The following Alpha Characters will be used for each variant:

Dental and Vision Benefit Variations (On and Off-Marketplace)

⃠ (No Alpha Character) = Pediatric Vision

- All plans must include pediatric vision benefits. No other benefit variants are included in this plan

P = Pediatric Dental (OFF Marketplace Only)

- Plan includes pediatric dental; in addition to pediatric vision benefits

V = Adult Vision and Dental

- Plan includes adult vision and dental benefits in addition to pediatric vision and dental benefits

Silver Cost Sharing Reductions (On-Marketplace Only)

Individuals with incomes between 100-250% of the Federal Poverty Level (FPL) are eligible for a Silver Cost Sharing Reduction plan. These plans provide significantly richer benefits than the base Bronze or Silver plans.

A = Individuals with income between 200-250 % FPL

B = Individuals with income between 150-200 % FPL

C = Individuals with income between 100-150 % FPL

American Indian Plan Variations (On-Marketplace Only)

American Indians are eligible for one of two American Indian Plan variations:

U = American Indians with income under 300% FPL

O = American Indians with income over 300% FPL

Metal Levels (On and Off-Marketplace)

All Individual plans, ON and OFF the Marketplace, must include EHBs, cost-sharing limits, and meet targeted Actuarial Values (AV), which is a measure of a plan's cost-sharing levels for EHBs. QHPs/NQHPs fall within four metal levels: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%).

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Vision and Dental

Pediatric Vision Care Costs shown below are for covered individuals who are under age 19[1].	**Amount Member Pays**
Exclusive In-network Provider Services	
Eye Examination	$0
Eye Glass Lenses	$0
Eyeglasses – Frame Benefit	
Pediatric Frame Selection	Included
Non-Selection Frame Allowance	Amount over standard $150 allowance, minus a 20% discount
Eyeglass Benefit - Spectacle Lenses	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any prescription)	$0
Oversize Lenses	$0
Tinting of Plastic Lenses	$0
Scratch-Resistant Coating	$0
Polycarbonate Lenses	$0
Standard Progressive Lenses	$0
Plastic Photosensitive Lenses	$0
Ultraviolet Coating	$0
One-Year Breakage Warranty	$0
Contact Lens Benefit (Instead of eyeglasses)	
Pediatric Contact Lens Selection	Included
Non-Selection Contact Lenses Including evaluation, fitting and follow up care	Amount over standard $150 allowance, minus a 15% discount
Medically Necessary Contact Lenses (Prior approval is required) Materials, Evaluation, Fitting & Follow-Up Care	$0
Additional Discounts* Available	
Standard Anti-Reflective (AR) Coating	$35
Premium AR Coating	$48
Ultra AR Coating	$60
Premium Progressives (Varilux®, etc.)	$90
Intermediate-Vision Lenses	$30
High-Index Lenses	$55
Polarized Lenses	$75
Photochromic Glass Lenses	$20
Blended Segment Lenses	$20
Ultra Progressive Lenses	$140
Scratch Protection Plan: Single Vision | Multifocal Lenses	$20 | $40
*Additional discounts will not accumulate to your Out-of-Pocket Maximum.	

Adult Vision Care Costs shown below are for covered individuals who are age 19[1] and older.	**Amount Member Pays**
Exclusive In-network Provider Services	
Eye Examination	$15
Eye Glass Lenses	$25
Eyeglasses – Frame Benefit	
Exclusive Frame Collection	$0, $15 or $40
Non-Collection Frame	Amount over standard $100 allowance, minus a 20% discount
Eyeglass Benefit - Spectacle Lenses	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any prescription)	$0
Oversize Lenses	$0
Tinting of Plastic Lenses	$15
Polycarbonate Lenses (Covered in full for monocular patients and patients with prescriptions +/- 6.00 diopters or greater)	$0 or $35
Standard Progressive Lenses	$65
Plastic Photosensitive Lenses	$70
Scratch-Resistant Coating	$0
Ultraviolet Coating	$15
Standard Anti-Reflective (AR) Coating	$40
Premium AR Coating	$55
Ultra AR Coating	$69
Premium Progressives (Varilux®, etc.)	$105
Intermediate-Vision Lenses	$30
High-Index Lenses	$60
Polarized Lenses	$75
Scratch Protection Plan: Single Vision | Multifocal Lenses	$20 | $40
One-Year Breakage Warranty	$0
Contact Lens Benefit	
Contact Lenses (Instead of eyeglasses)	Amount over standard $100 allowance, minus a 15% discount
Evaluation, Fitting & Follow-Up Care – Standard and Specialty Lens Types	15% discount
Medically Necessary Contact Lenses (with prior approval) Materials, Evaluation, Fitting & Follow-Up Care	$0
Additional Discounts Available	
Lasik	Up to 25% off the provider's Usual and Customary fees or a 5% discount on any in-network advertised special rates
Note: Adult vision costs do not count toward the deductible or out-of-pocket maximum of your health plan.	

