| BENEFIT HIGHLIGHTS | IN-NETWORK/OUT-OF-NETWORK | **Write “Match” or Fill In Differences** |
| --- | --- | --- |
| **Company and Plan Name:** | Florida Blue Plan 03160 / 03161 |  |
| **MEDICAL** | Employee ResponsibilityIn-Network / Out-of-Network |  |
| **Lifetime Maximum** | Unlimited |  |
| **Calendar Year Deductible**Individual | $1,500 / $3,000 |  |
| **Calendar Year Deductible**Family | $3,000 / $6,000 |  |
| **Out-of-Pocket Maximum**Individual(In-Network / Out-of-Network) | $3,000 / $6,000  |  |
| Family(In-Network / Out-of-Network) | $5,000 / $10,000 |  |
| What applies to Out-of-Pocket Maximum? | DeductibleCoinsurancePrescription Drugs |  |
| **Coinsurance**(Once Deductible is met) | 10% / 30% |  |
| **Medical Pharmacy**In-Network Monthly OOPIn-NetworkOut-of-Network | $200CYD + 10%CYD + 50% |  |
| **Physician Services** |
| Family Physician Office Visit | CYD + 10%/ CYD + 30% |  |
| Other Health Care Professionals Office Visit | CYD + 10%/ CYD + 30% |  |
| Urgent Care | CYD + 10%/ CYD + 30% |  |
| Independent Clinical Lab Services**Quest – Exclusive In-Network Provider**Out-of-Network | CYD + 10%CYD + 30% | Required Lab Provider? |
| Advanced Imaging Services | CYD + 10%/ CYD + 30% |  |
| **Preventive Health Services** |
| **Per Benefit Period** | Unlimited |  |
| **Adult Wellness Services**Routine Adult Physical Exams and ImmunizationsFamily Physician | $0 / 30% Coinsurance (No CYD) |  |
| Specialist | $0 / 30% Coinsurance (No CYD) |  |
| Mammograms | $0 / $0 |  |
| Routine Colonoscopy (50+) | $0 / $0 |  |
| **Well Child Care Services**Family Physician | $0 / 30% (No CYD) |  |
| Specialist | $0 / 30% (No CYD) |  |
| **Other Types of Facility and Provider Services** |
| **Inpatient**Facility | CYD + 10%/ CYD + 30% |  |
| Physician and other health care professional services | CYD + 10%/ CYD + 30% |  |
| **Outpatient**Facility – Opt 1 / Opt 2 | CYD + 10% / CYD + 25%CYD + 30% |  |
| Physician and other health care professional services | CYD + 10%/ CYD + 30% |  |
| **Emergency Room Visits**Facility | CYD + 10%/ CYD + 20% |  |
| Physician and other health care professional services | CYD + 10%/ IN-Net CYD + 10% |  |
| **Ambulance – Ground/Air & Water** | CYD + 10%/ In-Net CYD + 10% |  |
| **Ambulatory Surgical Center Facility Services** | CYD + 10%/ CYD + 30% |  |
| Radiology, Pathology, Anesthesiology Provider Services at an Ambulatory Surgical Center | CYD + 10%/ In-Net CYD + 10% |  |
| **Therapy Services**Cardiac Rehabilitation, Occupational, Speech, Physical, Massage & Spinal ManipulationsOutpatient Rehab Therapy Center In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network  | CYD + 10%/ CYD + 30%CYD + 10% / CYD + 25%CYD + 30% |  |
| Calendar Year Maximums: | 35 Total Visits annually |  |
| **Home Health Care**  | CYD + 10%/ CYD + 30% |  |
| Calendar Year Maximum: | 20 Visits |  |
| **Skilled Nursing Facility** | CYD + 10%/ CYD + 30% |  |
| Calendar Year Maximum: | 60 Days |  |
| **Hospice** | CYD + 10%/ CYD + 30% |  |
| Calendar Year Maximum: | Unlimited |  |
| **Durable Medical Equipment & Prosthetics and Orthotics** | CYD + 10%/ CYD + 30% |  |
| **Allergy Injections**Family PhysicianAll Others | CYD + 10%/ CYD + 30% |  |
| **Mental Health and Substance Abuse Services** |
| **Mental Health and Substance Dependency Care and Treatment Services**Inpatient / OutpatientFacility Services (Opt 1/Opt 2) | CYD + 10%/ CYD + 30% |  |
| Emergency Room | CYD only |  |
| Physician Services at Hospital and ER | CYD + 10%/ CYD + 10% |  |
| Physician and Other Health Care ProfessionalsFamily Physician Office | CYD + 10%/ CYD + 30% |  |
| Specialist Office | CYD + 10%/ CYD + 30% |  |
| **Prescription Drug Benefits** |
| **RETAIL – 30 DAY SUPPLY** |
| Pharmacy Deductible | Medical Deductible |  |
| Retail Preferred Generic | $15 copay / In-Net CYD + 50% |  |
| Retail Preferred Brand | $30 copay / In-Net CYD + 50% |  |
| Retail Non-Preferred Brand | $50 copay / In-Net CYD + 50% |  |
| **MAIL ORDER – 90 DAY SUPPLY** |
| Mail Order Generic | $40 Copay |  |
| Mail Order Brand Preferred | $75 Copay |  |
| Mail Order Brand Non-Preferred | $125 Copay |  |