

EPO 1250 Plan (Effective January 1, 2026)

VyStar Credit Union

	In-Network	Out-of-Network
Benefit Year Deductible (BYD)		
Individual amounts with any combination of family members accumulate towards the family amount. No one member will go over the individual amount.		
Individual Deductible	\$1,250	NOT COVERED
Family Deductible	\$2,500	NOT COVERED
Out-of-Pocket Maximum		
Individual Maximum	\$5,000	NOT COVERED
Family Maximum	\$10,000	NOT COVERED
Coinsurance		
Coinsurance (Plan pays after BYD has been satisfied.)	80%	NOT COVERED
Coinsurance (Member pays after plan pays their %.)	20%	NOT COVERED
Physician Office Services		
Primary Care Office Visit (PCP)	\$20 Copay	NOT COVERED
Specialist Office Visit (SP)	\$40 Copay	NOT COVERED
Convenient Care Clinics	\$10 Copay	NOT COVERED
Teladoc Services (1-866-789-8155) - General Medicine - Mental Health - Dermatology - Primary Care 360	\$0 Copay \$20 Copay \$20 Copay \$10 Copay	NOT COVERED
Wellness and Preventive Care (Routine Physical Exams and related labs)		
Primary Office Visit	0% No BYD	NOT COVERED
Specialist Office Visit	0% No BYD	NOT COVERED
Vision Exam	Subject to 1 exam per 24-month period	
Immunizations	0% No BYD	NOT COVERED
Flu / Pneumonia Vaccine	0% No BYD	NOT COVERED
Mammogram	0% No BYD	NOT COVERED
Colonoscopy (includes Cologuard)	0% No BYD	NOT COVERED
Routine Bone Density Screenings	0% No BYD	NOT COVERED
Hospital Services		
Inpatient	20% After BYD	NOT COVERED
Outpatient	20% After BYD	NOT COVERED
Inpatient and Outpatient Professionals	20% After BYD	NOT COVERED
Radiology, Anesthesiology and Pathology Providers Services at Hospital	20% After BYD	20% After BYD
Emergency Room		
Emergency Room Visit	\$500 Copay	
Emergency Room Professionals	0% No BYD	0% No BYD
Urgent Care Centers	\$30 Copay	NOT COVERED



In-Network		Out-of-Network
Mental Health/Substance Abuse		
Inpatient / Outpatient Facilities	20% After BYD	NOT COVERED
Inpatient and Outpatient Professionals	20% After BYD	NOT COVERED
Office Visit	\$20 PCP / \$40 SP Copay	NOT COVERED
Other Services		
Skilled Nursing Facility	100-Day Benefit Year Maximum	
	20% After BYD	NOT COVERED
Home Health Care	120-Day Benefit Year Maximum	
	20% After BYD	NOT COVERED
Private Duty Nursing	70-Day Benefit Year Maximum	
	0% After BYD	NOT COVERED
Hospice Facility	20% After BYD	NOT COVERED
Outpatient Therapies	60 Visit Benefit Year Maximum for Occupational, Physical, Speech & Chiropractic Therapies	
	PCP Office Visit	NOT COVERED
	Specialist Office Visit	
	Professional Service in a Facility	
Acupuncture	\$800 Benefit Period Maximum	
	20% After BYD	NOT COVERED
Ambulance	20% After BYD	NOT COVERED
Durable Medical Equipment	Pre-certification required on charges more than \$500	
	20% After BYD	NOT COVERED
Hearing Aids	\$5,000 Maximum every two years	
	20% After BYD	NOT COVERED
Infertility	\$10,000 Lifetime Max – Service provided by a Reproductive Endocrinologist	
	20% After BYD	NOT COVERED
Independent Diagnostic Lab and X-Ray (Free Standing Facility)	0% No BYD	NOT COVERED
ABA Therapy	20% After BYD	NOT COVERED
Advanced Imaging in Free Standing Facility (MRI, PET, CT Scan, etc.)	\$150 Copay	NOT COVERED
Varicose Vein Treatment	\$2,500 Benefit Year Maximum	
	20% After BYD	NOT COVERED
Obesity Surgical Procedures	\$20,000 Benefit Period Maximum	
	20% After BYD	NOT COVERED
Coronary Artery Scan	\$200 Benefit Year Maximum	
	20% After BYD	NOT COVERED
Nutritional Counseling	6 Visits Benefit Year Maximum	
	20% After BYD	NOT COVERED
Prescription Retail (31-day supply)		
Generic	\$15 copay	NOT COVERED
Brand	\$35 copay	NOT COVERED
Non-Preferred	\$60 copay	NOT COVERED
OptumRx Specialty Pharmacy (31-day supply)		
Specialty Drugs	\$200 Copay	NOT COVERED



	In-Network	Out-of-Network
Mail Order (90-day supply)		
Generic	\$37.50 Copay	NOT COVERED
Brand	\$87.50 Copay	NOT COVERED
Non-Preferred	\$150.00 Copay	NOT COVERED

- (1) Your group's benefit period is based on a Contract Year which runs from January 1 to December 31.
- (2) Plan Allowance is the maximum amount of the billed charge BCBS deems is payable by the plan for covered services or supplies.
- (3) The Out-of-Pocket Maximum excludes non-covered services, charges in excess of plan allowance, and penalties.
- (4) Precertification is required on all Inpatient Admissions as well as Outpatient Hospital services, Home Health Care, Ambulance Services, Durable Medical Equipment, and Advanced Imaging Services.

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 Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.

