

|                                                                                                                         | Employee Plan G                                                       | Employee Plan H                                                       | Employee Plan M                                                       |
|-------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------|
|                                                                                                                         | Blue Options<br>(HSA Compatible)                                      | Blue Options<br>(HSA Compatible)                                      | Blue Care<br>(HSA Compatible)                                         |
| <b>Cost Sharing - Member's Responsibility</b>                                                                           |                                                                       |                                                                       |                                                                       |
| <b>Deductible (DED) (Per Person/Family Aggregate)</b>                                                                   | 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                                                           |
| <b>Coinsurance (BCBSF pays / Member pays)</b>                                                                           |                                                                       |                                                                       |                                                                       |
| In-Network                                                                                                              | 80% / 20%                                                             | 80% / 20%                                                             | 80% / 20%                                                             |
| Out-of-Network                                                                                                          | 60% / 40%                                                             | 60% / 40%                                                             | Not Covered                                                           |
| <b>Out of Pocket Maximum (Per Person/Family Aggregate)</b><br><i>Includes Deductibles, copays, Coinsurance &amp; 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                                                           |
| <b>Medical Pharmacy OOP Maximum (Per Person Per Calendar Month)</b>                                                     |                                                                       |                                                                       |                                                                       |
| In-Network (Preferred/Non-Preferred)                                                                                    | N/A                                                                   | N/A                                                                   | \$200/\$700                                                           |
| Out-of-Network                                                                                                          | N/A                                                                   | N/A                                                                   | Not Covered                                                           |
| <b>Medical / Surgical Care by a Physician</b>                                                                           |                                                                       |                                                                       |                                                                       |
| <b>Office Services</b>                                                                                                  |                                                                       |                                                                       |                                                                       |
| 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                                                           |
| <b>Virtual Visits</b>                                                                                                   |                                                                       |                                                                       |                                                                       |
| 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                                                           |
| <b>Allergy Injections (Office)</b>                                                                                      |                                                                       |                                                                       |                                                                       |
| 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                                                           |
| <b>Health Care Professional Administered Medications in the Office (Medical Pharmacy)</b>                               |                                                                       |                                                                       |                                                                       |
| 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                                                           |
| <b>Maternity Office Services</b>                                                                                        |                                                                       |                                                                       |                                                                       |
| 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                                                           |
| <b>Convenient Care Center</b>                                                                                           |                                                                       |                                                                       |                                                                       |
| 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<br>(HSA Compatible) | Blue Options<br>(HSA Compatible) | Blue Care<br>(HSA Compatible) |
| <b>Physician Services at Hospital</b>                                                                                                                                     |                                  |                                  |                               |
| In-Network                                                                                                                                                                | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                                                                                                                            | INN DED + 20%                    | INN DED + 20%                    | Not Covered                   |
| <b>Radiology, Pathology and Anesthesiology Provider Services at Hospital</b>                                                                                              |                                  |                                  |                               |
| In-Network                                                                                                                                                                | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                                                                                                                            | INN DED + 20%                    | INN DED + 20%                    | Not Covered                   |
| <b>Radiology, Pathology and Anesthesiology Provider Services at ASC</b>                                                                                                   |                                  |                                  |                               |
| In-Network                                                                                                                                                                | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                                                                                                                            | INN DED + 20%                    | INN DED + 20%                    | Not Covered                   |
| <b>Physician Services at Locations other than Office, Hospital and ER</b>                                                                                                 |                                  |                                  |                               |
| 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                   |
| <b>Preventive Services-Adult Wellness Services</b>                                                                                                                        |                                  |                                  |                               |
| <b>Office Services</b>                                                                                                                                                    |                                  |                                  |                               |
| In-Network Family Physician                                                                                                                                               | \$0                              | \$0                              | \$0                           |
| In-Network Specialist                                                                                                                                                     | \$0                              | \$0                              | \$0                           |
| Out-of-Network                                                                                                                                                            | 40%                              | 40%                              | Not Covered                   |
| <b>Independent Clinical Laboratory</b><br><i>(Quest Diagnostics is the In-Network Lab in Florida)</i>                                                                     |                                  |                                  |                               |
| In-Network                                                                                                                                                                | \$0                              | \$0                              | \$0                           |
| Out-of-Network                                                                                                                                                            | 40%                              | 40%                              | Not Covered                   |
| <b>Mammograms</b> <i>(Routine Only)</i>                                                                                                                                   |                                  |                                  |                               |
| In-Network                                                                                                                                                                | \$0                              | \$0                              | \$0                           |
| Out-of-Network                                                                                                                                                            | \$0                              | \$0                              | Not Covered                   |
| <b>Colonoscopies</b><br><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                   |
| <b>Preventive Services-Well Child Services</b>                                                                                                                            |                                  |                                  |                               |
| <b>Office Services</b>                                                                                                                                                    |                                  |                                  |                               |
