BlueOptions	Predictable Cost Plan
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	Not Applicable
Preventive Care	
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	
Pharmacy Deductible ***Rx Deductible is combined IN & OON & applies to Mail Order***	$200 Brand
Generic/Brand/Non-preferred	$15 / 40% / 50%
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered
Emergency Medical Care	
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)	
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)	8 Days / 8 Visits
Substance Dependency (Lifetime max)	No Benefit Maximum
Other Provider Services	
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 Massage Therapies and Spinal Manipulations (PCY max)	25 Visits PCY
Home Health Care (subject to CYD + Coins)	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	CYD + 20% Coins / CYD + 20% Coins
Financial Features	
Calendar Year Deductible (CYD) (per person/family aggregate)	
In-Network	$500 / N/A
Out-of-Network	Combined w/In-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

[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

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BlueOptions	Predictable Cost Plans		
COST SHARING (amount member pays)	**Plan 0504**	**Plan 0505**	**Plan 0511**
Office Services			
Physician Office Services			
In-Network Family Physician / In-Network Specialist	$35 Copay / $50 Copay	$35 Copay / $50 Copay	$35 Copay / CYD + 20% Coins
Out-of-Network Office Visit / e-Office visit	CYD[1] + 40% Coins[2]	CYD + 40% Coins	CYD + 40% Coins
In-Network e-Office Visit	$10 Copay	$10 Copay	$10 Copay
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) In-Network	$250 Copay	$250 Copay	$250 Copay
Maternity (Rider available with certain plans)	Available	Available	Available
Allergy Injections (per visit) In-Network Family Physician	$10 Copay	$10 Copay	$10 Copay
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.		
In-Network Provider ($200 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 & Child Preventive Services, Wellness Services, and Immunizations			
In-Network / Out-of-Network	$0 / 40% Coins	$0 / 40% Coins	$0 / 40% Coins
Mammograms	$0	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$0	$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***	$300 Brand	$300 Brand	$1,500 Brand
Generic/Brand/Non-preferred	$10 / 40% / 50%	$10 / 40% / 50%	$10 / 40% / 50%
Mail Order (90 days) - Generic/Brand/Non-preferred	$25 / $125 / $200	$25 / $125 / $200	$25 / $125 / $200
Out-of-Network			
Pharmacy Deductible ***Rx Deductible is combined IN & OON & applies to Mail Order***	$300 Brand	$300 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	$60 Copay / CYD + 40% Coins	$60 Copay / CYD + 40% Coins	CYD + 20% Coins/CYD + 40% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	CYD / CYD	CYD / CYD	CYD + 20% Coins/CYD + 40% Coins
Ambulance Services (INN[3] & OON[4]); $5,000 per day max for combined ground, air & water travel	In-Network CYD	In-Network CYD	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	$75 Copay
In-Network Advanced Imaging Services (AIS) *(MRI, MRA PET, CT, Nuclear Med.)*	$250 Copay	$250 Copay	$250 Copay
Out-of-Network	CYD + 40% Coins	CYD + 40% Coins	CYD + 40% Coins
Independent Clinical Lab (e.g., blood work) In-Network / Out-of-Network	$0 / CYD + 40% Coins	$0 / CYD + 40% Coins	$0 / 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 + 40% Coins	CYD / CYD + 40% Coins	CYD + 20% Coins/CYD + 40% 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 + 20% Coins
Radiology, Pathology and Anesthesiology Provider Services at an ASC			
In-Network / Out-of-Network	In-Network CYD	In-Network CYD	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 / CYD + 40% Coins	CYD / CYD + 40% Coins	CYD + 20% 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	25 Visits PCY
Home Health Care (subject to CYD + Coins)	10 Visits PCY	10 Visits PCY	20 Visits PCY
Skilled Nursing Facility (subject to CYD + Coins)	60 days PCY	60 days PCY	60 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 + 40% Coins	CYD / CYD + 40% Coins	$200 Copay / CYD + 40% Coins
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
Inpatient Hospital Facility and Rehabilitation Services and Rehab Services	(per admission) (PCY) Limit 21 Days		
In-Network (Option 1 / Option 2)	CYD	CYD	CYD + 20% Coins
Out-of-Network	PAD + CYD + 40% Coins	PAD + CYD + 40% Coins	PAD + CYD + 40% Coins
Outpatient Hospital Facility Services (per visit)			
In-Network - Therapy Services (Option 1 / Option 2)	$55 Copay / $70 Copay	$55 Copay / $70 Copay	$55 Copay / $70 Copay
In-Network - All Other Services (Option 1 / Option 2)	CYD	CYD	CYD + 20% Coins
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% Coins
Financial Features			
Calendar Year Deductible (CYD) (per person/family aggregate)			
In-Network	$2,500 / $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)			
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
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

