

	Employee Plan G	Employee Plan H	Employee Plan M
	Blue Options (HSA Compatible)	Blue Options (HSA Compatible)	Blue Care (HSA Compatible)
Cost Sharing - Member's Responsibility			
Deductible (DED) (Per Person/Family Aggregate)	Individual DED Amounts do not apply under Family Plans	Individual DED Amounts do not apply under Family Plans	Individual DED Amounts do not apply under Family Plans
In-Network	\$1,400 / \$2,800	\$2,500 / \$5,000	\$2,500 / \$5,000
Out-of-Network	\$1,400 / \$2,800	\$5,000 / \$10,000	Not Covered
Coinsurance (BCBSF pays / Member pays)			
In-Network	80% / 20%	80% / 20%	80% / 20%
Out-of-Network	60% / 40%	60% / 40%	Not Covered
Out of Pocket Maximum (Per Person/Family Aggregate) <i>Includes Deductibles, copays, Coinsurance & RX</i>	Individual OOP amounts do apply towards the Family Maximum (Embedded)	Individual OOP amounts do apply towards the Family Maximum (Embedded)	Individual OOP amounts do apply towards the Family Maximum (Embedded)
In-Network	\$6,450/\$12,900	\$6,450/\$12,900	\$5,000 \$6,750 / \$10,000
Out-of-Network	\$12,900/\$25,800	\$12,900/\$25,800	Not Covered
Medical Pharmacy OOP Maximum (Per Person Per Calendar Month)			
In-Network (Preferred/Non-Preferred)	N/A	N/A	\$200/\$700
Out-of-Network	N/A	N/A	Not Covered
Medical / Surgical Care by a Physician			
Office Services			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Virtual Visits			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Allergy Injections (Office)			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Health Care Professional Administered Medications in the Office (Medical Pharmacy)			
In-Network (Preferred)	DED + 20%	DED + 20%	DED + 15%
In-Network (Non-Preferred)	DED + 20%	DED + 20%	DED + 35%
Out-of-Network	DED + 50%	DED + 50%	Not Covered
Maternity Office Services			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Convenient Care Center			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	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 G	Employee Plan H	Employee Plan M
	Blue Options (HSA Compatible)	Blue Options (HSA Compatible)	Blue Care (HSA Compatible)
Physician Services at Hospital			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Hospital			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at ASC			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	Not Covered
Physician Services at Locations other than Office, Hospital and ER			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Preventive Services-Adult Wellness Services			
Office Services			
In-Network Family Physician	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0
Out-of-Network	40%	40%	Not Covered
Independent Clinical Laboratory <i>(Quest Diagnostics is the In-Network Lab in Florida)</i>			
In-Network	\$0	\$0	\$0
Out-of-Network	40%	40%	Not Covered
Mammograms <i>(Routine Only)</i>			
In-Network	\$0	\$0	\$0
Out-of-Network	\$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
Out-of-Network	\$0	\$0	Not Covered
Preventive Services-Well Child Services			
Office Services			
In-Network Family Physician	\$0	\$0	\$0
In-Network Specialist	\$0	\$0	\$0
Out-of-Network	40%	40%	Not Covered
Independent Clinical Laboratory <i>(Quest Diagnostics is the In-Network Lab in Florida)</i>			
In-Network	\$0	\$0	\$0
Out-of-Network	40%	40%	Not Covered
Medical / Surgical Care at a Facility			
Ambulatory Surgical Center (ASC)			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered

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

	Employee Plan G	Employee Plan H	Employee Plan M
	Blue Options (HSA Compatible)	Blue Options (HSA Compatible)	Blue Care (HSA Compatible)
Inpatient Hospital Facility (per admit)			
In-Network	Option 1:DED + 20% Option 2:DED + 25% *	Option 1:DED + 20% Option 2:DED + 25% *	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Outpatient Hospital Facility (per visit)			
In-Network	Option 1:DED + 20% Option 2:DED + 25% *	Option 1:DED + 20% Option 2:DED + 25% *	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Emergency and Urgent Care			
Emergency Room Facility (per visit)			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 20%
Physician Services at ER (With or without Surgery performed or with or without admit)			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 20%
Urgent Care Centers			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	Not Covered
Ambulance			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 20%
Diagnostic Testing (e.g., Lab, x-ray)			
Physician Office			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Independent Clinical Laboratory <i>(Quest Diagnostics is the In-Network Lab in Florida)</i>			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Independent Diagnostic Testing Center			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Outpatient Hospital Facility			
In-Network	Option 1:DED + 20% Option 2:DED + 25% *	Option 1:DED + 20% Option 2:DED + 25% *	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered

* 25% Coinsurance: Option 2 Hospital facility. See BCBS Provider Directory for hospital facility tier status
 Note: OON providers can balance bill for amount above BC allowance. INN providers Not permitted to balance bill.

