	Predictable Cost Plan
BlueOptions	Tradictable Cost Fian
COST SHARING (amount member pays)	Plan 010
Office Services	
Physician Office Services	
In-Network Family Physician / In-Network Specialist	\$20 Copay / CYD ¹ + 20% Coins ²
Out-of-Network Office Visit / e-Office visit	CYD + 40% Coins
In-Network e-Office Visit	\$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network Family Physician / In-Network Specialist	\$20 Copay / CYD + 20% Coins
Maternity (Rider available with certain plans)	Available
Allergy Injections (per visit) In-Network Family Physician	\$10 Copay
Medical Pharmacy Preventive Care	Not Applicable
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network / Out-of-Network	\$0 / 40% Coins
Mammograms	\$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	\$0
Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit	
In-Network	
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	\$200 Brand
Generic/Brand/Non-preferred	\$15 / 40% / 40%
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered
Out-of-Network	444.5
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	\$200 Brand
Generic/Brand/Non-preferred	\$15 / 40% / 50% Not Covered
Mail Order (90 days) - Generic/Brand/Non-preferred Emergency Medical Care	Not Covered
Urgent Care Centers In-Network / Out-of-Network	CYD + 20% Coins / CYD + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	CYD + 20% Coins / CYD + 20% Coins
Ambulance Services (INN ³ & OON ⁴); \$5,000 per day max for combined ground, air & water travel	In-Network CYD + 20% Coins
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS)	\$100 Copay
In-Network Advanced Imaging Services (AIS) (MRI, MRA PET, CT, Nuclear Med.)	\$100 Copay
Out-of-Network	CYD + 40% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	\$0 / CYD + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)	4000
In-Network (Option 1 / Option 2) / Out-of-Network	\$200 Copay/\$300 Copay / CYD + 40% Coins
Mental Health / Substance Abuse Mental Health (Inpatient PCY ⁵ / Outpatient PCY)	9 Days / 9 Visits
Substance Dependency (Lifetime max)	8 Days / 8 Visits No Benefit Maximum
Other Provider Services	NO Delient Maximum
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network CYD + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network & Out-of-Network	In-Network CYD + 20% Coins
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician or In-Network Specialist / Out-of-Network	CYD + 20% Coins / CYD + 40% Coins
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and	OF Weiter DOV
Massage Therapies and Spinal Manipulations (PCY max) Home Health Care (subject to CYD + Coins)	25 Visits PCY 20 Visits PCY
Skilled Nursing Facility (subject to CYD + Coins)	60 days PCY
Hospice (subject to CYD + Coins)	No Benefit Maximum
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	\$100 Copay / CYD + 40% Coins
Provider Services Rendered at an ASC (Surgeon)	
In-Network Family Physician or In-Network Specialist / Out-of-Network	CYD + 20% Coins / CYD + 40% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days
In-Network (Option 1 / Option 2)	\$750 Copay / \$1,000 Copay
Out-of-Network	PAD + CYD + 40% Coins
Outpatient Hospital Facility Services (per visit)	
In-Network (Option 1 / Option 2) / Out-of-Network	\$200 Copay/\$300 Copay / CYD + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network Financial Features	CYD + 20% Coins / CYD + 20% Coins
Calendar Year Deductible (CYD) (per person/family aggregate)	
In-Network	\$500 / N/A
Out-of-Network	Combined w/ln-Network
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	\$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 40%
Out-of-Pocket Maximum (per person/family aggregate)	
In-Network	\$4,000 / \$8,000
Out-of-Network	\$25,000 / \$25,000
Total Lifetime Maximum Benefit	No Benefit Maximum
4	4

¹ CYD = Calendar Year Deductible ² Coins = Percentage based on our Allowed Amount ³ INN = In-Network ⁴ OON = Out-of-Network ⁵ PCY = Per Calendar Year This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.