| In-Network Family Physician                                                                                                                                               | \$0                              | \$0                              | \$0                           |
| In-Network Specialist                                                                                                                                                     | \$0                              | \$0                              | \$0                           |
| Out-of-Network                                                                                                                                                            | 40%                              | 40%                              | Not Covered                   |
| <b>Independent Clinical Laboratory</b> <i>(Quest Diagnostics is the In-Network Lab in Florida)</i>                                                                        |                                  |                                  |                               |
| In-Network                                                                                                                                                                | \$0                              | \$0                              | \$0                           |
| Out-of-Network                                                                                                                                                            | 40%                              | 40%                              | Not Covered                   |
| <b>Medical / Surgical Care at a Facility</b>                                                                                                                              |                                  |                                  |                               |
| <b>Ambulatory Surgical Center (ASC)</b>                                                                                                                                   |                                  |                                  |                               |
| 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<br>(HSA Compatible)           | Blue Options<br>(HSA Compatible)           | Blue Care<br>(HSA Compatible) |
| <b>Inpatient Hospital Facility (per admit)</b>                                                        |                                            |                                            |                               |
| In-Network                                                                                            | Option 1:DED + 20%<br>Option 2:DED + 25% * | Option 1:DED + 20%<br>Option 2:DED + 25% * | DED + 20%                     |
| Out-of-Network                                                                                        | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Outpatient Hospital Facility (per visit)</b>                                                       |                                            |                                            |                               |
| In-Network                                                                                            | Option 1:DED + 20%<br>Option 2:DED + 25% * | Option 1:DED + 20%<br>Option 2:DED + 25% * | DED + 20%                     |
| Out-of-Network                                                                                        | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Emergency and Urgent Care</b>                                                                      |                                            |                                            |                               |
| <b>Emergency Room Facility (per visit)</b>                                                            |                                            |                                            |                               |
| In-Network                                                                                            | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                        | INN DED + 20%                              | INN DED + 20%                              | INN DED + 20%                 |
| <b>Physician Services at ER (With or without Surgery performed or with or without admit)</b>          |                                            |                                            |                               |
| In-Network                                                                                            | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                        | INN DED + 20%                              | INN DED + 20%                              | INN DED + 20%                 |
| <b>Urgent Care Centers</b>                                                                            |                                            |                                            |                               |
| In-Network                                                                                            | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                        | INN DED + 20%                              | INN DED + 20%                              | Not Covered                   |
| <b>Ambulance</b>                                                                                      |                                            |                                            |                               |
| In-Network                                                                                            | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                        | INN DED + 20%                              | INN DED + 20%                              | INN DED + 20%                 |
| <b>Diagnostic Testing (e.g., Lab, x-ray)</b>                                                          |                                            |                                            |                               |
| <b>Physician Office</b>                                                                               |                                            |                                            |                               |
| 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                   |
| <b>Independent Clinical Laboratory</b><br><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                   |
| <b>Independent Diagnostic Testing Center</b>                                                          |                                            |                                            |                               |
| In-Network                                                                                            | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                        | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Outpatient Hospital Facility</b>                                                                   |                                            |                                            |                               |
| In-Network                                                                                            | Option 1:DED + 20%<br>Option 2:DED + 25% * | Option 1:DED + 20%<br>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<br>(HSA Compatible)           | Blue Options<br>(HSA Compatible)           | Blue Care<br>(HSA Compatible) |
| <b>Advanced Imaging (AIS) (MRI, MRA, PET, CT &amp; Nuclear Medicine) Subject to Prior Authorization</b> |                                            |                                            |                               |
| <b>Physician Office</b>                                                                                 |                                            |                                            |                               |
| 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                   |
| <b>Independent Diagnostic Testing Center</b>                                                            |                                            |                                            |                               |
| In-Network                                                                                              | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                          | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Outpatient Hospital Facility</b>                                                                     |                                            |                                            |                               |
| In-Network                                                                                              | Option 1:DED + 20%<br>Option 2:DED + 25% * | Option 1:DED + 20%<br>Option 2:DED + 25% * | DED + 20%                     |
| Out-of-Network                                                                                          | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Outpatient Therapy <i>**Serves include</i></b>                                                       |                                            |                                            |                               |
| <b>Physician Office</b>                                                                                 |                                            |                                            |                               |
| 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                   |
| <b>Outpatient Rehabilitation Facility</b>                                                               |                                            |                                            |                               |
| In-Network                                                                                              | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                          | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Outpatient Hospital Facility</b>                                                                     |                                            |                                            |                               |
| In-Network                                                                                              | Option 1:DED + 20%<br>Option 2:DED + 25% * | Option 1:DED + 20%<br>Option 2:DED + 25% * | DED + 20%                     |
| Out-of-Network                                                                                          | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Mental Health/Substance Dependency Services<br/><i>Subject to Prior Authorization</i></b>            |                                            |                                            |                               |
| <b>Physician Office</b>                                                                                 |                                            |                                            |                               |
| 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                   |
| <b>Inpatient Hospital Facility</b>                                                                      |                                            |                                            |                               |
| In-Network                                                                                              | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                          | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Outpatient Hospital Facility</b>                                                                     |                                            |                                            |                               |
| In-Network                                                                                              | DED + 20%                                  | DED + 20%                                  | DED + 20%                     |
| Out-of-Network                                                                                          | DED + 40%                                  | DED + 40%                                  | Not Covered                   |
| <b>Emergency Room Facility(per visit)</b>                                                               |                                            |                                            |                               |
| 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.