Pediatric Dental Care Costs shown below are for covered individuals who are under age 19[1].	**Amount Member Pays**
Exclusive In-network Provider Services	
Preventive Services	**No waiting period**
Oral exams, cleaning and fluoride treatments X-rays (bitewing) Space Maintainers Sealants	$0
Basic Services	**No waiting period**
Anesthesia Emergency Treatment (Palliative Care) Fillings (Complete Series) Extractions Minor Endodontics Minor Periodontics Minor Prosthodontics	$0
Major Services	**No waiting period**
Major Endodontics Major Periodontics Major Prosthodontics Medically Necessary Implants (Prior Authorization is required)	$0
Medically Necessary Orthodontics	**24 month waiting period**
Prior authorization is required	$0

Adult Dental Care Costs shown below are for covered individuals who are age 19[1] and older.	**Amount Member Pays**
Exclusive In-network Provider Services	
Preventive Services	**No waiting period**
Oral Evaluation X-rays (bitewing – two films) Cleanings (Adult)	0%
Basic Services	**No waiting period**
Fillings (Complete Series) X-rays Emergency Treatment	20% after Deductible
Major Services	**No waiting period**
Oral Surgery including Extractions Anesthesia in connection with covered Oral Surgery Endodontics Periodontics Prosthodontics	50% after Deductible
Orthodontics	**Not Covered**
Deductible	
Plan Year (per person for Basic and Major services)	$50
Maximum Benefits	
Plan Year (per person)	$1,000
Note: Adult dental costs do not count toward the medical deductible or out-of-pocket maximum of your health plan.	

[1]Pediatric Dental and Vision Benefits end on the last day of the month of the member's 19th birthday. Adult Dental and Vision Benefits begin on the first day of the month following the member's 19th birthday.

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Florida Blue

COST SHARING (amount member pays)	All Copay Plans (Platinum)			Everyday Health Plans (Platinum)		
	BlueOptions 1424, 1424P, 1424O	**BlueSelect 1457, 1457P, 1457O**	**BlueCare 1491, 1491P, 1491O**	**BlueOptions 1418, 1418P, 1418V, 1418O, 1418OV**	**BlueSelect 1451, 1451P, 1451V, 1451O, 1451OV**	**BlueCare 1485, 1485P, 1485O**
Financial Features						
Deductible (DED)[1] (per person / family aggregate)						
In-Network	$0 / $0			$800 / $1,600		
Out-of-Network	$500 / Not Applicable		Not Covered	$2,400 / $4,800		Not Covered
Coinsurance (Coins)[2] (amount member pays)						
In-Network	20%			10%		
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	50%		Not Covered
Out-of-Pocket Maximum (per person / family aggregate)						
In-Network	$2,000 / $4,000			$2,500 / $5,000		
Out-of-Network	$12,500 / $25,000		Not Covered	$5,400 / $10,800		Not Covered
Office Services						
Physician Office Services						
Family Physician (PCP[3]) and Blue Physician Recognition	$10 Copay			$0 for first 3 visits, then $15 Copay		
Specialist	$20 Copay			$20 Copay		
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	$150 Copay			DED + 10% Coins		
Allergy Injections (per visit) Family Physician	$10 Copay			DED + 10% Coins		
Medical Pharmacy	$60 Copay			$60 Copay		
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			$240 In-Network Monthly Member OOP Max		
Preventive Care						
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			$0		
Prescription Drug Program						
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $10			$0 / $4 / $10		
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$20 / $40 / $75 / $300			$20 / $40 / $75 / $300		
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $25			$0 / $0 / $25		
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$50 / $100 / $188 / NC			$50 / $100 / $188 / NC		
Urgent and Emergency Medical Care						
Convenient Care Center	$10 Copay			$15 Copay		
Urgent Care Centers	$50 Copay			$50 Copay		
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$75 Copay first visit, then $225 Copay			INN DED + 10% Coins		
Ambulance Services In-Network and Out-of-Network	$350 Copay			INN DED + 10% Coins		
Hospital / Surgical						
Ambulatory Surgical Center Facility (ASC)	$200 Copay			DED + 10% Coins		
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	$350 Copay per day ($1,050 max)			DED + 10% Coins		
Outpatient Hospital Facility Services (per visit)						
Therapy Services (BlueOptions - Option 1 / Option 2)	$300 Copay			DED + 10% Coins		
All Other Services (BlueOptions - Option 1 / Option 2)	$300 Copay			DED + 10% Coins		
Other Provider Services						
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			$0		
Provider Services at an ER In-Network & Out-of-Network	$0			$0		
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			$0		
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			$0		
Provider Services at Locations other than Office, Hospital and ER						
Family Physician	$10 Copay			$15 Copay		
Specialist	$20 Copay			$20 Copay		
Outpatient Diagnostic Services						
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)						
Diagnostic Services (except AIS)	$75 Copay			DED + 10% Coins		
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	$150 Copay			DED + 10% Coins		
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			$0		
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	$300 Copay			DED + 10% Coins		
Other Special Services						
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)						
Office Visit Family Physician	$10 Copay			$0 for first 3 visits, then $15 Copay		
Office Visit Specialist	$20 Copay			$20 Copay		
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	$300 Copay			DED + 10% Coins		
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered						
Motorized Wheelchairs	$500 Copay			$500 Copay		
All Other Services	$0			$0		
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			$0		
Skilled Nursing Facility (60 Days PBP)	20% up to $500 Copay per admission			DED + 10% Coins		
Hospice	$0			$0		