Plan 0584		<u> </u>	Predictable Cost Plans	
Infection of Temporary (1997) 200 Copy	BlueOptions	Plan 0504		Plan 0511
Page	<u>`</u>			
1.50 Coasy / 150 Coasy 150 150				
COTO	•	\$35 Copay / \$50 Copay	\$35 Conay / \$50 Conay	\$35 Conay / CVD + 20% Coins
Internation of Ciffice Visit	· · · · · · · · · · · · · · · · · · ·			
Advanced processor (Assertion (
March Primary Carlo Carlo Primary	Maternity (Rider available with certain plans)			
Medical Philipsians	Allergy Injections (per visit) In-Network Family Physician	\$10 Copay	\$10 Copay	\$10 Copay
Interest Provider (2000 Nation) Nombros COP Natar) (Ober Affertines Ferrodes)		(Applies to Office Setting & Sp	ecialty Pharmacy Vendor) (NOTE:	Medical Pharmacy cost-share is in
International Control Contro	Medical Pharmacy		,	ude immunizations & allergy injections
Notice Author Core Sort Age	· · · · · · · · · · · · · · · · · · ·	20% Coins / CYD + 50% Coins	20% Coins / CYD + 50% Coins	20% Coins / CYD + 50% Coins
International Characteristics \$0 / 40% Colors \$0 / 40% Color				
Technological Processing Control Programs		\$0 / 40% Coins	\$0 / 40% Coins	\$0 / 40% Coins
Preservicy for Content	Mammograms	\$0	\$0	\$0
Permany Debuchillo	Colonoscopies (Routine for age 50+ then frequency schedule applies)	\$0	\$0	\$0
Primaring poducidation An Option Studies	Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit			
\$10 / 40% 50% \$10 / 40% 50% \$25 / 34% \$200 \$23 / 34% \$200	In-Network			
Mail Order (10 days) - Connect EnrandNon-preferred \$26 / \$102 / \$200 \$26 / \$102 / \$200 \$26 / \$102 / \$200 \$26 / \$102 / \$200 \$26 / \$102 / \$200 \$	· · · · · · · · · · · · · · · · · · ·	·	\$300 Brand	* /
Dute-Oh-Network	· · · · · · · · · · · · · · · · · · ·		·	
Plannings Deductable & combined & GON & applies to Mail Order	• • • • • • • • • • • • • • • • • • • •	\$25 / \$125 / \$200	\$25 / \$125 / \$200	\$25 / \$125 / \$200
Semeration Spik Coins Spi	Out-of-Network			
Mail Older (190 days) - Cerearic Desard-Not-preferred 50% Coins 50% Coin	· · · · · · · · · · · · · · · · · · ·	'	*****	
Emergency Medical Care Topic Care In-Network (Obs-of-Network S80 Copay (CYD + 40% Coins S80 Copay (CYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% CorneCYD + 40% Coins CYD / CYD CYD + 20% Coins CYD / CYD CYD + 20% Coins CYD / CYD CYD + 20% Coins CYD / CYD CYD + 20% Coins CYD / CYD / CYD + 20% Coins CYD / CYD / CYD + 20% Coins CYD / CY	· · · · · · · · · · · · · · · · · · ·			
		50% Coins	50% Coins	50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network (and-Network Mushance Services (RNY & 2007); \$250,000 pt and yman for combined ground, air & water travel In-Network CYD In-Network CYD In-Network CYD In-Network CYD In-Network CYD 20% Coins CYD + 20% Coins CYD + 20% Coins CYD + 40% Coin	• •			
In-Network CYD	•		· •	
Dispositic Services Dispositic Services Earlity Services [prt viii] (e.g., X-rays) Includes Provider Services S75 Coppy \$75	· · · · · · · · · · · · · · · · · · ·			
Independent Diagnostic Tearing Facility Services [pr std] [6.9]. Knpp] (Includes Provider Services) S75 Copey S75 Copey S20 Copey		In-Network CYD	In-Network CYD	In-Network CYD + 20% Coins
In-Network Diagnostic Services (except AIS)	·			
In-Network Advanced Imaging Services (AIS) (MRI, MRA PET, CT, Nuclear Med.) \$200 Copay \$250 Copay \$25		A	075.0	ATT 0
Out-of-Network			· · ·	
Integration Clinical Lab (e.g., blood work) in Network / Out-of-Network \$0 / CYD + 40% Coins \$0 / CYD + 40				
Duppatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) In-Network (Option 1 / Option 2) / Out-of-Network (Option 2 / Option 2 /				
In-Network (Option 1 / Option 2 / Out-of-Network CYD / CYD + 40% Coins CYD / CYD / CYD + 20% Coins/CYD + 40% Coins CYD / CYD / CYD / CYD / CYD / CYD + 20% Coins/CYD + 20% Coins/CYD + 20% Coins/CYD + 20% Coins/CYD +		\$07 C 1D + 40% Collis	\$0 / C I D + 40% Collis	\$0 / C I D + 40% Collis
Mental Health (Inpatient PCV ² / Outpatient PCY)		CVD / CVD + 40% Coins	CVD / CVD + 40% Coins	CVD + 20% Coins/CVD + 40% Coin
State St		C1D7 C1D + 40% Collis	CTB/ CTB + 40% Collis	C1D + 20 % Collis/C1D + 40 % Colli
No Benefit Maximum No Bene		8 Dave / 8 Visite	8 Dave / 8 Visite	8 Dave / 8 Visite
Cheer Provider Services Cheer Provider Services Cheer Provider Services at Hospital and ER In-Network / Out-of-Network In-Network CYD In-Network CYD In-Network CYD + 20% Coins Readinglogy, Pathology and Anasthesiology Provider Services at an ASC In-Network CYD In-Network CYD In-Network CYD + 20% Coins Provider Services at Locations other than Office, Hospital and ER In-Network Specialist / Out-of-Network CYD / CYD + 40% Coins CYD / CYD + 20% Coins CYD /	,	·	•	•
Provider Services at Hospital and ER In-Network / Out-of-Network In-Network CYD In-	, ,	No Benefit Waximum	140 Benefit Waximum	140 Benefit Waximum
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network (*Ott-of-Network (*Ott-of		In-Network CYD	In-Network CYD	In-Network CYD + 20% Coins
In-Network / Out-of-Network In-Network CYD 20% Coins CYD / 20% Coi	<u>'</u>			
In-Network Cyp Cyp 40% Coins Cyp Cyp 40% Coins Cyp 20% Coins/Cyp 40% Coins Cyp 25% Visits Cyp 26% Visits		In-Network CYD	In-Network CYD	In-Network CYD + 20% Coins
In-Network Family Physician or In-Network Specialist / Out-of-Network CYD / CYD + 40% Coins CYD / CYD + 40% Coins CYD + 20% Coins/CYD + 20% Coins CYD + 20	Provider Services at Locations other than Office, Hospital and ER			
Deter Special Services Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PCY max) 25 Visits PCY 26 Visits		CYD / CYD + 40% Coins	CYD / CYD + 40% Coins	CYD + 20% Coins/CYD + 40% Coin
Speech and Massage Therapies and Spinal Manipulations (PCY max) 25 Visits PCY 25 Visits PCY 25 Visits PCY 10 Visits PCY 20 Visits PCY 30 Visits	Other Special Services			
No Health Care (subject to CYD + Coins)	Combined Outpatient Cardiac Rehabilitation and Occupational, Physical,			
Skilled Nursing Facility (subject to CYD + Coins) 60 days PCY 60 days PCY 60 days PCY	Speech and Massage Therapies and Spinal Manipulations (PCY max)			
No Benefit Maximum No Bene	,			
CYD CYD 40% Coins \$200 Copay CYD 40% Coins CYD CYD	,	· · · · · · · · · · · · · · · · · · ·	•	<u> </u>
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network CYD / CYD + 40% Coins CYD / CYD / CYD + 40% Coins CYD / CY	• • • •	No Benetit Maximum	No Benefit Maximum	No Benetit Maximum
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network CYD / CYD + 40% Coins CYD / CYD + 40% Coins CYD + 20% Coins/CYD + 40% Coins CYD + 20% Coins/CYD + 40% Coins CYD / CYD + 20% Coins/CYD + 40% Coins CYD / CYD + 20% Coins CYD + 20% Coins CYD + 20% Coins CYD - 20% Coins CYD + 20% Coins CYD - 20% Coins CYD + 20% Coins CYD - 20%	· · · · · ·	CVD / CVD : 400/ O-1-	CVD / CVD : 400/ O-1	#200 Caray / CVD + 400/ C :
In-Network (Option 1 / Option 2) CYD	, , ,			
In-Network (Option 1 / Option 2)	, , , , , ,	01D / 01D + 40% COIRS		
Out-of-Network PAD + CYD + 40% Coins PAD + CYD + 40% Coins PAD + CYD + 40% Coins Dutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) \$55 Copay / \$70 Copay \$500 COPD / \$70 COPD \$55 Copay / \$70 Copay \$55 Copay / \$	•	CVD	, , ,	·
Coutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) \$55 Copay / \$70 Copay \$7500 \$, , , ,			
In-Network - Therapy Services (Option 1 / Option 2) \$55 Copay / \$70 Copay \$55 Copay / \$70 Copay		. 710 1 0 10 1 40 /0 001113	. 7.5 1 0 15 + 40 /0 00/18	1775 1 515 + 4070 COMB
In-Network - All Other Services (Option 1 / Option 2) CYD CYD CYD + 20% Coins		\$55 Copay / \$70 Copay	\$55 Copay / \$70 Copay	\$55 Copay / \$70 Copay
Out-of-Network CYD + 40% Coins CYD + 40% Coins CYD + 40% Coins ER Facility Services (per visit) In-Network / Out-of-Network CYD / CYD CYD / CYD CYD + 20% Coins/CYD + 20% Co Calendar Year Deductible (CYD) (per person/family aggregate) ***S.500 / \$7,500 \$3,500 / \$10,500 \$1,500 / N/A Out-of-Network \$4,500 / \$9,000 \$5,500 / \$11,000 \$3,500 / \$6,500 Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) \$500 \$500 \$500 Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network 0% / 40% 0% / 40% 20% / 40% Out-of-Pocket Maximum (per person/family aggregate) ***S.500 / \$1,500 \$5,000 / \$10,000 \$5,000 / \$10,000 Out-of-Network \$2,500 / \$7,500 \$3,500 / \$10,500 \$5,000 / \$10,000 Out-of-Network \$7,500 / \$15,000 \$8,500 / \$17,000 \$25,000 / \$25,000	, , , , , , , , , , , , , , , , , , , ,			
CYD / CYD CYD / CYD CYD / CYD CYD + 20% Coins/CYD + 20	, , ,			
Calendar Year Deductible (CYD) (per person/family aggregate)				CYD + 20% Coins/CYD + 20% Coin
In-Network \$2,500 / \$7,500 \$3,500 / \$10,500 \$1,500 / N/A	Financial Features			
In-Network \$2,500 / \$7,500 \$3,500 / \$10,500 \$1,500 / N/A	Calendar Year Deductible (CYD) (per person/family aggregate)			
Out-of-Network \$4,500 / \$9,000 \$5,500 / \$11,000 \$3,500 / \$6,500 Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) \$500 \$500 \$500 Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network 0% / 40% 0% / 40% 20% / 40% Out-of-Pocket Maximum (per person/family aggregate) \$2,500 / \$7,500 \$3,500 / \$10,500 \$5,000 / \$10,000 Out-of-Network \$7,500 / \$15,000 \$8,500 / \$17,000 \$25,000 / \$25,000	, , , , , , , , , , , , , , , , , , , ,	\$2,500 / \$7,500	\$3,500 / \$10,500	\$1,500 / N/A
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) \$500 \$500 \$500 Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network 0% / 40% 0% / 40% 20% / 40% Out-of-Pocket Maximum (per person/family aggregate) \$2,500 / \$7,500 \$3,500 / \$10,500 \$5,000 / \$10,000 Out-of-Network \$7,500 / \$15,000 \$8,500 / \$17,000 \$25,000 / \$25,000				
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network 0% / 40% 0% / 40% 20% / 40% Out-of-Pocket Maximum (per person/family aggregate) \$2,500 / \$7,500 \$3,500 / \$10,500 \$5,000 / \$10,000 Out-of-Network \$7,500 / \$15,000 \$8,500 / \$17,000 \$25,000 / \$25,000				
Dut-of-Pocket Maximum (per person/family aggregate) \$2,500 / \$7,500 \$3,500 / \$10,500 \$5,000 / \$10,000 In-Network \$7,500 / \$15,000 \$8,500 / \$17,000 \$25,000 / \$25,000 Out-of-Network \$7,500 / \$15,000 \$8,500 / \$17,000 \$25,000 / \$25,000				
In-Network \$2,500 / \$7,500 \$3,500 / \$10,500 \$5,000 / \$10,000 Out-of-Network \$7,500 / \$15,000 \$8,500 / \$17,000 \$25,000 / \$25,000	Out-of-Pocket Maximum (per person/family aggregate)			•
		\$2,500 / \$7,500	\$3,500 / \$10,500	\$5,000 / \$10,000
Total Lifetime Maximum Benefit Maximum No Benefit Maximum No Benefit Maximum No Benefit Maximum No Benefit Maximum	Out-of-Network	\$7,500 / \$15,000	\$8,500 / \$17,000	\$25,000 / \$25,000
	Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum

