

| Summary of Benefits for Covered Services | Amount Member Pays | |
|--|--|--|
| | In-Network | Out-of-Network |
| Financial Features | | |
| Deductible (DED¹) (PBP²) (DED is the amount the member is responsible for before Florida Blue pays) | \$1,500 per person \$4,500 per family | \$3,000 per person \$6,000 per family |
| Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD) | Not Applicable | \$500 |
| Coinsurance (Coinsurance is the percentage the member pays for services) | 20% of the allowed amount | 50% of the allowed amount |
| Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs) | \$4,500 per person \$9,000 per family | \$6,000 per person \$12,000 per family |
| Office Services | | |
| Physician Office Services Primary Care Physician Specialist Convenient Care e-Office Visit | \$30 Copay 20% after Deductible \$30 Copay \$10 Copay | 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible |
| Maternity (Cost Share for initial visit only) Primary Care Physician Specialist | \$30 Copay 20% after Deductible | 50% after Deductible 50% after Deductible |
| Allergy Injections (per visit) Primary Care Physician Specialist | \$10 Copay \$10 Copay | 50% after Deductible 50% after Deductible |
| Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) | \$250 Copay | 50% after Deductible |
| Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum ³ Provider | \$0 0% | 0% |
| Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the <i>medical</i> benefit. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit. | | |
| Preventive Care | | |
| Routine Adult & Child Preventive Services, Wellness Services, and Immunizations | \$0 | 50% |
| Mammograms | \$0 | \$0 |
| Colonoscopy (Routine for age 50+ then frequency schedule applies) | \$0 | \$0 |
| Emergency Medical Care | | |
| Urgent Care Centers | \$60 Copay | \$60 Copay after Deductible |
| Emergency Room Facility Services (per visit) (copayment waived if admitted) | \$250 Copay | \$250 Copay ⁴ |
| Ambulance Services | 20% after Deductible | 20% after In-Network Deductible |

¹ DED = Deductible

² PBP = Per Benefit Period

³ In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

⁴ If admitted as an Inpatient from the Emergency Room member pays Out-of-Network DED and In-Network Emergency Room Copay.

Note: Out-of-Network services may be subject to balance billing.

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BlueOptions

For Large Groups

Predictable Cost Health Benefit Plan 05771

| Summary of Benefits for Covered Services | Amount Member Pays | |
|---|--|--|
| | In-Network | Out-of-Network |
| Outpatient Diagnostic Services | | |
| Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) | \$50 Copay \$250 Copay | 50% after Deductible 50% after Deductible |
| Independent Clinical Lab (e.g., Blood Work) | \$0 | 50% after Deductible |
| Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays) Option 1 Option 2 | 20% after Deductible 20% after Deductible | 50% after Deductible 50% after Deductible |
| Hospital / Surgical | | |
| Ambulatory Surgical Center Facility (ASC) | 20% after Deductible | 50% after Deductible |
| Outpatient Hospital Facility Services (per visit) Therapy Services Option 1 Option 2 All other Services Option 1 Option 2 | \$55 Copay \$80 Copay 20% after Deductible 20% after Deductible | 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible |
| Inpatient Hospital Facility and Rehabilitation Services (per admit) Option 1 Option 2 | 20% after Deductible 20% after Deductible | \$500 PAD, then 50% after Deductible ⁴ \$500 PAD, then 50% after Deductible ⁴ |
| Mental Health / Substance Dependency | | |
| Inpatient Hospitalization Facility Services (per admit) Option 1 and Option 2 | \$0 | 50% ⁴ |
| Outpatient Hospitalization Facility Service (per visit) Option 1 and Option 2 | \$0 | 50% |
| Emergency Room Facility Services (per visit) | \$0 | \$0 |
| Provider Services at Hospital and ER Primary Care Physician / Specialist | \$0 | \$0 |
| Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist | \$0 | 50% |
| Outpatient Office Visit Primary Care Physician / Specialist | \$0 | 50% |
| Other Provider Services | | |
| Provider Services at Hospital and ER | 20% after Deductible | 20% after In-Network Deductible |
| Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) | \$55 Copay | \$55 Copay |
| Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist | \$30 Copay \$55 Copay | 50% after Deductible 50% after Deductible |
| Other Special Services | | |
| Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit) Option 1 Option 2 | \$55 Copay \$55 Copay \$80 Copay | 50% after Deductible 50% after Deductible 50% after Deductible |

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Predictable Cost Health Benefit Plan 05771

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| Other Special Services (continued) | | |
| Durable Medical Equipment, Prosthetics and Orthotics | 20% after Deductible | 50% after Deductible |
| Home Health Care | 20% after Deductible | 50% after Deductible |
| Skilled Nursing Facility | 20% after Deductible | 50% after Deductible |
| Hospice | 20% after Deductible | 50% after Deductible |

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services **you need to get an approval** from Florida Blue before your service or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

| Benefit Maximums | |
|----------------------------------|---|
| Home Health Care | 20 Visits PBP |
| Inpatient Rehabilitation Therapy | 30 Days PBP |
| Outpatient Therapy | 35 Visits PBP |
| Spinal Manipulations | 26 PBP (accumulates towards the Outpatient Therapy maximum) |
| Skilled Nursing Facility | 60 Days PBP |

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

BlueScript Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them. **Important Note:** Your health plan may include prescription drug coverage that only provides coverage at Exclusive Pharmacies except for emergency situations.

Access to Our Strong Networks

NetworkBlueSM is the Preferred Provider Network designated as "In-Network" for BlueOptions. While In-Network providers remain the best value, members are still **protected from balance billing** if they go Out-of-Network to someone who is part of our Traditional Provider Network. You may also receive **out-of-state coverage through the BlueCard[®]** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, Florida Blue does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at floridablue.com.

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.