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount

[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	All Copay Plans (Gold)			Essential Plan (Gold)	Gold
	BlueOptions 1505, 1505P, 1505O	BlueSelect 1535, 1535P, 1535O	BlueCare 1565, 1565P, 1565O	BlueOptions 1401P	myBlue 1605, 1605P, 1605O
Financial Features					
Deductible (DED)[1] (per person / family aggregate)					
In-Network	$0 / $0			$1,300 / $2,600	$900 / $1,800
Out-of-Network	$500 / Not Applicable		Not Covered	$2,600 / $5,200	Not Covered
Coinsurance (Coins)[2] (amount member pays)					
In-Network	40%			10%	15%
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	50%	Not Covered
Out-of-Pocket Maximum (per person / family aggregate)					
In-Network	$3,000 / $6,000			$2,600 / $5,200	$4,700 / $9,400
Out-of-Network	$12,500 / $25,000		Not Covered	$5,200 / $10,400	Not Covered
Office Services					
Physician Office Services					
Family Physician (PCP[3]) and Blue Physician Recognition	$25 Copay			DED + 10% Coins	$65 Copay
Specialist	$60 Copay			DED + 10% Coins	$125 Copay
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	$250 Copay			DED + 10% Coins	DED + 15% Coins
Allergy Injections (per visit) Family Physician	$10 Copay			DED + 10% Coins	$10 Copay
Medical Pharmacy	$60 Copay			DED + 10% Coins	$60 Copay
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			$240 In-Network Monthly Member OOP Max	$240 In-Network Monthly Member OOP Max
Preventive Care					
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			$0	$0
Prescription Drug Program					
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $10			$0 / $4 / $10[6]	$0 / $4 / $10
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$20 / $40 / $75 / $300			$20 / $40[6] / $70[6] / $150[6]	15%[6] / 15%[6] / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $25			$0 / $0 / $25[6]	$0 / $0 / $25
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$50 / $100 / $188 / NC			$50 / $100[6] / $175[6] / NC	15%[6] / 15%[6] / NC / NC
Urgent and Emergency Medical Care					
Convenient Care Center	$25 Copay			DED + 10% Coins	$65 Copay
Urgent Care Centers	$65 Copay			DED + 10% Coins	$150 Copay
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$350 Copay			INN DED + 10% Coins	INN DED + 15% Coins
Ambulance Services In-Network and Out-of-Network	$350 Copay			INN DED + 10% Coins	INN DED + 15% Coins
Hospital / Surgical					
Ambulatory Surgical Center Facility (ASC)	$400 Copay			DED + 10% Coins	DED + 15% Coins
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	$600 Copay per day ($1,800 max)			DED + 10% Coins	DED + 15% Coins
Outpatient Hospital Facility Services (per visit)					
Therapy Services (BlueOptions - Option 1 / Option 2)	$450 Copay			DED + 10% Coins	DED + 15% Coins
All Other Services (BlueOptions - Option 1 / Option 2)	$450 Copay			DED + 10% Coins	DED + 15% Coins
Other Provider Services					
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			INN DED + 10% Coins	DED + 15% Coins
Provider Services at an ER In-Network & Out-of-Network	$0			INN DED + 10% Coins	INN DED + 15% Coins
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			INN DED + 10% Coins	DED + 15% Coins
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			INN DED + 10% Coins	DED + 15% Coins
Provider Services at Locations other than Office, Hospital and ER					
Family Physician	$25 Copay			DED + 10% Coins	$65 Copay
Specialist	$60 Copay			DED + 10% Coins	$125 Copay
Outpatient Diagnostic Services					
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)					
Diagnostic Services (except AIS)	$100 Copay			DED + 10% Coins	DED + 15% Coins
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	$250 Copay			DED + 10% Coins	DED + 15% Coins
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			DED + 10% Coins	$0
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	$450 Copay			DED + 10% Coins	DED + 15% Coins
Other Special Services					
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)					
Office Visit Family Physician	$25 Copay			DED + 10% Coins	$65 Copay
Office Visit Specialist	$60 Copay			DED + 10% Coins	$125 Copay
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	$450 Copay			DED + 10% Coins	DED + 15% Coins
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered					
Motorized Wheelchairs	$500 Copay			DED + 10% Coins	$500 Copay
All Other Services	$0			DED + 10% Coins	$0
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			DED + 10% Coins	$0
Skilled Nursing Facility (60 Days PBP)	40% up to $500 Copay per admission			DED + 10% Coins	DED + 15% Coins
Hospice	$0			DED + 10% Coins	$0