¹ CYD = Calendar Year Deductible ² Coins = Percentage based on our Allowed Amount ³ INN = In-Network ⁴ OON = Out-of-Network ⁵ PCY = Per Calendar Year This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.

	Predictable Cost Plans		
BlueOptions COST SHARING (amount member pays)	Plan 514	Plan 515	
Office Services			
Physician Office Services			
In-Network Family Physician / In-Network Specialist	\$35 Copay / \$75 Copay	\$35 Copay / \$75 Copay	
Out-of-Network Office Visit / e-Office visit	CYD ¹ + 50% Coins ²	CYD + 50% Coins	
In-Network e-Office Visit (Family Physician / Specialist)	\$10 Copay	\$10 Copay	
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	\$300 Copay	\$300 Copay	
Maternity (Rider available with certain plans)	Available	Available	
Allergy Injections (per visit) In-Network Family Physician	\$10 Copay	\$10 Copay	
Medical Pharmacy	(Applies to Office Setting & Specialty Pharmacy V addition to the Physician Office Services cost-share)		
In-Network Provider (\$200 Monthly Member OOP Max) / Out-of-Network Provider	20% Coins / CYD + 50% Coins	20% Coins / CYD + 50% Coins	
Preventive Care			
Routine Adult Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	
Mammograms In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	
Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	
Routine Child Preventive Services, Wellness Services, and Immunizations In-Network / Out-of-Network	\$0 / 50% Coins	#0 / F09/ Caina	
	\$0 / 50% Coins	\$0 / 50% Coins	
Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit In-Network			
Pharmacy Deductible Rx Deductible is combined IN and OON and applies to Mail Order	\$1,500 Brand	\$1,500 Brand	
Generic/Brand/Non-preferred	\$10 / \$60 / \$100	\$10 / \$60 / \$100	
Mail Order (90 days) - Generic/Brand/Non-preferred	\$25 / \$150 / \$250	\$25 / \$150 / \$250	
Out-of-Network	•	·	
Pharmacy Deductible Rx Deductible is combined IN and OON and applies to Mail Order	\$1,500 Brand	\$1,500 Brand	
Generic/Brand/Non-preferred	50% Coins / CYD + 50% Coins	50% Coins / CYD + 50% Coins	
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins / CYD + 50% Coins	50% Coins / CYD + 50% Coins	
Emergency Medical Care			
Urgent Care Centers In-Network / Out-of-Network	\$100 Copay / CYD + 50% Coins	\$100 Copay / CYD + 50% Coins	
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins	
Ambulance Services (INN ³ & OON ⁴); \$5,000 per day max for combined ground, air & water travel	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins	
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS)	\$75 Copay	\$75 Copay	
In-Network Diagnostic Services (except Aid) In-NetworkAdvanced Imaging Services (AIS) (MRI, MRA PET, CT, Nuclear Med.)	\$200 Copay	\$200 Copay	
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY ⁵ / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	
Substance Dependency (Lifetime max)	No Benefit Maximum	No Benefit Maximum	
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins	
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network / Out-of-Network	In-Network CYD + 20% Coins	In Naturali CVD + 2007 Cains	
Provider Services at Locations other than Office, Hospital and ER	III-Network CYD + 20% Coiris	In-Network CYD + 20% Coins	
In-Network Family Physician or In-Network Specialist / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Other Special Services	C1D + 20 /6 COIIIS/C1D + 30 /6 COIIIS	C1D + 20 /6 COIIIS/C1D + 30 /6 COIIIS	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech			
and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	
Home Health Care (subject to CYD + Coins)	40 Visits PCY	40 Visits PCY	
Skilled Nursing Facility (subject to CYD + Coins)	60 days PCY	60 days PCY	
	No Benefit Maximum	No Benefit Maximum	
Hospital/Surgical		CVD + 200/ Caina/OVD + 500/ Octor	
Hospital/Surgical Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Hospital/Surgical Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Hospital/Surgical Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days CYD + 20% Coins/CYD + 50% Coins	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network (Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network Outpatient Hospital Facility Services (per visit)	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2)	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network Inpatient Hospital Facility and Rehabilitation Services and Rehab Services In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network Financial Features Calendar Year Deductible (CYD) (per person/family aggregate)	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network Financial Features Calendar Year Deductible (CYD) (per person/family aggregate) In-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$2,500 / N/A	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$3,500 / N/A	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network In-Network - All Other Services (Option 1 / Option 2) In-Network - All Other Services (ER) (per visit) In-Network / Out-of-Network In-Network - Out-of-Network In-Network - Out-of-Network In-Network - Out-of-Network In-Network - Out-of-Network Out-of-Network Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$2,500 / N/A \$4,500 / \$7,500	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75Copay CYD + 20% Coins CYD + 20% Coins In-Network CYD + 20% Coins \$3,500 / N/A \$5,500 / \$8,500	
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network Inpatient Hospital Facility and Rehabilitation Services and Rehab Services In-Network (Option 1/Option 2) / Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network Financial Features Calendar Year Deductible (CYD) (per person/family aggregate) In-Network Out-of-Network Out-of-Network Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$2,500 / N/A \$4,500 / \$7,500 \$0	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$3,500 / N/A \$5,500 / \$8,500 \$0	
Ambulatory Surgical Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network Inpatient Hospital Facility and Rehabilitation Services and Rehab Services In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network Emarcial Features Calendar Year Deductible (CYD) (per person/family aggregate) In-Network Out-of-Network Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$2,500 / N/A \$4,500 / \$7,500	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75Copay CYD + 20% Coins CYD + 20% Coins In-Network CYD + 20% Coins \$3,500 / N/A \$5,500 / \$8,500	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility and Rehabilitation Services and Rehab Services In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network In-Network Out-of-Network Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network Out-of-Pocket Maximum (per person/family aggregate)	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 20% Coins In-Network CYD + 20% Coins \$2,500 / N/A \$4,500 / \$7,500 \$0 20% / 50%	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$3,500 / N/A \$5,500 / \$8,500 \$0 20% / 50%	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network Inpatient Hospital Facility and Rehabilitation Services and Rehab Services In-Network (Option 1/Option 2) / Out-of-Network Dutpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network In-Network In-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Out-of-Network Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins CYD + 20% Coins/CYD + 50% Coins (per admission) (P CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75 Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$2,500 / N/A \$4,500 / \$7,500 \$0	CYD + 20% Coins/CYD + 50% Coins CY) Limit 21 Days CYD + 20% Coins/CYD + 50% Coins \$55 Copay / \$75Copay CYD + 20% Coins CYD + 50% Coins In-Network CYD + 20% Coins \$3,500 / N/A \$5,500 / \$8,500 \$0	

