

| | Employee Plan B | Employee Plan C | Employee Plan I | Employee Plan L |
|---|----------------------------------|----------------------------------|-------------------------------------|------------------|
| | Blue Options | Blue Options | Blue Options | Blue Care (HMO) |
| Cost Sharing - Member's Responsibility | | | | |
| Deductible (DED) (Per Person/Family Aggregate) | Amounts are combined INN and OON | Amounts are combined INN and OON | Deductible amounts cross accumulate | Embedded |
| In-Network | \$500/\$1,500 | \$500/\$1500 | \$1,500/\$3,000 | \$5,000/\$10,000 |
| Out-of-Network | | | \$3,000/\$6,000 | NA / NA |
| Coinsurance (BCBSF pays / Member pays) | | | | |
| In-Network | 80%/20% | 80%/20% | 70% / 30% | 70% / 30% |
| Out-of-Network | 50%/50% | 60%/40% | 50% / 50% | NA / NA |
| Out of Pocket Maximum (Per Person/Family Aggregate) | | | | Embedded |
| <i>Includes Deductibles, Copays, Coinsurance & RX</i> | | | | |
| In-Network | \$6,450/\$12,900 | \$6,450/\$12,900 | \$6,450/\$12,900 | \$6,350/\$12,700 |
| Out-of-Network | \$12,900/\$25,800 | \$12,900/\$25,800 | \$12,900/\$25,800 | NA / NA |
| Medical Pharmacy OOP Maximum (Per Person Per Calendar Month) | | | | |
| In-Network (Preferred) | \$200 | \$200 | \$200 | \$200 |
| Out-of-Network | N/A | N/A | N/A | NA |
| Medical / Surgical Care by a Physician | | | | |
| Office Services | | | | |
| In-Network Family Physician | \$20 | DED + 20% | \$30 | \$40 |
| In-Network Specialist | DED + 20% | DED + 20% | \$55 | \$65 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| E-Visits | | | | |
| In-Network Family Physician | \$10 | \$10 | \$10 | \$10 |
| In-Network Specialist | \$10 | \$10 | \$10 | \$10 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Allergy Injections (Office) | | | | |
| In-Network Family Physician | \$10 | \$10 | \$10 | \$10 |
| In-Network Specialist | \$10 | \$10 | \$10 | \$10 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Health Care Professional Administered Medications in the Office (Medical Pharmacy) | | | | |
| In-Network (Preferred) | 20% | 20% | 20% | 20% |
| In-Network (Non-Preferred) | 20% | 20% | 20% | 20% |
| Out-of-Network | DED + 50% | DED + 50% | DED + 50% | Not Covered |
| Maternity Office Services | | | | |
| In-Network Family Physician | \$20 | DED + 20% | \$30 | \$40 |
| In-Network Specialist | DED + 20% | DED + 20% | \$55 | \$65 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Convenient Care Center | | | | |
| In-Network | \$20 | DED + 20% | \$30 | \$40 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |

Note: INN PCP: Family practice, General practice, Internal Medicine & Pediatrician/ Note: OON providers can balance bill for amount above BC allowance. INN providers Not permitted to balance bill.

| | Employee Plan B | Employee Plan C | Employee Plan I | Employee Plan L |
|---|-----------------|-----------------|-----------------|-----------------|
| | Blue Options | Blue Options | Blue Options | Blue Care (HMO) |
| Physician Services at Hospital | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | INN DED + 20% | INN DED + 20% | INN DED + 30% | Not Covered |
| Radiology, Pathology and Anesthesiology Provider Services at Hospital | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | INN DED + 20% | INN DED + 20% | INN DED + 30% | Not Covered |
| Radiology, Pathology and Anesthesiology Provider Services at ASC | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | \$100 |
| Out-of-Network | INN DED + 20% | INN DED + 20% | INN DED + 30% | Not Covered |
| Physician Services at Locations other than Office, Hospital and ER | | | | |
| In-Network Family Physician | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| In-Network Specialist | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Accident Benefit | | | | |
| In-Network | 20% | 20% | 30% | 30% |
| Out-of-Network | 50% | 40% | 50% | Not Covered |
| Preventive Services-Adult Wellness Services | | | | |
| Office Services | | | | |
| In-Network Family Physician | \$0 | \$0 | \$0 | \$0 |
| In-Network Specialist | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | 50% | 40% | 50% | Not Covered |
| Independent Clinical Laboratory <i>(Quest Diagnostics is the In-Network Lab in Florida)</i> | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | 50% | 40% | 50% | Not Covered |
| Mammograms <i>(Routine & Diagnostic)</i> | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | \$0 | \$0 | \$0 | Not Covered |
| Colonoscopies <i>Routine/Screening colonoscopy is recommended for average risk adults every ten years, beginning at age 50. Routine includes polyp removal.</i> | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | \$0 | \$0 | \$0 | Not Covered |
| Preventive Services-Well Child Services | | | | |
| Office Services | | | | |
| In-Network Family Physician | \$0 | \$0 | \$0 | \$0 |
| In-Network Specialist | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | 50% | 40% | 50% | Not Covered |