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount

[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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COST SHARING (amount member pays)	Essential (HSA) Plans (Silver)		
	BlueOptions 1409, 1409P	**BlueSelect 1442, 1442P**	**BlueCare 1476, 1476P**
Financial Features			
Deductible (DED)[1] (per person / family aggregate)			
In-Network	$3,600 / $7,200		
Out-of-Network	$7,200 / $14,400		Not Covered
Coinsurance (Coins)[2] (amount member pays)			
In-Network	0%		
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered
Out-of-Pocket Maximum (per person / family aggregate)			
In-Network	$3,600 / $7,200		
Out-of-Network	$25,000 / $25,000		Not Covered
Office Services			
Physician Office Services			
Family Physician (PCP[3]) and Blue Physician Recognition	DED		
Specialist	DED		
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED		
Allergy Injections (per visit) Family Physician	DED		
Medical Pharmacy	DED		
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	Not Applicable		
Preventive Care			
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0		
Prescription Drug Program			
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $0[6]		
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$30 / $0[6] / $0[6] / $0[6]		
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $0[6]		
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$75 / $0[6] / $0[6] / NC		
Urgent and Emergency Medical Care			
Convenient Care Center	DED		
Urgent Care Centers	DED		
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	INN DED		
Ambulance Services In-Network and Out-of-Network	INN DED		
Hospital / Surgical			
Ambulatory Surgical Center Facility (ASC)	DED		
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED		
Outpatient Hospital Facility Services (per visit)			
Therapy Services (BlueOptions - Option 1 / Option 2)	DED		
All Other Services (BlueOptions - Option 1 / Option 2)	DED		
Other Provider Services			
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Provider Services at an ER In-Network & Out-of-Network	INN DED		
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Provider Services at Locations other than Office, Hospital and ER			
Family Physician	DED		
Specialist	DED		
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
Diagnostic Services (except AIS)	DED		
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED		
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	DED		
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED		
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)			
Office Visit Family Physician	DED		
Office Visit Specialist	DED		
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED		
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered			
Motorized Wheelchairs	DED		
All Other Services	DED		
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	DED		
Skilled Nursing Facility (60 Days PBP)	DED		
Hospice	DED		

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount

[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1410, 1410P, 1410O	BlueSelect 1443, 1443P, 1443O	BlueCare 1477, 1477P, 1477O	myBlue 1604, 1604P, 1604O
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$6,100 / $12,200			
Out-of-Network	$12,200 / $24,400		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	30%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$6,850 / $13,700			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first visit, then $65 Copay			
Specialist	DED + $90 Copay			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED + 30% Coins			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $30[6]			$0 / $4 / $30[6]
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$23 / $45[6] / $160[6] / $200[6]			$45[6] / 30%[6] / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $75[6]			$0 / $0 / $75[6]
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$58 / $113[6] / $400[6] / NC			$113[6] / 30%[6] / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$65 Copay			
Urgent Care Centers	DED + $250 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	INN DED + $600 Copay			
Ambulance Services In-Network and Out-of-Network	INN DED + 30% Coins			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	DED + 30% Coins			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
All Other Services (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$65 Copay			
Specialist	DED + $90 Copay			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$4 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED + 30% Coins			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$0 for first visit, then $65 Copay			
Office Visit Specialist	DED + $90 Copay			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	DED + 30% Coins			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount