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BlueOptions	**Predictable Cost Plans**	
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 Vendor) (NOTE: Medical Pharmacy cost-share is in addition to the Physician Office Services cost-share) Does not include immunizations & allergy injections.	
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 / 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-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-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 + 50% Coins	CYD + 20% Coins/CYD + 50% 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)	40 Visits PCY	40 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
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
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 + 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)	$55 Copay / $75 Copay	$55 Copay / $75Copay
In-Network - All Other Services (Option 1 / Option 2)	CYD + 20% Coins	CYD + 20% Coins
Out-of-Network	CYD + 50% 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
Financial Features		
Calendar Year Deductible (CYD) (per person/family aggregate)		
In-Network	$2,500 / N/A	$3,500 / N/A
Out-of-Network	$4,500 / $7,500	$5,500 / $8,500
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$0	$0
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	20% / 50%	20% / 50%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$6,000 / $12,000	$7,000 / $14,000
Out-of-Network	$25,000 / $25,000	$25,000 / $25,000
Total Lifetime Maximum Benefit	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

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BlueOptions	Predictable Cost Plans		
COST SHARING (amount member pays)	**Plan 530**	**Plan 531**	**Plan 532**
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
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.		
In-Network Provider ($200 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			
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	$100 Copay / CYD + 50% Coins	$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	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			
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			
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	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% Coins	CYD + 20% Coins/CYD + 50% 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	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	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	(per admission) (PCY) Limit 21 Days		
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
Out-of-Network	CYD + 50% Coins	CYD + 50% 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] 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.

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BlueOptions	Predictable Cost Plans		
COST SHARING (amount member pays)	**Plan 533**	**Plan 534**	**Plan 535**
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
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.		
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			
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	$100 Copay / CYD + 50% Coins	$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	In-Network CYD	In-Network CYD
Ambulance Services (INN[3] & OON[4]); $5,000 per day max for combined ground, air & water travel	In-Network CYD	In-Network CYD	In-Network CYD
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	$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	CYD / CYD + 50% Coins	CYD / CYD + 50% Coins	CYD / CYD + 50% 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	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		(per admission) (PCY) Limit 21 Days	
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)			
In-Network - Therapy Services (Option 1 / Option 2)	CYD	CYD	CYD
In-Network - All Other Services (Option 1 / Option 2)	CYD	CYD	CYD
Out-of-Network	CYD + 50% Coins	CYD + 50% Coins	CYD + 50% Coins
Emergency Room Facility Services (ER) (per visit) In-Network / Out-of-Network	In-Network CYD	In-Network CYD	In-Network CYD
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	$10,000 / $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