	Employee Plan G	Employee Plan H	Employee Plan M
	Blue Options (HSA Compatible)	Blue Options (HSA Compatible)	Blue Care (HSA Compatible)
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine) Subject to Prior Authorization			
Physician Office			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Independent Diagnostic Testing Center			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Outpatient Hospital Facility			
In-Network	Option 1:DED + 20% Option 2:DED + 25% *	Option 1:DED + 20% Option 2:DED + 25% *	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Outpatient Therapy <i>**Serves include</i>			
Physician Office			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Outpatient Rehabilitation Facility			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Outpatient Hospital Facility			
In-Network	Option 1:DED + 20% Option 2:DED + 25% *	Option 1:DED + 20% Option 2:DED + 25% *	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Mental Health/Substance Dependency Services <i>Subject to Prior Authorization</i>			
Physician Office			
In-Network Family Physician	DED + 20%	DED + 20%	DED + 20%
In-Network Specialist	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Inpatient Hospital Facility			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Outpatient Hospital Facility			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Emergency Room Facility(per visit)			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%	INN DED + 20%

* 25% Coinsurance: Option 2 Hospital facility. See BCBS Provider Directory for hospital facility tier status

**Medically Necessary Chiropractic, Physical Therapy, Massage Therapy, Speech Therapy, & Occupational Therapy. Medical Policy Guidelines apply.

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

	Employee Plan G	Employee Plan H	Employee Plan M
	Blue Options (HSA Compatible)	Blue Options (HSA Compatible)	Blue Care (HSA Compatible)
Physician Services at Hospital and ER			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network ER	INN DED + 20%	INN DED + 20%	INN DED + 20%
Out-of-Network Hospital	INN DED + 20%	INN DED + 20%	Not Covered
Other Special Services and Locations			
Durable Medical Equipment/Orthotics & Prosthetics			
In-Network Motorized Wheelchairs	DED + 20%	DED + 20%	DED + 20%
In-Network All Other	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Skilled Nursing Facility			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Home Health Care			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Hospice			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Dialysis Center			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Birthing Center			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Diabetic Equipment & Supplies			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Wisdom Teeth (Surgical removal of impacted Wisdom Teeth)			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Accidental Dental Injury treatment *			
In-Network	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	DED + 40%	DED + 40%	Not Covered
Benefit Maximums			
Home Health Care			
Combined (INN & OON)	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 (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 G	Employee Plan H	Employee Plan M
	Blue Options (HSA Compatible)	Blue Options (HSA Compatible)	Blue Care (HSA Compatible)
Outpatient Therapy & Spinal Manipulations			
Combined (INN & OON)	75 Visits PBP	75 Visits PBP	30 Visits PBP (INN ONLY)
Skilled Nursing Facility			
Combined (INN & OON)	60 Days PBP	60 Days PBP	45 Days PBP (INN ONLY)
Spinal Manipulations			
Combined (INN & OON)	26 PBP	26 PBP	30 PBP (INN ONLY)
Prescription Drugs			
	OPEN FORMULARY	CLOSED FORMULARY	CLOSED FORMULARY
Deductible	Integrated with Health	Integrated with Health	Integrated with Health
In-Network			
Retail			
Generic/Brand/Non-Preferred	DED, then 20%/30%/50%	DED, then \$10/\$30/Not Covered	DED, then \$10/\$30/Not Covered
Mail Order **			
Generic/Brand/Non-Preferred	DED, then 20%/30%/50%	DED, then \$20/\$60/Not Covered	DED, then \$20/\$60/Not Covered
Out-of-Network			
Retail			
Generic/Brand/Non-Preferred	DED, then 50%/50%/50%	DED, then 50%/50%/Not Covered	Not Covered
Mail Order **			
Generic/Brand/Non-Preferred	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

Open Formulary Note:

- Condition Care Rx Program HSA Preventive list. Waive deductible.

• **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**

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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