[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1410A	BlueSelect 1443A	BlueCare 1477A	myBlue 1604A
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$4,300 / $8,600			
Out-of-Network	$12,200 / $24,400		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	30%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$4,500 / $9,000			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 2 visits, then $65 Copay			$0 for first visit, then $65 Copay
Specialist	$85 Copay			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED + 30% Coins			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $20			$0 / $4 / $20
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$23 / $45[6] / $150[6] / $200[6]			$45[6] / 30%[6] / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $50			$0 / $0 / $50
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$58 / $113[6] / $375[6] / NC			$113[6] / 30%[6] / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$65 Copay			
Urgent Care Centers	$100 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$600 Copay			
Ambulance Services In-Network and Out-of-Network	INN DED + 30% Coins			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	DED + 30% Coins			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
All Other Services (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$65 Copay			
Specialist	$85 Copay			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$4 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED + 30% Coins			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$0 for first 2 visits, then $65 Copay			$0 for first visit, then $65 Copay
Office Visit Specialist	$85 Copay			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED + 30% Coins			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	DED + 30% Coins			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1410B	BlueSelect 1443B	BlueCare 1477B	myBlue 1604B
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$0 / $0			
Out-of-Network	$12,200 / $24,400		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	30%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$2,250 / $4,500			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 2 visits, then $2 Copay			
Specialist	$25 Copay			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	30% Coins			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $16			$0 / $4 / $15
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$23 / $45 / $80 / $200			$45 / 20% / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $40			$0 / $0 / $38
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$58 / $113 / $200 / NC			$113 / 20% / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$5 Copay			
Urgent Care Centers	$35 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$500 Copay			
Ambulance Services In-Network and Out-of-Network	30% Coins			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	30% Coins			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	30% Coins			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	30% Coins			
All Other Services (BlueOptions - Option 1 / Option 2)	30% Coins			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$2 Copay			
Specialist	$25 Copay			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$4 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	30% Coins			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	30% Coins			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$0 for first 2 visits, then $2 Copay			
Office Visit Specialist	$25 Copay			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	30% Coins			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	30% Coins			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1410C	BlueSelect 1443C	BlueCare 1477C	myBlue 1604C
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$0 / $0			
Out-of-Network	$12,200 / $24,400		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	30%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$950 / $1,900			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 2 visits, then $1 Copay			
Specialist	$10 Copay			$3 Copay
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	30% Coins			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $1 / $2			$0 / $1 / $2
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$3 / $5 / $40 / $75			$10 / 20% / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $5			$0 / $0 / $5
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$8 / $13 / $100 / NC			$25 / 20% / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$5 Copay			
Urgent Care Centers	$25 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$100 Copay			
Ambulance Services In-Network and Out-of-Network	30% Coins			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	30% Coins			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	30% Coins			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	30% Coins			
All Other Services (BlueOptions - Option 1 / Option 2)	30% Coins			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$1 Copay			
Specialist	$10 Copay			$3 Copay
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$4 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	30% Coins			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	30% Coins			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$0 for first 2 visits, then $1 Copay			
Office Visit Specialist	$10 Copay			$3 Copay
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	30% Coins			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	30% Coins			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1423, 1423P, 1423O	**BlueSelect 1456, 1456P, 1456O**	**BlueCare 1490, 1490P, 1490O**	**myBlue 1603, 1603P, 1603O**
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$5,500 / $11,000			
Out-of-Network	$11,000 / $22,000		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	40%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$6,850 / $13,700			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$125 Copay			
Specialist	$180 Copay			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	$400 Copay			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $10			$0 / $4 / $10
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$34 / $67[7] / $150[7] / $150[7]			$67[7] / 40%[7] / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $25			$0 / $0 / $25
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$85 / $168[7] / $375[7] / NC			$168[7] / 40%[7] / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$125 Copay			
Urgent Care Centers	DED + $100 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	INN DED + $400 Copay			
Ambulance Services In-Network and Out-of-Network	$400 Copay			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	DED + $350 Copay			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED + $600 Copay			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
All Other Services (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$125 Copay			
Specialist	$180 Copay			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$50 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	$400 Copay			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$125 Copay			
Office Visit Specialist	$180 Copay			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	40% up to $500 Copay per admission			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1423A	BlueSelect 1456A	BlueCare 1490A	myBlue 1603A
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$3,800 / $7,600			
Out-of-Network	$11,000 / $22,000		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	40%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$5,200 / $10,400			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$85 Copay			
Specialist	$150 Copay			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	$400 Copay			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $10			$0 / $4 / $10
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$34 / $67[7] / $150[7] / $150[7]			$67[7] / 40%[7] / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $25			$0 / $0 / $25
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$85 / $168[7] / $375[7] / NC			$168[7] / 40%[7] / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$85 Copay			
Urgent Care Centers	DED + $100 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	INN DED + $400 Copay			
Ambulance Services In-Network and Out-of-Network	$400 Copay			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	DED + $350 Copay			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED + $600 Copay			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
All Other Services (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$85 Copay			
Specialist	$150 Copay			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$50 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	$400 Copay			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$85 Copay			
Office Visit Specialist	$150 Copay			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED + $500 Copay			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	40% up to $500 Copay per admission			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1423B	BlueSelect 1456B	BlueCare 1490B	myBlue 1603B
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$0 / $0			
Out-of-Network	$11,000 / $22,000		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	40%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$2,000 / $4,000			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 3 visits, then $3 Copay			
Specialist	$15 Copay			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	$125 Copay			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $5			$0 / $4 / $5
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$15 / $30 / $80 / $150			$25 / 40% / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $13			$0 / $0 / $13
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$38 / $75 / $200 / NC			$63 / 40% / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$5 Copay			
Urgent Care Centers	$30 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$200 Copay			
Ambulance Services In-Network and Out-of-Network	$350 Copay			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	$200 Copay			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	$400 Copay			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	$300 Copay			
All Other Services (BlueOptions - Option 1 / Option 2)	$300 Copay			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$3 Copay			
Specialist	$15 Copay			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$25 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	$125 Copay			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	$300 Copay			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$0 for first 3 visits, then $3 Copay			
Office Visit Specialist	$15 Copay			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	$300 Copay			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	40% up to $350 Copay per admission			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)			Silver
	BlueOptions 1423C	BlueSelect 1456C	BlueCare 1490C	myBlue 1603C
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$0 / $0			
Out-of-Network	$11,000 / $22,000		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	20%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$1,000 / $2,000			
Out-of-Network	$12,500 / $25,000		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 3 visits, then $1 Copay			
Specialist	$10 Copay			$5 Copay
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	$50 Copay			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $1 / $2			$0 / $1 / $2
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$3 / $5 / $40 / $75			$5 / 20% / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $5			$0 / $0 / $5
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$8 / $13 / $100 / NC			$13 / 20% / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$5 Copay			
Urgent Care Centers	$10 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$50 Copay			
Ambulance Services In-Network and Out-of-Network	$300 Copay			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	$100 Copay			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	$300 Copay			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	$200 Copay			
All Other Services (BlueOptions - Option 1 / Option 2)	$200 Copay			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at an ER In-Network & Out-of-Network	$0			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	$0			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$1 Copay			
Specialist	$10 Copay			$5 Copay
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	$25 Copay			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	$50 Copay			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	$200 Copay			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$0 for first 3 visits, then $1 Copay			
Office Visit Specialist	$10 Copay			$5 Copay
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	$200 Copay			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	20% up to $250 Copay per admission			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)		
	BlueOptions 1431, 1431P, 1431O	**BlueSelect 1464, 1464P, 1464O**	**BlueCare 1498, 1498P, 1498O**
Financial Features			
Deductible (DED)[1] (per person / family aggregate)			
In-Network	$5,000 / $10,000		
Out-of-Network	$10,000 / $20,000		Not Covered
Coinsurance (Coins)[2] (amount member pays)			
In-Network	10%		
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered
Out-of-Pocket Maximum (per person / family aggregate)			
In-Network	$6,350 / $12,700		
Out-of-Network	$12,500 / $25,000		Not Covered
Office Services			
Physician Office Services			
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 3 visits, then $25 Copay		
Specialist	$50 Copay		
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED + 10% Coins		
Allergy Injections (per visit) Family Physician	DED + 10% Coins		
Medical Pharmacy	$60 Copay		
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max		
Preventive Care			
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0		
Prescription Drug Program			
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $25		
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$30 / $60 / $75 / $250		
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $63		
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$75 / $150 / $188 / NC		
Urgent and Emergency Medical Care			
Convenient Care Center	$25 Copay		
Urgent Care Centers	$75 Copay		
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$500 Copay		
Ambulance Services In-Network and Out-of-Network	INN DED + 10% Coins		
Hospital / Surgical			
Ambulatory Surgical Center Facility (ASC)	$450 Copay		
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Outpatient Hospital Facility Services (per visit)			
Therapy Services (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
All Other Services (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Other Provider Services			
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED + 10% Coins		
Provider Services at an ER In-Network & Out-of-Network	$0		
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED + 10% Coins		
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED + 10% Coins		
Provider Services at Locations other than Office, Hospital and ER			
Family Physician	$25 Copay		
Specialist	$50 Copay		
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
Diagnostic Services (except AIS)	DED + 10% Coins		
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED + 10% Coins		
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)			
Office Visit Family Physician	$0 for first 3 visits, then $25 Copay		
Office Visit Specialist	$50 Copay		
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered			
Motorized Wheelchairs	$500 Copay		
All Other Services	$0		
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Skilled Nursing Facility (60 Days PBP)	DED + 10% Coins		
Hospice	$0		