¹ CYD = Calendar Year Deductible ² Coins = Percentage based on our Allowed Amount ³ INN = In-Network ⁴ OON = Out-of-Network ⁵ PCY = Per Calendar Year This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.

	Predictable Cost Plans		
BlueOptions	Plan 530	Plan 531	Plan 532
COST SHARING (amount member pays)			1 1211 232
Office Services Physician Office Services			
In-Network Family Physician / In-Network Specialist	\$40 Copay / \$75 Copay	\$50 Copay / \$85 Copay	\$60 Copay / \$85 Copay
Out-of-Network Office Visit / e-Office visit	CYD ¹ + 50% Coins ²	CYD + 50% Coins	CYD + 50% Coins
In-Network e-Office Visit (Family Physician / Specialist)	\$40 Copay / \$75 Copay	\$50 Copay / \$85 Copay	\$60 Copay / \$85 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	\$300 Copay	\$300 Copay	\$300 Copay
Maternity (Rider available with certain plans)	Available	Available	Available
Allergy Injections (per visit) In-Network Family Physician	\$10 Copay	\$10 Copay	\$10 Copay
		Pharmacy Vendor) (NOTE: Medical Ph	
Medical Pharmacy		cost-share) Does not include immuniz 20% Coins / CYD + 50% Coins	
In-Network Provider (\$200 Monthly Member OOP Max) / Out-of-Network Provider Preventive Care	20% Coins / CYD + 50% Coins	20% Coins / CYD + 50% Coins	20% Coins / CYD + 50% Coins
Routine Adult Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Mammograms In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Routine Child Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	\$0 / 50% Coins	\$0 / 50% Coins	\$0 / 50% Coins
Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit			
In-Network			
Pharmacy Deductible Rx Deductible is combined IN and OON and applies to Mail Order	\$1,500 Brand	\$1,500 Brand	\$1,500 Brand
Generic/Brand/Non-preferred	\$10 / \$60 / \$100	\$10 / \$60 / \$100	\$10 / \$60 / \$100
Mail Order (90 days) - Generic/Brand/Non-preferred	\$25 / \$150 / \$250	\$25 / \$150 / \$250	\$25 / \$150 / \$250
Out-of-Network			
Pharmacy Deductible Rx Deductible is combined IN and OON and applies to Mail Order	\$1,500 Brand	\$1,500 Brand	\$1,500 Brand
Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Emergency Medical Care Urgent Care Centers In-Network / Out-of-Network	\$400 Canay / CVD + 500/ Caina	\$400 Caray / CVD + 500/ Caira	\$400 Caray / CVD + 500/ Caina
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	\$100 Copay / CYD + 50% Coins In-Network CYD + 20% Coins	\$100 Copay / CYD + 50% Coins In-Network CYD + 20% Coins	\$100 Copay / CYD + 50% Coins In-Network CYD + 20% Coins
Ambulance Services (INN ³ & OON ⁴); \$5,000 per day max for combined ground, air & water travel	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins
Outpatient Diagnostic Services	III-IVELWOIK CTD + 2070 COIIIS	III-INGLWOIK OTD + 2070 COIIIS	III-IVELWOIK OTD + 2070 COIIIS
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
In-Network Diagnostic Services (except AIS)	\$75 Copay	\$75 Copay	\$75 Copay
In-NetworkAdvanced Imaging Services (AIS) (MRI, MRA_PET, CT, Nuclear Med.)	\$200 Copay	\$200 Copay	\$200 Copay
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY ⁵ / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency (Lifetime max)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC	1 N 1 1 0 VD 100 V 0 1		T + N + + OVD - 000/ O :
In-Network / Out-of-Network	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician or In-Network Specialist / Out-of-Network	CVD + 20% Coins/CVD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	CVD + 20% Coins/CVD + 50% Coins
Other Special Services	C1D + 20% Collis/C1D + 30% Collis	C1D + 20% Collis/C1D + 30% Collis	C1D + 20% COIIIS/C1D + 30% COIIIS
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech			
and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to CYD + Coins)	45 Visits PCY	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to CYD + Coins)	45 days PCY	45 days PCY	45 days PCY
Hospice (subject to CYD + Coins)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical			
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	0.45 0.04 0 ; (0.45 5.04 0 ;	(per admission) (PCY) Limit 21 Days	LOVE
In-Network (Option 1/Option 2) / Out-of-Network	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins
Outpatient Hospital Facility Services (per visit) In-Network - Therapy Services (Option 1 / Option 2)	CYD + 20% Coins	CYD + 20% Coins	CYD + 20% Coins
In-Network - All Other Services (Option 1 / Option 2)	CYD + 20% Coins	CYD + 20% Coins CYD + 20% Coins	CYD + 20% Coins
Out-of-Network Out-of-Network	CYD + 20% Coins CYD + 50% Coins	CYD + 20% Coins CYD + 50% Coins	CYD + 20% Coins CYD + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins	In-Network CYD + 20% Coins
Financial Features			
Calendar Year Deductible (CYD) (per person/family aggregate)			
In-Network	\$5,000 / \$10,000	\$7,500 / \$15,000	\$10,000 / \$20,000
Out-of-Network	\$10,0000 / \$20,000	\$15,000 / \$30,000	\$20,000 / \$40,000
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 50%	20% / 50%	20% / 50%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	\$10,0000 / \$20,000	\$15,000 / \$25,000	\$20,000 / \$30,000
Out-of-Network	\$25,000 / \$30,000	\$25,000 / \$35,000	\$25,000 / \$45,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
1 CVD - Colondar Voor Doductible 2 Coins - Percentage based on our Allowed Amount 3 ININ -	In Notwork 4 OON - Out of Notwork	r	

