

	Employee Plan B	Employee Plan C	Employee Plan I	Employee Plan L
	Blue Options	Blue Options	Blue Options	Blue Care (HMO)
<b>Cost Sharing - Member's Responsibility</b>				
<b>Deductible (DED) (Per Person/Family Aggregate)</b>	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
<b>Coinsurance (BCBSF pays / Member pays)</b>				
In-Network	80%/20%	80%/20%	70% / 30%	70% / 30%
Out-of-Network	50%/50%	60%/40%	50% / 50%	NA / NA
<b>Out of Pocket Maximum (Per Person/Family Aggregate)</b>				Embedded
<i>Includes Deductibles, Copays, Coinsurance &amp; 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
<b>Medical Pharmacy OOP Maximum (Per Person Per Calendar Month)</b>				
In-Network (Preferred)	\$200	\$200	\$200	\$200
Out-of-Network	N/A	N/A	N/A	NA
<b>Medical / Surgical Care by a Physician</b>				
<b>Office Services</b>				
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
<b>Virtual Visits</b>				
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
<b>Allergy Injections (Office)</b>				
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
<b>Health Care Professional Administered Medications in the Office (Medical Pharmacy)</b>				
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
<b>Maternity Office Services</b>				
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
<b>Convenient Care Center</b>				
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)
<b>Physician Services at Hospital</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	Not Covered
<b>Radiology, Pathology and Anesthesiology Provider Services at Hospital</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	Not Covered
<b>Radiology, Pathology and Anesthesiology Provider Services at ASC</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	\$100
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 30%	Not Covered
<b>Physician Services at Locations other than Office, Hospital and ER</b>				
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
<b>Accident Benefit</b>				
In-Network	20%	20%	30%	30%
Out-of-Network	50%	40%	50%	Not Covered
<b>Preventive Services-Adult Wellness Services</b>				
<b>Office Services</b>				
In-Network Family Physician	\$0	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0	\$0
Out-of-Network	50%	40%	50%	Not Covered
<b>Independent Clinical Laboratory</b> <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
<b>Mammograms</b> <i>(Routine &amp; Diagnostic)</i>				
In-Network	\$0	\$0	\$0	\$0
Out-of-Network	\$0	\$0	\$0	Not Covered
<b>Colonoscopies</b> <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
<b>Preventive Services-Well Child Services</b>				
<b>Office Services</b>				
In-Network Family Physician	\$0	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0	\$0
Out-of-Network	50%	40%	50%	Not Covered

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

	Employee Plan B Blue Options	Employee Plan C Blue Options	Employee Plan I Blue Options	Employee Plan L Blue Care (HMO)
<b>Independent Clinical Laboratory</b> <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
<b>Medical / Surgical Care at a Facility</b>				
<b>Ambulatory Surgical Center (ASC)</b>				
In-Network	\$100	\$100	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Inpatient Hospital Facility (per admit)</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Outpatient Hospital Facility (per visit)</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Emergency and Urgent Care</b>				
<b>Emergency Room Facility (per visit)</b>				
In-Network	\$100	DED + 20%	DED + 30%	\$300
Out-of-Network	\$100	INN DED + 20%	INN DED + 30%	\$300
<b>Physician Services at ER (With or without Surgery performed or with or without admit)</b>				
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%
<b>Urgent Care Centers</b>				
In-Network	\$40	\$40	\$60	\$85
Out-of-Network	INN DED + \$40	INN DED + \$40	INN DED + \$60	Not Covered
<b>Ambulance</b>				
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%
<b>Diagnostic Testing (e.g., Lab, x-ray)</b>				
<b>Physician Office</b>				
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
<b>Independent Clinical Laboratory</b> <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
<b>Independent Diagnostic Testing Center</b>				
In-Network	\$50	\$50	\$50	\$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Outpatient Hospital Facility</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered

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)
<b>Advanced Imaging (AIS) (MRI, MRA, PET, CT &amp; Nuclear Medicine)</b> <i>Subject to Prior Authorization</i>				
<b>Physician Office</b>				
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
<b>Independent Diagnostic Testing Center</b>				
In-Network	\$100	\$100	\$100	\$200
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Outpatient Hospital Facility</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Outpatient Therapy</b> <i>*Services Include:</i>				
<b>Physician Office</b>				
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
<b>Outpatient Rehabilitation Facility</b>				
In-Network	DED + 20%	DED + 20%	\$55	\$65
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Outpatient Hospital Facility</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	\$85
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Mental Health/Substance Dependency Services</b> <i>Subject to Prior Authorization</i>				
<b>Physician Office</b>				
In-Network Family Physician	\$0	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0	\$0
Out-of-Network	50%	40%	50%	Not Covered
<b>Inpatient Hospital Facility</b>				
In-Network	\$0	\$0	\$0	\$0
Out-of-Network	50%	40%	50%	Not Covered
<b>Outpatient Hospital Facility</b>				
In-Network	\$0	\$0	\$0	\$0
Out-of-Network	50%	40%	50%	Not Covered
<b>Emergency Room Facility(per visit)</b>				
In-Network	\$0	\$0	\$0	\$0
Out-of-Network	\$0	\$0	\$0	\$0
<b>Physician Services at Hospital and ER</b>				
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)
<b>Other Special Services and Locations</b>				
<b>Durable Medical Equipment/Orthotics &amp; Prosthetics</b> <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
<b>Skilled Nursing Facility</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Home Health Care</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	\$0
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Hospice</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Dialysis Center</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Birthing Center</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	DED + 30%
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Diabetic Equipment &amp; Supplies</b>				
In-Network	DED + 20%	DED + 20%	DED + 30%	\$0
Out-of-Network	DED + 50%	DED + 40%	DED + 50%	Not Covered
<b>Wisdom Teeth (Surgical removal of impacted Wisdom Teeth)</b>				
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
<b>Accidental Dental Injury treatment *</b>				
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
<b>Benefit Maximums</b>				
<b>Home Health Care</b>				
Combined (INN & OON)	30 Visits PBP	30 Visits PBP	30 Visits PBP	60 Visits PBP (INN ONLY)
<b>Inpatient Rehabilitation</b>				
Combined (INN & OON)	30 Days PBP	30 Days PBP	30 Days PBP	30 Days PBP (INN ONLY)
<b>Outpatient Therapy &amp; Spinal Manipulations</b>				
Combined (INN & OON)	75 Visits PBP	75 Visits PBP	75 Visits PBP	30 Visits PBP (INN ONLY)
<b>Skilled Nursing Facility</b>				
Combined (INN & OON)	60 Days PBP	60 Days PBP	60 Days PBP	45 Days PBP (INN ONLY)
<b>Spinal Manipulations</b>				
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 Blue Options	Employee Plan C Blue Options	Employee Plan I Blue Options	Employee Plan L Blue Care (HMO)
<b>Prescription Drugs</b>				
	<b>OPEN FORMULARY*</b>	<b>OPEN FORMULARY*</b>	<b>CLOSED FORMULARY</b>	<b>CLOSED FORMULARY*</b>
<b>Deductible</b>	N/A	\$100 (Brand Only)	\$800 (Brand Only)	Integrated with Health
<b>In-Network</b>				
<b>Retail</b>				
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
<b>Mail Order **</b>				
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
<b>Out-of-Network</b>				
<b>Retail</b>				
Generic/Brand/Non-Preferred	50%/50%/50%	50%/50%/50%	50%/50%/Not Covered	Not Covered
<b>Mail Order</b>				
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](http://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, & L 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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