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount

[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)		
	BlueOptions 1431A	BlueSelect 1464A	BlueCare 1498A
Financial Features			
Deductible (DED)[1] (per person / family aggregate)			
In-Network	$3,500 / $7,000		
Out-of-Network	$10,000 / $20,000		Not Covered
Coinsurance (Coins)[2] (amount member pays)			
In-Network	10%		
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered
Out-of-Pocket Maximum (per person / family aggregate)			
In-Network	$5,200 / $10,400		
Out-of-Network	$12,500 / $25,000		Not Covered
Office Services			
Physician Office Services			
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 3 visits, then $25 Copay		
Specialist	$50 Copay		
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED + 10% Coins		
Allergy Injections (per visit) Family Physician	DED + 10% Coins		
Medical Pharmacy	$60 Copay		
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max		
Preventive Care			
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0		
Prescription Drug Program			
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $25		
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$30 / $60 / $75 / $250		
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $63		
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$75 / $150 / $188 / NC		
Urgent and Emergency Medical Care			
Convenient Care Center	$25 Copay		
Urgent Care Centers	$75 Copay		
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$300 Copay		
Ambulance Services In-Network and Out-of-Network	INN DED + 10% Coins		
Hospital / Surgical			
Ambulatory Surgical Center Facility (ASC)	$350 Copay		
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Outpatient Hospital Facility Services (per visit)			
Therapy Services (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
All Other Services (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Other Provider Services			
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED + 10% Coins		
Provider Services at an ER In-Network & Out-of-Network	$0		
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED + 10% Coins		
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED + 10% Coins		
Provider Services at Locations other than Office, Hospital and ER			
Family Physician	$25 Copay		
Specialist	$50 Copay		
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
Diagnostic Services (except AIS)	DED + 10% Coins		
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED + 10% Coins		
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)			
Office Visit Family Physician	$0 for first 3 visits, then $25 Copay		
Office Visit Specialist	$50 Copay		
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED + 10% Coins		
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered			
Motorized Wheelchairs	$500 Copay		
All Other Services	$0		
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Skilled Nursing Facility (60 Days PBP)	DED + 10% Coins		
Hospice	$0		

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount [3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)		
	BlueOptions 1431B	**BlueSelect 1464B**	**BlueCare 1498B**
Financial Features			
Deductible (DED)[1] (per person / family aggregate)			
In-Network	$1,500 / $3,000		
Out-of-Network	$10,000 / $20,000		Not Covered
Coinsurance (Coins)[2] (amount member pays)			
In-Network	0%		
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered
Out-of-Pocket Maximum (per person / family aggregate)			
In-Network	$2,250 / $4,500		
Out-of-Network	$12,500 / $25,000		Not Covered
Office Services			
Physician Office Services			
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 3 visits, then $10 Copay		
Specialist	$40 Copay		
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED		
Allergy Injections (per visit) Family Physician	DED		
Medical Pharmacy	$60 Copay		
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max		
Preventive Care			
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0		
Prescription Drug Program			
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $2 / $4		
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$8 / $16 / $30 / $150		
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $10		
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$20 / $40 / $75 / NC		
Urgent and Emergency Medical Care			
Convenient Care Center	$10 Copay		
Urgent Care Centers	$50 Copay		
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$200 Copay		
Ambulance Services In-Network and Out-of-Network	INN DED		
Hospital / Surgical			
Ambulatory Surgical Center Facility (ASC)	$300 Copay		
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED		
Outpatient Hospital Facility Services (per visit)			
Therapy Services (BlueOptions - Option 1 / Option 2)	DED		
All Other Services (BlueOptions - Option 1 / Option 2)	DED		
Other Provider Services			
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Provider Services at an ER In-Network & Out-of-Network	$0		
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Provider Services at Locations other than Office, Hospital and ER			
Family Physician	$10 Copay		
Specialist	$40 Copay		
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
Diagnostic Services (except AIS)	DED		
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED		
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED		
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)			
Office Visit Family Physician	$0 for first 3 visits, then $10 Copay		
Office Visit Specialist	$40 Copay		
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED		
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered			
Motorized Wheelchairs	$500 Copay		
All Other Services	$0		
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Skilled Nursing Facility (60 Days PBP)	DED		
Hospice	$0		