CYD = Calendar Year Deductible ² Coins = Percentage based on our Allowed Amount ³ INN = In-Network ⁴ OON = Out-of-Network ⁵ PCY = Per Calendar Year This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.

		Predictable Cost Plans	
BlueOptions	Plan 533	Plan 534	Plan 535
COST SHARING (amount member pays)	Tiuli 000	1 1011 004	1 1011 000
Office Services Physician Office Services			
In-Network Family Physician / In-Network Specialist	\$40 Copay / \$75 Copay	\$50 Copay / \$85 Copay	\$60 Copay / \$85 Copay
Out-of-Network Office Visit / e-Office visit	CYD ¹ + 50% Coins ²	CYD + 50% Coins	CYD + 50% Coins
In-Network e-Office Visit (Family Physician / Specialist)	\$40 Copay / \$75 Copay	\$50 Copay / \$85 Copay	\$60 Copay / \$85 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	\$300 Copay	\$300 Copay	\$300 Copay
Maternity (Rider available with certain plans)	Available	Available	Available
Allergy Injections (per visit) In-Network Family Physician	\$10 Copay	\$10 Copay	\$10 Copay
		ty Pharmacy Vendor) (NOTE: Medica	
Medical Pharmacy		es cost-share) Does not include imm	
In-Network Provider (\$300 Monthly Member OOP Max) / Out-of-Network Provider	20% Coins / CYD + 50% Coins	20% Coins / CYD + 50% Coins	20% Coins / CYD + 50% Coins
Preventive Care Routine Adult Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Mammograms In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Routine Child Preventive Services, Wellness Services, and Immunizations	• •••••••••••••••••••••••••••••••••••	4 07 0 1 2 1 0 0 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	* * * * * * * * * * * * * * * * * * *
In-Network / Out-of-Network	\$0 / 50% Coins	\$0 / 50% Coins	\$0 / 50% Coins
Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit			
In-Network			
Pharmacy Deductible Rx Deductible is combined IN and OON and applies to Mail Order	\$1,500 Brand	\$1,500 Brand	\$1,500 Brand
Generic/Brand/Non-preferred	\$10 / \$60 / \$100	\$10 / \$60 / \$100	\$10 / \$60 / \$100
Mail Order (90 days) - Generic/Brand/Non-preferred	\$25 / \$150 / \$250	\$25 / \$150 / \$250	\$25 / \$150 / \$250
Out-of-Network		,	
Pharmacy Deductible Rx Deductible is combined IN and OON and applies to Mail Order	\$1,500 Brand	\$1,500 Brand	\$1,500 Brand
Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins	50% Coins	50% Coins
Emergency Medical Care	#400 Ostravi / OV/D + 500/ Ostra	#400 O / OVD + 500/ O-1	\$400 Octobril 10VP + 500V Octobril
Urgent Care Centers In-Network / Out-of-Network Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	\$100 Copay / CYD + 50% Coins In-Network CYD	\$100 Copay / CYD + 50% Coins In-Network CYD	\$100 Copay / CYD + 50% Coins In-Network CYD
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network Ambulance Services (INN³ & OON⁴); \$5,000 per day max for combined ground, air & water travel	In-Network CYD	In-Network CYD	In-Network CYD
Outpatient Diagnostic Services	III-Network CTD	III-INGLWOIK CTD	III-INELWOIK CTD
Independent Diagnostic Services Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)			
In-Network Diagnostic Services (except AIS)	\$75 Copay	\$75 Copay	\$75 Copay
In-NetworkAdvanced Imaging Services (AIS) (MRI, MRA PET, CT, Nuclear Med.)	\$200 Copay	\$200 Copay	\$200 Copay
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)			
In-Network (Option 1 / Option 2) / Out-of-Network	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY ⁵ / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency (Lifetime max)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network CYD	In-Network CYD	In-Network CYD
Radiology, Pathology and Anesthesiology Provider Services at an ASC			
In-Network / Out-of-Network	In-Network CYD	In-Network CYD	In-Network CYD
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician or In-Network Specialist / Out-of-Network	CVD / CVD + F00/ Coins	CVD / CVD + F00/ Coins	CVD / CVD + FOR/ Cains
Other Special Services	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech			
and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to CYD + Coins)	45 Visits PCY	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to CYD + Coins)	45 days PCY	45 days PCY	45 days PCY
Hospice (subject to CYD + Coins)	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical			
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	0)/D / 6) /5	(per admission) (PCY) Limit 21 Days	0)/0 / 0) 7
In-Network (Option 1/Option 2) / Out-of-Network	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins
Outpatient Hospital Facility Services (per visit)	CVD	CVD	CVD
In-Network - Therapy Services (Option 1 / Option 2)	CYD	CYD	CYD
In-Network - All Other Services (Option 1 / Option 2) Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	CYD + 50% Coins In-Network CYD	CYD + 50% Coins In-Network CYD	CYD + 50% Coins In-Network CYD
Financial Features	III-IVGUWUIK GTD	III-INGEWOIK OTD	III-INGLWOIK CTD
Calendar Year Deductible (CYD) (per person/family aggregate)			
In-Network	\$5,000 / \$10,000	\$7,500 / \$15,000	\$10,000 / \$20,000
Out-of-Network	\$10,000 / \$20,000	\$15,000 / \$30,000	\$20,000 / \$40,000
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	0% / 50%	0% / 50%	0% / 50%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	\$5,0000 / \$10,000	\$7,500 / \$15,000	\$10,000 / \$20,000
Out-of-Network	\$25,000 / \$30,000	\$25,000 / \$35,000	\$25,000 / \$45,000
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum
		5 DCV - Dor Colondor Voor	

CYD = Calendar Year Deductible ² Coins = Percentage based on our Allowed Amount ³ INN = In-Network ⁴ OON = Out-of-Network ⁵ PCY = Per Calendar Year This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.

