Services at Hospital and ER		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Provider Services at Other Locations		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%

Radiology, Pathology and Anesthesiology Provider Services at Ambulatory Surgical Center or Hospital		
In-Network Specialist	ASC: DED + 20% Hospital: DED + 20%	ASC: DED + 20% Hospital: DED + 20%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%
PREVENTIVE CARE		
Adult Wellness Office Services		
In-Network Family Physician & Specialist	\$0	\$0
Out-of-Network	40% (No DED)	40% (No DED)
Colonoscopies (Routine)	Age 45	Age 45
In-Network	\$0	\$0
Out-of-Network	\$0	\$0
Mammograms (Routine and Dx; excludes 3-D)		
In-Network & Out-of-Network	\$0	\$0
Well Child Office Visits (No BPM)		
In-Network Family Physician & Specialist	\$0	\$0
Out-of-Network	40% (No DED)	40% (No DED)
EMERGENCY / URGENT / CONVENIENT CARE		
Ambulance Maximum (ground, air and water)		
In-Network	No maximum DED + 20%	No maximum DED + 20%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Convenient Care Centers (CCC)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 20%	DED + 20%
Urgent Care Centers (UCC)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 20%	DED + 20%
FACILITY SERVICES - HOSP/SURG/ICL/IDTF		
Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.		
Ambulatory Surgical Center		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Independent Clinical Lab	DED / DED + 40%	DED / DED + 40%
In-Network Out-of-Network		
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)		

In-Network - Advanced Imaging Services (AIS)	DED + 20%	DED + 20%
In-Network - Other Diagnostic Services	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Inpatient Hospital (per admit)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Inpatient Rehab Maximum	30 Days	30 Days
Outpatient Hospital (per visit)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Therapy at Outpatient Hospital		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Outpatient Hospitalization (per visit)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Provider Services at Hospital and ER		
In-Network Family Physician or Specialist	DED + 20%	DED + 20%
Out-of-Network Provider	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Physician Office Visit		
In-Network Family Physician or Specialist	DED + 20%	DED + 20%
Out-of-Network Provider	DED + 40%	DED + 40%
Emergency Room Facility Services (per visit)		
In-Network	DED + 20%	DED + 20%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%
Provider Services at Locations other than Hospital and ER		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network Provider	DED + 40%	DED + 40%
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office		
In-Network Family Physician	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%

Birthing Center		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Durable Medical Equipment, Prosthetics, Orthotics BPM	Enteral Formulas:\$2,500 All Other: No Maximum	Enteral Formulas:\$2,500 All Other: No Maximum
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Home Health Care BPM	60 Visits	60 Visits
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Hospice LTM	No Maximum	No Maximum
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
Outpatient Therapy and Spinal Manipulations BPM	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	60 Days	60 Days
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%
PRESCRIPTION DRUGS		
Deductible	Medical Deductible	Medical Deductible
In-Network		
Retail (30 days)		
Generic/Preferred Brand/Non-Preferred	\$10/\$50/\$80 after DED	\$10/\$50/\$80 after DED
Mail Order (90 days)		
Generic/Preferred Brand/Non-Preferred	\$20/\$100/\$160 after DED	\$20/\$100/\$160 after DED
Out-of-Network		
Retail (30 days)		
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%
Mail Order (90 days)		
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%
Specialty Pharmacy / Drugs (30 day supply limit) CareMark in network provider 1-866-278-8108		
In-Network – CareMark	DED then Applicable copay DED + 50% w/ \$1000 coverage cap	DED then Applicable copay DED + 50% w/ \$1000 coverage cap
Out of Network – any pharmacy other than CareMark	Calendar year Deductible waived Applicable copayments apply	Calendar year Deductible waived Applicable copayments apply
Condition Care Preventive Medications		
Please see on-line Medication Guide pg VII for current medication listed under the HSA Preventive Drug list		
MONTHLY RATES		
Employee Only	\$87.86 monthly	N/A
Employee/Family	N/A	\$384.76 monthly

* (1) Medical Pharmacy Monthly OOP Max applies in-network only and is combined Preferred and Non-Preferred unless otherwise noted. It includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.

Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Florida Blue, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Florida Blue's Benefit Booklet and Schedule of Benefits; their terms prevail.

The information contained in this document includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary. Additionally, Interim rules released by the Federal Government February 2, 2010 require BCBSF to test all benefit plans to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAE). Benefits and rates reflected in the proposal are subject to change based on the outcomes of the test.