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount

[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Silver)		
	BlueOptions 1431C	**BlueSelect 1464C**	**BlueCare 1498C**
Financial Features			
Deductible (DED)[1] (per person / family aggregate)			
In-Network	$500 / $1,000		
Out-of-Network	$10,000 / $20,000		Not Covered
Coinsurance (Coins)[2] (amount member pays)			
In-Network	0%		
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered
Out-of-Pocket Maximum (per person / family aggregate)			
In-Network	$2,250 / $4,500		
Out-of-Network	$12,500 / $25,000		Not Covered
Office Services			
Physician Office Services			
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 3 visits, then $4 Copay		
Specialist	$10 Copay		
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED		
Allergy Injections (per visit) Family Physician	DED		
Medical Pharmacy	$60 Copay		
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max		
Preventive Care			
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0		
Prescription Drug Program			
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $2 / $4		
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$5 / $10 / $30 / $75		
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $10		
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$10 / $25 / $75 / NC		
Urgent and Emergency Medical Care			
Convenient Care Center	$4 Copay		
Urgent Care Centers	$30 Copay		
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	$100 Copay		
Ambulance Services In-Network and Out-of-Network	INN DED		
Hospital / Surgical			
Ambulatory Surgical Center Facility (ASC)	$250 Copay		
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED		
Outpatient Hospital Facility Services (per visit)			
Therapy Services (BlueOptions - Option 1 / Option 2)	DED		
All Other Services (BlueOptions - Option 1 / Option 2)	DED		
Other Provider Services			
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Provider Services at an ER In-Network & Out-of-Network	$0		
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED		
Provider Services at Locations other than Office, Hospital and ER			
Family Physician	$4 Copay		
Specialist	$10 Copay		
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
Diagnostic Services (except AIS)	DED		
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED		
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED		
Other Special Services			
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)			
Office Visit Family Physician	$0 for first 3 visits, then $4 Copay		
Office Visit Specialist	$10 Copay		
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED		
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered			
Motorized Wheelchairs	$500 Copay		
All Other Services	$0		
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0		
Skilled Nursing Facility (60 Days PBP)	DED		
Hospice	$0		

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount

[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Everyday Health Plans (Bronze)			Bronze
	BlueOptions 1416, 1416P, 1416O	BlueSelect 1449, 1449P, 1449O	BlueCare 1483, 1483P, 1483O	myBlue 1601, 1601P, 1601O
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$6,700 / $13,400			
Out-of-Network	$13,400 / $26,800		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	50%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$6,850 / $13,700			
Out-of-Network	$26,800 / $26,800		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	$0 for first 3 visits, then $50 Copay			
Specialist	$85 Copay			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED + 50% Coins			
Allergy Injections (per visit) Family Physician	$10 Copay			
Medical Pharmacy	$60 Copay			
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $32			$0 / $4 / $32
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$30 / 50%[6] / $50%[6] / $50%[6]			50%[6] / 50%[6] / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $80			$0 / $0 / $80
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$75 / $50%[6] / $50%[6] / NC			50%[6] / 50%[6] / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	$50 Copay			
Urgent Care Centers	$125 Copay			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	INN DED + 50% Coins			
Ambulance Services In-Network and Out-of-Network	INN DED + 50% Coins			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	DED + $100 Copay			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED + $150 Copay			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	DED + $125 Copay			
All Other Services (BlueOptions - Option 1 / Option 2)	DED + $125 Copay			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED			
Provider Services at an ER In-Network & Out-of-Network	INN DED			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	$50 Copay			
Specialist	$85 Copay			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	DED + 50% Coins			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED + 50% Coins			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED + $125 Copay			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	$0 for first 3 visits, then $50 Copay			
Office Visit Specialist	$85 Copay			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED + $125 Copay			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	$500 Copay			
All Other Services	$0			
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	$0			
Skilled Nursing Facility (60 Days PBP)	DED + 50% Coins			
Hospice	$0			

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

[1] DED (Deductible) = The fixed dollar amount that must be paid in a benefit period for covered health care expenses before insurance begins to pay. [2] Coins = Percentage based on our Allowed Amount
[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