Ohno Omthoma		ans (HSA Compatible)
BlueOptions	Plans 0622 / 0623	Plans 0640 / 0641
COST SHARING (amount member pays) Office Services	Single / Family	Single / Family
Physician Office Services	ovel / ove	0VD + 400/ Onit = /0VD + 400/ Onit =
In-Network Family Physician / In-Network Specialist	CYD¹/CYD	CYD + 10% Coins/CYD + 10% Coins
Out-of-Network Office Visit / e-Office visit	CYD + 20% Coins ²	CYD + 40% Coins
In-Network e-Office Visit	CYD	CYD + 10% Coins
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	CYD	CYD + 10% Coins
Maternity (Rider available with certain plans)	Not Available	Not Available
Milergy Injections (per visit) In-Network Family Physician	CYD	CYD + 10% Coins
Medical Pharmacy Monthly OOP Max does not apply until the In-Network CYD is met or HSA Plans (Monthly OOP Max does not apply to 100% plans)	(Applies to Office Setting & Specialty Pharmacy Vendors to the Physician Office Services agent shorts).	dor) (NOTE: Medical Pharmacy cost-share is in a loes not include immunizations & allergy injections
In-Network Provider (\$200 Monthly Member OOP Max) / Out-of-Network Provider	In-Network Coins/CYD + 50% Coins	20% Coins / CYD + 50% Coins
Preventive Care	III-INELWOIR COILIS/CTD + 30 /6 COILIS	20% COIIIS / CTD + 30% COIIIS
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	\$0 / 20% Coins	\$0 / 40% Coins
	\$0 / 20% Coms \$0	\$0 / 40% Coms
Mammograms Colonia (Pouting for ago 50), then frequency cabadula applies)	\$0 \$0	\$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	\$0	\$0
Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit		
n-Network	Lie alth Diag INING OVD	Lizzille Dizz ININ OVD
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	Health Plan INN ³ CYD	Health Plan INN CYD
Generic/Brand/Non-preferred	100% after INN CYD	\$10 / \$50 / \$80
Mail Order (90 days) - Generic/Brand/Non-preferred	100% after INN CYD	\$25 / \$125 / \$200
Out-of-Network	Lisalith Disc. IAIALOVO	Health Disc INN OVD
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	Health Plan INN CYD	Health Plan INN CYD
Generic/Brand/Non-preferred	50% Coins after INN CYD	50% Coins after INN CYD
Mail Order (90 days) - Generic/Brand/Non-preferred	50% Coins after INN CYD	50% Coins after INN CYD
mergency Medical Care	0.05 (0.05	T
Jrgent Care Centers In-Network / Out-of-Network	CYD / CYD + 20% Coins	CYD + 10% Coins/CYD + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	CYD / CYD	CYD + 10% Coins/CYD + 10% Coins
Ambulance Services (INN & OON ⁴); \$5,000 per day max for combined ground, air & water travel	In-Network CYD	In-Network CYD + 10% Coins
Outpatient Diagnostic Services		
ndependent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		
In-Network Diagnostic Services (except AIS)	CYD	CYD + 10% Coins
In-Network Advanced Imaging Services (AIS) (MRI, MRA PET, CT, Nuclear Med.)	CYD	CYD + 10% Coins
Out-of-Network	CYD + 20% Coins	CYD + 40% Coins
ndependent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	CYD / CYD + 20% Coins	CYD + 10% Coins/CYD + 40% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays)		
In-Network (Option 1 / Option 2) / Out-of-Network	CYD / CYD + 20% Coins	CYD + 10% Coins/CYD + 40% Coins
Mental Health / Substance Abuse		
Mental Health (Inpatient PCY ⁵ / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits
Substance Dependency (Lifetime max)	No Benefit Maximum	No Benefit Maximum
Other Provider Services		
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network CYD	In-Network CYD + 10% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC		
In-Network / Out-of-Network	In-Network CYD	In-Network CYD + 10% Coins
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician or In-Network Specialist / Out-of-Network	CYD / CYD + 20% Coins	CYD + 10% Coins/CYD + 40% Coins
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical,		
Speech and Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY
Home Health Care (subject to CYD + Coins)	20 Visits PCY	20 Visits PCY
Skilled Nursing Facility (subject to CYD + Coins)	60 days PCY	60 days PCY
Hospice (subject to CYD + Coins)	No Benefit Maximum	No Benefit Maximum
lospital/Surgical		
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network	CYD / CYD + 20% Coins	CYD + 10% Coins/CYD + 40% Coins
Provider Services Rendered at an ASC (Surgeon) In-Network Specialist / Out-of-Network	CYD / CYD + 20% Coins	CYD + 10% Coins/CYD + 40% Coins
npatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days
In-Network (Option 1 / Option 2)	CYD	CYD + 10% Coins
Out-of-Network	PAD + CYD + 20% Coins	PAD + CYD + 40% Coins
Outpatient Hospital Facility Services (per visit)		
In-Network - Therapy Services (Option 1 / Option 2)	CYD	CYD + 10% Coins
In-Network - All Other Services (Option 1 / Option 2)	CYD	CYD + 10% Coins
Out-of-Network	CYD + 20% Coins	CYD + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	CYD / CYD	CYD + 10% Coins/CYD + 10% Coins
inancial Features		
Calendar Year Deductible (CYD) (per person/family aggregate)		
In-Network	\$2,500/N/A \$5,000/\$5,000	\$1,500 / N/A \$3,000 / \$3,000
	\$5,000/N/A \$10,000/\$10,000	\$3,000 / N/A \$6,000 / \$6,000
Out-of-Network	\$5,000/14/A \$10,000/\$10,000	\$5,000 / 14/A \$0,000 / \$0,000
Out-of-Network Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)		ψουσ
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	·	10% / 40%
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	0% / 20%	10% / 40%
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only) coinsurance (Coins) (amount member pays) In-Network / Out-of-Network Out-of-Pocket Maximum (per person/family aggregate)	0% / 20%	
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	·	10% / 40% \$3,000/N/A \$6,000/\$6,000 \$6,000/N/A \$12,000/\$12,000

¹ CYD = Calendar Year Deductible ² Coins = Percentage based on our Allowed Amount ³ INN = In-Network ⁴ OON = Out-of-Network ⁵ PCY = Per Calendar Year This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.