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|---|-----------------|-----------------|-----------------|-----------------|
| | Blue Options | Blue Options | Blue Options | Blue Care (HMO) |
| Independent Clinical Laboratory <i>(Quest Diagnostics is the In-Network Lab in Florida)</i> | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | 50% | 40% | 50% | Not Covered |
| Medical / Surgical Care at a Facility | | | | |
| Ambulatory Surgical Center (ASC) | | | | |
| In-Network | \$100 | \$100 | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Inpatient Hospital Facility (per admit) | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Outpatient Hospital Facility (per visit) | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Emergency and Urgent Care | | | | |
| Emergency Room Facility (per visit) | | | | |
| In-Network | \$100 | DED + 20% | DED + 30% | \$300 |
| Out-of-Network | \$100 | INN DED + 20% | INN DED + 30% | \$300 |
| Physician Services at ER (With or without Surgery performed or with or without admit) | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | INN DED + 20% | INN DED + 20% | INN DED + 30% | INN DED + 30% |
| Urgent Care Centers | | | | |
| In-Network | \$40 | \$40 | \$60 | \$85 |
| Out-of-Network | INN DED + \$40 | INN DED + \$40 | INN DED + \$60 | Not Covered |
| Ambulance | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | INN DED + 20% | INN DED + 20% | INN DED + 30% | INN DED + 30% |
| Diagnostic Testing (e.g., Lab, x-ray) | | | | |
| Physician Office | | | | |
| In-Network Family Physician | \$20 | DED + 20% | \$30 | \$40 |
| In-Network Specialist | DED + 20% | DED + 20% | \$55 | \$65 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Independent Clinical Laboratory <i>(Quest Diagnostics is the In-Network Lab in Florida)</i> | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Independent Diagnostic Testing Center | | | | |
| In-Network | \$50 | \$50 | \$50 | \$65 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Outpatient Hospital Facility | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |

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| | Employee Plan B | Employee Plan C | Employee Plan I | Employee Plan L |
|--|-----------------|-----------------|-----------------|-----------------|
| | Blue Options | Blue Options | Blue Options | Blue Care (HMO) |
| Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) <i>Subject to Prior Authorization</i> | | | | |
| Physician Office | | | | |
| In-Network Family Physician | \$100 | \$100 | \$100 | \$300 |
| In-Network Specialist | \$100 | \$100 | \$100 | \$300 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Independent Diagnostic Testing Center | | | | |
| In-Network | \$100 | \$100 | \$100 | \$200 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Outpatient Hospital Facility | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Outpatient Therapy <i>*Services Include:</i> | | | | |
| Physician Office | | | | |
| In-Network Family Physician | \$20 | DED + 20% | \$30 | \$40 |
| In-Network Specialist | DED + 20% | DED + 20% | \$55 | \$65 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Outpatient Rehabilitation Facility | | | | |
| In-Network | DED + 20% | DED + 20% | \$55 | \$65 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Outpatient Hospital Facility | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | \$85 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Mental Health/Substance Dependency Services <i>Subject to Prior Authorization</i> | | | | |
| Physician Office | | | | |
| In-Network Family Physician | \$0 | \$0 | \$0 | \$0 |
| In-Network Specialist | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | 50% | 40% | 50% | Not Covered |
| Inpatient Hospital Facility | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | 50% | 40% | 50% | Not Covered |
| Outpatient Hospital Facility | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | 50% | 40% | 50% | Not Covered |
| Emergency Room Facility(per visit) | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network | \$0 | \$0 | \$0 | \$0 |
| Physician Services at Hospital and ER | | | | |
| In-Network | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network ER | \$0 | \$0 | \$0 | \$0 |
| Out-of-Network Hospital | \$0 | \$0 | \$0 | Not Covered |

**Medically necessary Chiropractic, Physical Therapy, Massage Therapy, Speech Therapy & Occupational Therapy. Medical policy guidelines apply.*

