| BENEFIT HIGHLIGHTS | IN-NETWORK/OUT-OF-NETWORK | **Write “Match” or Fill In Differences** |
| --- | --- | --- |
| **Company and Plan Name:** | Florida Blue Plan 03359 |  |
| **MEDICAL** | Employee Responsibility  In-Network / Out-of-Network |  |
| **Lifetime Maximum** | Unlimited |  |
| **Calendar Year Deductible**  Individual | $1,000 Combined |  |
| **Calendar Year Deductible**  Family | $3,000 Combined |  |
| **Out-of-Pocket Maximum**  Individual/Family  (In-Network / Out-of-Network) | $4,000 / $12,000 |  |
| What applies to Out-of-Pocket Maximum? | Deductible Coinsurance Copayments  Prescription Drugs |  |
| **Coinsurance**  (Once Deductible is met) | 20% / 40% |  |
| **Medical Pharmacy**  In-Network Monthly OOP  In-Network  Out-of-Network | $200  20% coins  Ded + 50% coins |  |
| **Physician Services** | | |
| Family Physician Office Visit | $25 Copay / CYD + 40% |  |
| Other Health Care Professionals Office Visit | $35 Copay / CYD + 40% |  |
| Urgent Care | CYD + 20%/ CYD + 40% |  |
| Independent Clinical Lab Services  **Quest – Exclusive In-Network Provider**  Out-of-Network | $0  CYD + 40% | Required Lab Provider? |
| Advanced Imaging Services | $125 copay / CYD + 40% |  |
| **Preventive Health Services** | | |
| **Per Benefit Period** | Unlimited |  |
| **Adult Wellness Services**  Routine Adult Physical Exams and Immunizations  Family Physician | $0 / 40% Coinsurance (No CYD) |  |
| Specialist | $0 / 40% Coinsurance (No CYD) |  |
| Mammograms | $0 / $0 |  |
| Routine Colonoscopy (50+) | $0 / $0 |  |
| **Well Child Care Services**  Family Physician | $0 / 40% (No CYD) |  |
| Specialist | $0 / 40% (No CYD) |  |
| **Other Types of Facility and Provider Services** | | |
| **Inpatient**  Facility (Opt 1/Opt 2) | $500 copay / $1,000 copay  CYD + 40% |  |
| Physician and other health care professional services | CYD + 20% / CYD + 20% |  |
| **Outpatient**  Facility (Opt 1/Opt 2) | $150 copay / $250 copay  CYD + 40% |  |
| Physician and other health care professional services | CYD + 20% / CYD + 20% |  |
| **Emergency Room Visits**  Facility | $100 copay / 20% (No CYD) |  |
| Physician and other health care professional services | CYD + 20% / CYD + 20% |  |
| **Ambulance – Ground/Air & Water** | CYD + 20% / CYD + 20% |  |
| **Ambulatory Surgical Center Facility Services** | $100 copay / CYD + 40% |  |
| Radiology, Pathology, Anesthesiology Provider Services at an Ambulatory Surgical Center | CYD + 20% / CYD + 20% |  |
| **Therapy Services**  Cardiac Rehabilitation, Occupational, Speech, Physical, Massage & Spinal Manipulations  Outpatient Rehab Therapy Center  In-Network  Out-of-Network  Outpatient Hospital Facility Services (per visit)  In-Network (Option 1 / Option 2)  Out-of-Network | DED + 20% Coinsurance DED + 40% Coinsurance  $45 Copayment / $60 Copayment DED + 40% Coinsurance |  |
| Calendar Year Maximums: | 35 Total Visits annually |  |
| **Home Health Care** | CYD + 20% / CYD + 40% |  |
| Calendar Year Maximum: | 20 Visits |  |
| **Skilled Nursing Facility** | CYD + 20% / CYD + 40% |  |
| Calendar Year Maximum: | 60 Days |  |
| **Hospice** | CYD + 20% / CYD + 40% |  |
| Calendar Year Maximum: | Unlimited |  |
| **Durable Medical Equipment & Prosthetics and Orthotics** | CYD + 20% / CYD + 40% |  |
| **Allergy Injections**  Family Physician  All Others | $10 Copay  CYD + 20% / CYD + 40% |  |
| **Mental Health and Substance Abuse Services** | | |
| **Mental Health and Substance Dependency Care and Treatment Services**  Inpatient / Outpatient  Facility Services  (Opt 1/Opt 2) | $500 copay / $500 copay  CYD + 40% |  |
| Emergency Room | $0 |  |
| Physician Services at Hospital and ER | $0 |  |
| Physician and Other Health Care Professionals  Family Physician Office | $0 / CYD + 40% |  |
| Specialist Office | $0 / CYD + 40% |  |
| **Prescription Drug Benefits** | | |
| **RETAIL – 30 DAY SUPPLY** | | |
| Pharmacy Deductible | $100 – both retail and mail |  |
| Retail Preferred Generic | $20 copay / 50% |  |
| Retail Preferred Brand | $40 copay / 50% |  |
| Retail Non-Preferred Brand | $60 copay / 50% |  |
| **MAIL ORDER – 90 DAY SUPPLY** | | |
| Mail Order Generic | $50 Copay |  |
| Mail Order Brand Preferred | $100 Copay |  |
| Mail Order Brand Non-Preferred | $150 Copay |  |