	Health Plans with Dental		
BlueOptions	Plan 0598	Plan 700	Plan 704
COST SHARING (amount member pays) Office Services		Hospital Surgical Plus	Hospital Surgical Plus
Physician Office Services			
In-Network Office Visit and e-Office Visit Family Physician / Specialist	\$35 Copay / \$50 Copay	\$50/Balance ¹ / \$75/Balance	\$50/Balance
Out-of-Network Office Visit / e-Office Visit Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	CYD ² + 50% Coins ³	\$50/Balance	\$50/Balance
In-Network Family Physician / In-Network Specialist	\$200 Copay	\$50/Balance / \$75/Balance	\$50/Balance
Maternity (Rider available with certain plans)	Available	Available	Available
Allergy Injections (per visit) In-Network Family Physician / In-Network Specialist	\$10 Copay	\$50/Balance / \$75/Balance	\$50 / Balance
Medical Pharmacy (Applies to Office Setting & Specialty Pharmacy Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.			No separate member cost share for these plans.
In-Network Provider (\$200 Monthly Member OOP Max) / Out-of-Network Provider	20% Coins / CYD + 50% Coins	N/A	N/A
Preventive Care			
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations In-Network / Out-of-Network	\$0 / 50% Coins	\$0 / \$50/Balance	\$0 / \$50/Balance
Mammograms In-Network / Out-of-Network	\$0	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	\$0	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit In-Network			
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	\$0	\$800 Brand	\$800 Brand
Generic/Brand/Non-preferred	\$10 / Not Covered	\$10 / \$60 / \$100	\$10 / \$60 / \$100
Mail Order (90 days) - Generic/Brand/Non-preferred Out-of-Network	\$25 / Not Covered	\$25 / \$150 / \$250	\$25 / \$150 / \$250
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	\$0	\$800 Brand	\$800 Brand
Generic/Brand/Non-preferred	50% / Not Covered	50% Coins	50% Coins
Mail Order (90 days) - Generic/Brand/Non-preferred Emergency Medical Care	50% / Not Covered	50% Coins	50% Coins
Urgent Care Centers In-Network / Out-of-Network	\$55 Copay / CYD + 50% Coins	\$50/Balance	\$50/Balance
Emergency Room Facility Services (ER) (per visit)			
In-Network (PVD applies for Non Surgical Services w/o admit for Plans 700 and 704) Out-of-Network (PVD applies for Non Surgical Services w/o admit for Plans 700 and 704)	\$300 Copay \$300 Copay	CYD + 10% Coins In-Network CYD + 10% Coins	CYD + 20% Coins In-Network CYD + 20% Coins
Ambulance Services (INN ⁴ & OON ⁵); \$5,000 per day max for combined ground, air & water travel	In-Network CYD + 25% Coins	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS)	\$50 Copay	\$75 Copay	\$75 Copay
In-Network Advanced Imaging Services (AIS) (MRI, MRA PET, CT, Nuclear Med.)	\$200 Copay	\$150 Copay	\$250 Copay
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) In-Network (Option 1 / Option 2) / Out-of-Network	CYD + 25% Coins/CYD + 50% Coins	CYD + 10% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins
Mental Health / Substance Abuse			
Mental Health (Inpatient PCY ⁶ / Outpatient PCY)	8 Days / 8 Visits No Benefit Maximum	8 Days / 8 Visits No Benefit Maximum	8 Days / 8 Visits No Benefit Maximum
Substance Dependency (Lifetime max) Other Provider Services	No Beriefft Maximum	No benefit waximum	No benefit waximum
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network CYD + 25% Coins	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network & Out-of-Network	In-Network CYD + 25% Coins	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician / In-Network Specialist	CYD + 25% Coins	\$50/Balance / \$75/Balance	\$50/Balance
Out-of-Network	CYD + 40% Coins	\$50/Balance	\$50/Balance
Other Special Services Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage			
Therapies and Spinal Manipulations (PCY max)	35 Visits PCY	25 Visits PCY	25 Visits PCY
Home Health Care (subject to CYD + Coins)	10 Visits PCY	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to CYD + Coins) Hospice (subject to CYD + Coins)	60 Days PCY No Benefit Maximum	45 Days PCY No Benefit Maximum	45 Days PCY No Benefit Maximum
Hospital/Surgical			Short maximum
Ambulatory Surgical Center Facility (ASC)	OVD - 050/ C - 10/5	OVD - 400/ C - 100/5	0)/D : 000/ C : /0)/F
In-Network / Out-of-Network (Surgical Services only for Plans 700 and 704) Provider Services Rendered at an ASC (Surgeon)	CYD + 25% Coins/CYD + 50% Coins	CYD + 10% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins
In-Network Specialist / Out-of-Network (Surgical Services only for Plans 700 and 704)	CYD + 25% Coins/CYD + 50% Coins	\$50/Balance / \$75/Balance	\$50/Balance
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services		(per admission) (PCY) Limit 21 Days	
In-Network (Option 1 / Option 2) Out-of-Network	CYD + 25% Coins PAD + CYD + 50% Coins	CYD + 10% Coins PAD + CYD + 50% Coins	CYD + 20% Coins PAD + CYD + 50% Coins
Outpatient Hospital Facility Services (per visit)	TAD TOTO T 50% COIRS	TAD TOTO TOOM COIRS	170 1010 ± 00% COIIIS
In-Network - Therapy Services (Option 1 / Option 2)	\$55 Copay / \$70 Copay	Not Covered	Not Covered
In-Network - All Other Services (Option 1 / Option 2) (Surgical Services only for Plans 700 and 704) Out-of-Network (Surgical Services only for Plans 700 and 704)	CYD + 25% Coins CYD + 50% Coins	CYD + 10% Coins CYD + 50% Coins	CYD + 20% Coins CYD + 50% Coins
Cut-of-Network (Surgical Services only for Plans 700 and 704) Emergency Room Facility Services (ER) (per visit)	C1D + 50% COINS	01D + 50% COINS	C1D + 50% COINS
In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit for Plans 700 and 704)	\$300 Copay / \$300 Copay	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins
Dental Coverage Dental Preventive Services / Dental Basic Services	\$0 / 20% Coins	\$50/Balance / \$50/Balance	\$50/Balance / \$50/Balance
In-Network Individual Dental Deductible (CYD) (Per Person/Family Aggregate)(Out-of-Network combined w/INN)	\$0 / 20% Coins \$75 / \$225	\$50/Balance / \$50/Balance N/A	\$50/Balance / \$50/Balance N/A
Dental Benefit Period Maximum	\$750	N/A	N/A
Financial Features Calendar Vear Deductible (CVD) (per percentamily aggregate)			
Calendar Year Deductible (CYD) (per person/family aggregate) In-Network	\$3,000 / N/A	\$250 / N/A	\$2,500 / N/A
Out-of-Network	\$6,000 / N/A	\$750 / N/A	\$5,000 / N/A
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	\$500	\$500	\$700
- 490	· · · · · · · · · · · · · · · · · · ·	0500	
admit) Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	N/A	\$500 10% / 50%	\$750 20% / 50%
admit) Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network Out-of-Pocket Maximum (per person/family aggregate)	· · · · · · · · · · · · · · · · · · ·	\$500 10% / 50%	\$750 20% / 50%
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network Out-of-Pocket Maximum (per person/family aggregate) In-Network	N/A 25% / 50% \$7,500 / \$15,000	10% / 50% \$2,500 / N/A	20% / 50% \$7,500 / N/A
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network Out-of-Pocket Maximum (per person/family aggregate)	N/A 25% / 50%	10% / 50%	20% / 50%

Balance = BCBS pays the Amount indicated or the Allowed Amount (whichever is lower) and the Member pays the Balance up to the Allowed Amount.