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|                                                                 | Employee Plan G                  | Employee Plan H                  | Employee Plan M               |
|-----------------------------------------------------------------|----------------------------------|----------------------------------|-------------------------------|
|                                                                 | Blue Options<br>(HSA Compatible) | Blue Options<br>(HSA Compatible) | Blue Care<br>(HSA Compatible) |
| <b>Physician Services at Hospital and ER</b>                    |                                  |                                  |                               |
| 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                   |
| <b>Other Special Services and Locations</b>                     |                                  |                                  |                               |
| <b>Durable Medical Equipment/Orthotics &amp; Prosthetics</b>    |                                  |                                  |                               |
| 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                   |
| <b>Skilled Nursing Facility</b>                                 |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Home Health Care</b>                                         |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Hospice</b>                                                  |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Dialysis Center</b>                                          |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Birthing Center</b>                                          |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Diabetic Equipment &amp; Supplies</b>                        |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Wisdom Teeth (Surgical removal of impacted Wisdom Teeth)</b> |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Accidental Dental Injury treatment *</b>                     |                                  |                                  |                               |
| In-Network                                                      | DED + 20%                        | DED + 20%                        | DED + 20%                     |
| Out-of-Network                                                  | DED + 40%                        | DED + 40%                        | Not Covered                   |
| <b>Benefit Maximums</b>                                         |                                  |                                  |                               |
| <b>Home Health Care</b>                                         |                                  |                                  |                               |
| Combined (INN & OON)                                            | 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 (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.

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|------------------------------------------------------|----------------------------------|----------------------------------|---------------------------------|
|                                                      | Blue Options<br>(HSA Compatible) | Blue Options<br>(HSA Compatible) | Blue Care<br>(HSA Compatible)   |
| <b>Outpatient Therapy &amp; Spinal Manipulations</b> |                                  |                                  |                                 |
| Combined (INN & OON)                                 | 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                      | 45 Days PBP (INN ONLY)          |
| <b>Spinal Manipulations</b>                          |                                  |                                  |                                 |
| Combined (INN & OON)                                 | 26 PBP                           | 26 PBP                           | 30 PBP (INN ONLY)               |
| <b>Prescription Drugs</b>                            |                                  |                                  |                                 |
|                                                      | <b>OPEN FORMULARY</b>            | <b>CLOSED FORMULARY</b>          | <b>CLOSED FORMULARY</b>         |
| <b>Deductible</b>                                    | Integrated with Health           | Integrated with Health           | Integrated with Health          |
| <b>In-Network</b>                                    |                                  |                                  |                                 |
| <b>Retail</b>                                        |                                  |                                  |                                 |
| Generic/Brand/Non-Preferred                          | DED, then 20%/30%/50%            | DED, then \$10/\$30/Not Covered  | DED, then \$10/\$30/Not Covered |
| <b>Mail Order **</b>                                 |                                  |                                  |                                 |
| Generic/Brand/Non-Preferred                          | DED, then 20%/30%/50%            | DED, then \$20/\$60/Not Covered  | DED, then \$20/\$60/Not Covered |
| <b>Out-of-Network</b>                                |                                  |                                  |                                 |
| <b>Retail</b>                                        |                                  |                                  |                                 |
| Generic/Brand/Non-Preferred                          | DED, then 50%/50%/50%            | DED, then 50%/50%/Not Covered    | Not Covered                     |
| <b>Mail Order **</b>                                 |                                  |                                  |                                 |
| 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](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

**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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