[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

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BlueOptions	High-Deductible Plans (HSA Compatible)	
COST SHARING (amount member pays)	**Plans 0622 / 0623 Single / Family**	**Plans 0640 / 0641 Single / Family**
Office Services		
Physician Office Services		
In-Network Family Physician / In-Network Specialist	CYD[1] / 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
Allergy 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 for HSA Plans (Monthly OOP Max does not apply to 100% plans)	(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.	
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		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network / Out-of-Network	$0 / 20% Coins	$0 / 40% Coins
Mammograms	$0	$0
Colonoscopies (Routine for age 50+ then frequency schedule applies)	$0	$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***	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		
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
Emergency Medical Care		
Urgent 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		
Independent 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
Independent 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
Hospital/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
Inpatient 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
Financial 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
Out-of-Network	$5,000/N/A $10,000/$10,000	$3,000 / N/A $6,000 / $6,000
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$500
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	0% / 20%	10% / 40%
Out-of-Pocket Maximum (per person/family aggregate)		
In-Network	$2,500/N/A $5,000/$5,000	$3,000/N/A $6,000/$6,000
Out-of-Network	$10,000/N/A $20,000/$20,000	$6,000/N/A $12,000/$12,000
Total Lifetime Maximum Benefit	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

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BlueOptions	**Health Plans with Dental**		
COST SHARING (amount member pays)	**Plan 0598**	**Plan 700 Hospital Surgical Plus**	**Plan 704 Hospital Surgical Plus**
Office Services			
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	CYD[2] + 50% Coins[3]	$50/Balance	$50/Balance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)			
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.		Included in Office Services Benefit. No separate member cost share for this benefit on 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	$25 / Not Covered	$25 / $150 / $250	$25 / $150 / $250
Out-of-Network			
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	50% / Not Covered	50% Coins	50% Coins
Emergency Medical Care			
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)	$300 Copay	CYD + 10% Coins	CYD + 20% Coins
Out-of-Network (PVD applies for Non Surgical Services w/o admit for Plans 700 and 704)	$300 Copay	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 + 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	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 + 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)	60 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 (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
Provider Services Rendered at an ASC (Surgeon)			
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)	CYD + 25% Coins	CYD + 10% Coins	CYD + 20% Coins
Out-of-Network	PAD + CYD + 50% Coins	PAD + CYD + 50% Coins	PAD + CYD + 50% Coins
Outpatient Hospital Facility Services (per visit)			
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)	CYD + 25% Coins	CYD + 10% Coins	CYD + 20% Coins
Out-of-Network (Surgical Services only for Plans 700 and 704)	CYD + 50% Coins	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 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)	$75 / $225	N/A	N/A
Dental Benefit Period Maximum	$750	N/A	N/A
Financial Features			
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
admit)	N/A	$500	$750
Coinsurance (Coins) (amount member pays) In-Network / Out-of-Network	25% / 50%	10% / 50%	20% / 50%
Out-of-Pocket Maximum (per person/family aggregate)			
In-Network	$7,500 / $15,000	$2,500 / N/A	$7,500 / N/A
Out-of-Network	$25,000 / $25,000	$5,000 / N/A	$15,000 / N/A
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum	No Benefit Maximum

[1] 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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BlueOptions COST SHARING (amount member pays)	Health Plans with Dental Plan 706 Hospital Surgical Plus	 Plan 710 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	$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	$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
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	$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
Generic/Brand/Non-preferred	$15/Balance	$15/Balance
Mail Order (90 days) - Generic/Brand/Non-preferred	Not Covered	Not Covered
Emergency Medical Care		
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.)*	$150 Copay	$250 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 + 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	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/Balance
Out-of-Network	$50/Balance	$50/Balance
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)	45 Visits PCY	45 Visits PCY
Skilled Nursing Facility (subject to CYD + Coins)	45 Days PCY	45 Days PCY
Hospice (subject to CYD + Coins)	No Benefit Maximum	No Benefit Maximum
Hospital/Surgical		
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)		
In-Network - Therapy Services (Option 1 / Option 2)	Not Covered	Not Covered
In-Network - All Other Services (Option 1 / Option 2) (Surgical Services only)	CYD + 10% Coins	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)		
In-Network	$250 / N/A	$2,500 / N/A
Out-of-Network	$750 / N/A	$5,000 / N/A
Per Admission Deductible (PAD) (applies to OON Inpt Hospital only)	$500	$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	$5,000 / N/A	$15,000 / N/A
Total Lifetime Maximum Benefit	No Benefit Maximum	No Benefit Maximum

[1] 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.

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