2 CYD = Calendar Year Deductible

3 Coins = Percentage based on our Allowed Amount

4 INN = In-Network

5 OON = Out-of-Network

6 PCY = Per Calendar Year
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	Health Plans with Dental		
BlueOptions	Plan 706	Plan 710	
COST SHARING (amount member pays)	Hospital Surgical Plus	Hospital Surgical Plus	
Office Services			
Physician Office Services In-Network Office Visit and e-Office Visit Family Physician / Specialist	\$50/Balance ¹ / \$75/Balance	\$50/Balance	
Out-of-Network Office Visit / e-Office Visit Out-of-Network Office Visit / e-Office Visit	\$50/Balance	\$50/Balance	
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network Family Physician / In-Network Specialist	\$50/Balance / \$75/Balance	\$50/Balance	
Maternity (Rider available with certain plans)	Available	Available	
Allergy Injections (per visit) In-Network Family Physician / In-Network Specialist	\$50/Balance / \$75/Balance	\$50 / Balance	
Medical Pharmacy Included in Office Services Benefit. No separate member cost share for this benefit on these plans.			
Preventive Care			
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations In-Network / Out-of-Network	\$0 / \$50/Balance	\$0 / \$50/Balance	
Mammograms In-Network / Out-of-Network Colonoscopies (Routine for age 50+ then frequency schedule applies) In-Network / Out-of-Network	\$0 / CYD + 50% Coins \$0 / CYD + 50% Coins	\$0 / CYD + 50% Coins \$0 / CYD + 50% Coins	
Prescription Drug Program Diabetic equipment & supplies covered under Rx Benefit	\$07 CTD + 30% COIIIS	\$07 CTD + 30% COIRS	
In-Network			
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	\$0	\$0	
Generic/Brand/Non-preferred	\$15/Balance	\$15/Balance	
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered	Not Covered	
Out-of-Network			
Pharmacy Deductible Rx Deductible is combined IN & OON & applies to Mail Order	\$0	\$0 045/Dalaman	
Generic/Brand/Non-preferred Mail Order (00 dous) Constit/Brand/Non-preferred	\$15/Balance	\$15/Balance Not Covered	
Mail Order (90 days) - Generic/Brand/Non-preferred Emergency Medical Care	Not Covered	inot Covered	
Urgent Care Centers In-Network / Out-of-Network	\$50/Balance	\$50/Balance	
Emergency Room Facility Services (ER) (per visit)	,	, , , , , , , , , , , , , , , , , , , ,	
In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit for)	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins	
Ambulance Services (INN ⁴ & OON ⁵); \$5,000 per day max for combined ground, air & water travel	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins	
Outpatient Diagnostic Services			
Independent Diagnostic Testing Facility Services (per visit) (e.g., X-rays) (Includes Provider Services)		,	
In-Network Diagnostic Services (except AIS)	\$75 Copay	\$75 Copay	
In-Network Advanced Imaging Services (AIS) (MRI, MRA PET, CT, Nuclear Med.) Out-of-Network	\$150 Copay	\$250 Copay	
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	CYD + 50% Coins \$0 / CYD + 50% Coins	CYD + 50% Coins \$0 / CYD + 50% Coins	
Outpatient Hospital Facility Services (per visit) (e.g., blood work and X-rays) In-Network (Option 1 / Option 2) / Out-of-Network	CYD + 10% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Mental Health / Substance Abuse	0.12 1 10% Commarc 12 1 Co% Commo	0.12 / 20% comarc.12 / co% come	
Mental Health (Inpatient PCY ⁶ / Outpatient PCY)	8 Days / 8 Visits	8 Days / 8 Visits	
Substance Dependency (Lifetime max)	No Benefit Maximum	No Benefit Maximum	
Other Provider Services			
Provider Services at Hospital and ER In-Network / Out-of-Network	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins	
Radiology, Pathology and Anesthesiology Provider Services at an ASC In-Network & Out-of-Network	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins	
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician / In-Network Specialist	\$50/Balance / \$75/Balance	¢50/Polones	
Out-of-Network	\$50/Balance	\$50/Balance \$50/Balance	
Other Special Services	\$00, Balaines	\$00,244.100	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage			
Therapies and Spinal Manipulations (PCY max)	25 Visits PCY	25 Visits PCY	
Home Health Care (subject to CYD + Coins)	45 Visits PCY	45 Visits PCY	
Skilled Nursing Facility (subject to CYD + Coins) Hospice (subject to CYD + Coins)	45 Days PCY No Benefit Maximum	45 Days PCY No Benefit Maximum	
Hospital/Surgical	NO Delient Maximum	No Delient Maximum	
Ambulatory Surgical Center Facility (ASC) In-Network / Out-of-Network (Surgical Services only)	CYD + 10% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	
Provider Services Rendered at an ASC (Surgeon)			
In-Network Specialist / Out-of-Network (Surgical Services only)	\$50/Balance / \$75/Balance	\$50/Balance	
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services			
In-Network (Option 1 / Option 2)	CYD + 10% Coins	CYD + 20% Coins	
Out-of-Network	PAD + CYD + 50% Coins	PAD + CYD + 50% Coins	
Outpatient Hospital Facility Services (per visit)	Not Covered	Not Covered	
In-Network - Therapy Services (Option 1 / Option 2) In-Network - All Other Services (Option 1 / Option 2) (Surgical Services only)	Not Covered CYD + 10% Coins	Not Covered CYD + 20% Coins	
Out-of-Network (Surgical Services only)	CYD + 50% Coins	CYD + 50% Coins	
Emergency Room Facility Services (ER) (per visit)			
In-Network / Out-of-Network (PVD applies for Non Surgical Services w/o admit for)	In-Network CYD + 10% Coins	In-Network CYD + 20% Coins	
Dental Coverage			
Dental Preventive Services / Dental Basic Services	\$50/Balance	\$50/Balance	
Financial Features			
Calendar Year Deductible (CYD) (per person/family aggregate)	\$250 / NI/A	\$2 FOO / N/A	
In-Network Out-of-Network	\$250 / N/A \$750 / N/A	\$2,500 / N/A \$5,000 / N/A	
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	\$500	\$5,000 / N/A \$700	
Emergency Room Per Visit Deductible (PVD) (applies INN and OON for Non Surgical Services w/o admit)	\$500	\$750	
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	10% / 50%	20% / 50%	
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	\$2,500 / N/A	\$7,500 / N/A	
Out-of-Network Tetal Lifetime Maximum Benefit	\$5,000 / N/A	\$15,000 / N/A	
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	

Balance = BCBS pays the Amount indicated or the Allowed Amount (whichever is lower) and the Member pays the Balance up to the Allowed Amount.

² CYD = Calendar Year Deductible ³ Coins = Percentage based on our Allowed Amount ⁴ INN = In-Network ⁵ OON = Out-of-Network ⁶ PCY = Per Calendar Year This is only a partial description of the many benefits and services provided or authorized by Blue Cross and Blue Shield of Florida Inc., an independent licensee of the Blue Cross and Blue Shield Association. This matrix does not constitute a Contract.