COST SHARING (amount member pays)	Essential Plans (Bronze)			Bronze
	BlueOptions 1419, 1419P, 1419O	BlueSelect 1452, 1452P, 1452O	BlueCare 1486, 1486P, 1486O	myBlue 1602, 1602P, 1602O
Financial Features				
Deductible (DED)[1] (per person / family aggregate)				
In-Network	$6,850 / $13,700			
Out-of-Network	$13,700 / $27,400		Not Covered	
Coinsurance (Coins)[2] (amount member pays)				
In-Network	0%			
Out-of-Network (For BlueOptions and BlueSelect plans member pays out-of-network DED + Coins unless otherwise noted below) (For BlueCare and myBlue plans out-of-network services are not covered - except for emergency services)	50%		Not Covered	
Out-of-Pocket Maximum (per person / family aggregate)				
In-Network	$6,850 / $13,700			
Out-of-Network	$13,700 / $27,400		Not Covered	
Office Services				
Physician Office Services				
Family Physician (PCP[3]) and Blue Physician Recognition	DED			
Specialist	DED			
Advanced Imaging Services (AIS) (MRI, MRE, PET, CT, Nuclear Med.)	DED			
Allergy Injections (per visit) Family Physician	DED			
Medical Pharmacy	DED			$60 Copay
Medical pharmacy cost-share is per drug, per billing provider, in addition to the Physician Office Services cost-share and it does not include immunizations and allergy injections.	$240 In-Network Monthly Member OOP Max			
Preventive Care				
Routine Adult and Child Preventive Services, Wellness Services, and Immunizations	$0			
Prescription Drug Program				
Retail - Generic 1 / Generic 2 / Generic 3	$0 / $4 / $0[6]			$0 / $4 / $0[6]
Retail - Brand 1 / Brand 2 / Non-Preferred / Specialty	$30 / $0[6] / $0[6] / $0[6]			$0[6] / $0[6] / NC / NC
Mail Order (90 days) - Generic 1/ Generic 2 / Generic 3	$0 / $0 / $0[6]			$0 / $0 / $0[6]
Mail Order (90 days) - Brand 1 / Brand 2 / Non-Preferred / Specialty	$75 / $0[6] / $0[6] / NC			$0[6] / $0[6] / NC / NC
Urgent and Emergency Medical Care				
Convenient Care Center	DED			
Urgent Care Centers	DED			
Emergency Room Facility Services (ER) (per visit) In-Network (INN)[4] & Out-of-Network	INN DED			
Ambulance Services In-Network and Out-of-Network	INN DED			
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	DED			
Inpatient Hospital Facility and Rehabilitation/Habilitation Services (per admission) (PBP[5]) Limit 30 Days (BlueOptions - Option 1 / Option 2)	DED			
Outpatient Hospital Facility Services (per visit)				
Therapy Services (BlueOptions - Option 1 / Option 2)	DED			
All Other Services (BlueOptions - Option 1 / Option 2)	DED			
Other Provider Services				
Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED			
Provider Services at an ER In-Network & Out-of-Network	INN DED			
Provider Services at an Ambulatory Surgical Center (ASC) (Surgeon) BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED			
Radiology, Pathology and Anesthesiology Provider Services at a Hospital BlueOptions and BlueSelect: In-Network & Out-of-Network BlueCare and myBlue: In-Network	INN DED			
Provider Services at Locations other than Office, Hospital and ER				
Family Physician	DED			
Specialist	DED			
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)				
Diagnostic Services (except AIS)	DED			
Imaging Services (AIS) *(MRI, MRE PET, CT, Nuclear Med.)*	DED			
Independent Clinical Lab (e.g., blood work) In-Network BlueSelect: Out-of-Network Not Covered	DED			
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) (BlueOptions - Option 1 / Option 2)	DED			
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (35 Visits PBP)				
Office Visit Family Physician	DED			
Office Visit Specialist	DED			
Outpatient Hospital Facility (BlueOptions - Option 1 / Option 2)	DED			
Durable Medical Equipment In-Network BlueSelect: Out-of-Network Not Covered				
Motorized Wheelchairs	DED			
All Other Services	DED			$0
Home Health Care (30 Visits PBP) In-Network BlueSelect: Out-of-Network Not Covered	DED			$0
Skilled Nursing Facility (60 Days PBP)	DED			
Hospice	DED			$0

Note: Maternity, Mental Health and Substance Abuse benefits are covered and based on the location where services are provided.

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[3] PCP = Primary Care Physician [4] INN = In-Network [5] PBP = Per Benefit Period [6] Applies after INN DED is met [7] Applies after $3,000 Rx DED is met

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Florida Blue

Cost Share Reduction for American Indian (AI/AN <300% FPL) Plans

BlueOptions

Platinum Plans	Gold Plans	Silver Plans	Bronze Plans
Everyday Health Plan 1418U	All Copay Plan 1505U	Everyday Health Plan 1410U	Everyday Health Plan 1416U
Everyday Health Premier Plan 1418UV		Everyday Health Plan 1423U	Essential Plan 1419U
All Copay Plan 1424U		Everyday Health Plan 1431U	

BlueSelect

Platinum Plans	Gold Plans	Silver Plans	Bronze Plans
Everyday Health Plan 1451U	All Copay Plan 1535U	Everyday Health Plan 1443U	Everyday Health Plan 1449U
Everyday Health Premier Plan 1451UV		Everyday Health Plan 1456U	Essential Plan 1452U
All Copay Plan 1457U		Everyday Health Plan 1464U	

BlueCare

Platinum Plans	Gold Plans	Silver Plans	Bronze Plans
Everyday Health Plan 1485U	All Copay Plan 1565U	Everyday Health Plan 1477U	Everyday Health Plan 1483U
All Copay Plan 1491U		Everyday Health Plan 1490U	Essential Plan 1486U
		Everyday Health Plan 1498U	

myBlue

Gold Plans	Silver Plans	Bronze Plans
Plan 1605U	Plan 1603U	Plan 1601U
	Plan 1604U	Plan 1602U

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Florida Blue