| | Employee Plan B | Employee Plan C | Employee Plan I | Employee Plan L |
|--|----------------------|----------------------|----------------------|--------------------------|
| | Blue Options | Blue Options | Blue Options | Blue Care (HMO) |
| Other Special Services and Locations | | | | |
| Durable Medical Equipment/Orthotics & Prosthetics <i>Subject to Prior Authorization</i> | | | | |
| In-Network Motorized Wheelchairs | DED + 20% | DED + 20% | DED + 30% | \$500 |
| In-Network All Other | DED + 20% | DED + 20% | DED + 30% | \$0 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Skilled Nursing Facility | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Home Health Care | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | \$0 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Hospice | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Dialysis Center | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Birthing Center | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Diabetic Equipment & Supplies | | | | |
| In-Network | DED + 20% | DED + 20% | DED + 30% | \$0 |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Wisdom Teeth (Surgical removal of impacted Wisdom Teeth) | | | | |
| In-Network | Covered based on LOS | Covered based on LOS | Covered based on LOS | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Accidental Dental Injury treatment * | | | | |
| In-Network | Covered based on LOS | Covered based on LOS | Covered based on LOS | DED + 30% |
| Out-of-Network | DED + 50% | DED + 40% | DED + 50% | Not Covered |
| Benefit Maximums | | | | |
| Home Health Care | | | | |
| Combined (INN & OON) | 30 Visits PBP | 30 Visits PBP | 30 Visits PBP | 60 Visits PBP (INN ONLY) |
| Inpatient Rehabilitation | | | | |
| Combined (INN & OON) | 30 Days PBP | 30 Days PBP | 30 Days PBP | 30 Days PBP (INN ONLY) |
| Outpatient Therapy & Spinal Manipulations | | | | |
| Combined (INN & OON) | 75 Visits PBP | 75 Visits PBP | 75 Visits PBP | 30 Visits PBP (INN ONLY) |
| Skilled Nursing Facility | | | | |
| Combined (INN & OON) | 60 Days PBP | 60 Days PBP | 60 Days PBP | 45 Days PBP (INN ONLY) |
| Spinal Manipulations | | | | |
| Combined (INN & OON) | 26 PBP | 26 PBP | 26 PBP | 30 PBP (INN ONLY) |

**Initiated within 62 days of the date of the accidental injury for the treatment of damage to sound, natural teeth. No time limit applies to complete treatment if initiated within 62 days.*

Note: OON providers can balance bill for amount above BC allowance. INN providers Not permitted to balance bill.

| | Employee Plan B | Employee Plan C | Employee Plan I | Employee Plan L |
|-----------------------------|------------------------|---------------------------------|-------------------------------------|--|
| | Blue Options | Blue Options | Blue Options | Blue Care (HMO) |
| Prescription Drugs | | | | |
| | OPEN FORMULARY* | OPEN FORMULARY* | CLOSED FORMULARY | CLOSED FORMULARY* |
| Deductible | N/A | \$100 (Brand Only) | \$800 (Brand Only) | Integrated with Health |
| In-Network | | | | |
| Retail | | | | |
| Generic/Brand/Non-Preferred | 20%/40%/40% | 20%/40% after DED/50% after DED | \$10/\$60 after Rx DED/Not Covered | \$10 after DED/ \$60 after DED/ Not Covered |
| Mail Order ** | | | | |
| Generic/Brand/Non-Preferred | 20%/40%/40% | 20%/40% after DED/50% after DED | \$20/\$120 after Rx DED/Not Covered | \$20 after DED/ \$120 after DED/ Not Covered |
| Out-of-Network | | | | |
| Retail | | | | |
| Generic/Brand/Non-Preferred | 50%/50%/50% | 50%/50%/50% | 50%/50%/Not Covered | Not Covered |
| Mail Order | | | | |
| Generic/Brand/Non-Preferred | Not Covered | Not Covered | Not Covered | Not Covered |

All Pharmacy Medication Guides are available at <https://www.floridablue.com/tools-resources/pharmacy/medication-guide>.

- See current medication guide for a listing of specialty medications. Updates are made in January and July
- OON Pharmacy services are subject to the pharmacy deductible (where applicable) and paid at 50% of allowance.
- 90 day supply available at select retail extended supply pharmacies. Visit the providers directory at www.FloridaBlue.com to find retail.
- Pharmacy utilization programs (eg) Responsible Rx, Mandatory Generic Rx, Exclusions apply to all plans (see Medication Guide).

Closed Formulary Note:

- Rx-Specialty Medication – Not Covered – Except for oral oncology and HIV Medications

Plans B, C, & I Rx* Note:

- Condition Care Rx Program Value List applies: \$0 Copay for listed Brand Medications

• **Medical Pharmacy (Office Setting):** Coverage for self-administered specialty medications are excluded except for medications used for immediate stabilization (e.g. securing an airway, controlling a hemorrhage, or treating shock).

Please refer to retail pharmacy for coverage of self-administered specialty medications.

**90 day supply available through Prime Therapeutics

***All RX meet Center for Medicare and Medicaid Part D-Creditable Coverage Guidelines.

This is a summary of benefits and not a contract. All benefits are subject to the provisions, exclusions and limitations set forth in the master contract.

To verify a provider's specialty or participation status, the insured may contact Florida Blue, or review the most recent Provider Directory.

It is the insured's sole responsibility to select and verify a provider's network participation status at the time services are rendered.

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