The information contained in this document includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency.

### COST SHARING

<table>
<thead>
<tr>
<th></th>
<th>BlueCare 042</th>
<th>BlueChoice 0727</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible (DED) (Per Person/Family Agg)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$500 / $1,000</td>
<td>$500 / $1,500</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Not Applicable</td>
<td>Combined w/In-Ntwk</td>
</tr>
<tr>
<td><strong>Coinsurance (Member Responsibility)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Not Applicable</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Out of Pocket Maximum (Per Person/Family Agg)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-Network</td>
<td>$3,500 / $7,000</td>
<td>$2,000 / $6,000</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Not Applicable</td>
<td>Combined w/In-Ntwk</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PROFESSIONAL PROVIDER SERVICES

#### Allergy Injections
- In-Network Family Physician: $10
- In-Network Specialist: $10
- Out-of-Network: Not Covered

#### E-Office Visit Services
- In-Network Family Physician: $20
- In-Network Specialist: $40
- Out-of-Network: Not Covered

#### Office Services
- In-Network Family Physician: $20 PCP
- In-Network Specialist: $40 SP
- Out-of-Network: Not Covered

#### Provider Services at Hospital and ER
- In-Network Family Physician: $0
- In-Network Specialist: $0
- Out-of-Network: Not Covered

#### Provider Services at Other Locations
- In-Network Family Physician: $0
- In-Network Specialist: $0
- Out-of-Network: Not Covered

#### Radiology, Pathology and Anesthesiology

<table>
<thead>
<tr>
<th>Provider Services at Hospital or Ambulatory Surgical Center</th>
<th>BlueCare 042</th>
<th>BlueChoice 0727</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Specialist</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Not Covered</td>
<td>DED + 20%</td>
</tr>
</tbody>
</table>

### PREVENTIVE CARE

#### Adult Wellness Office Services
- In-Network Family Physician: $0
- In-Network Specialist: $0
- Out-of-Network: Not Covered

#### Colonoscopies
- Age 50+ then Frequency Schedule Applies
  - In-Network: $0
  - Out-of-Network: Not Covered

#### Independent Clinical Lab
- In-Network: $0
- Out-of-Network: Not Covered

#### Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)
- In-Network - Advanced Imaging Services (AIS): $0
- In-Network - Other Diagnostic Services: $0
- Out-of-Network: Not Covered

#### Mammograms (Routine and Dx)
- In-Network: $0
- Out-of-Network: Not Covered

#### Outpatient Hospital (per visit)
- In-Network: $0
- Out-of-Network: Not Covered
## COST SHARING

Maximums shown are Per Benefit Period (BPM) unless noted.

### Provider Services at Outpatient Facility
- **In-Network Family Physician**
  - BlueCare: $0
  - BlueChoice: $0
- **In-Network Specialist**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: 30% (No DED)

### Well Child Office Visits
- **In-Network Family Physician**
  - BlueCare: $0
  - BlueChoice: $0
- **In-Network Specialist**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: 30% (No DED)

### EMERGENCY/URGENT/CONVENIENT CARE

#### Ambulance Maximum (per day)
- **In-Network**
  - BlueCare: No Maximum
  - BlueChoice: DED + 10%
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: In-Ntwk DED + 20%

#### Convenient Care Centers (CCC)
- **In-Network**
  - BlueCare: $20 PCP
  - BlueChoice: $25 FP
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: DED + 30%

#### Emergency Room Facility Services
(also see Professional Provider Services)
- **In-Network**
  - BlueCare: $100
  - BlueChoice: DED + 20%
- **Out-of-Network**
  - BlueCare: $100
  - BlueChoice: DED + 20%

#### Urgent Care Centers (UCC)
- **In-Network**
  - BlueCare: $40
  - BlueChoice: $25 FP
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: DED + 30%

### FACILITY SERVICES - HOSP/SURG/ICL/IDTF

Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.

#### Ambulatory Surgical Center
- **In-Network**
  - BlueCare: DED + 10%
  - BlueChoice: DED + 20%
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: DED + 30%

#### Independent Clinical Lab
- **In-Network**
  - BlueCare: $0
  - BlueChoice: 20% (No DED)
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: 30% (No DED)

#### Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)
- **In-Network - Advanced Imaging Services (AIS)**
  - BlueCare: $50
  - BlueChoice: $25 SP
- **In-Network - Other Diagnostic Services**
  - BlueCare: $20
  - BlueChoice: $25 SP
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: DED + 30%

#### Inpatient Hospital (per admit)
- **In-Network**
  - BlueCare: $325 per Day up to $1,625
  - BlueChoice: DED + 20%
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: $300 PAD + DED + 30%

#### Inpatient Rehab Maximum
- **In-Network**
  - BlueCare: No Maximum
  - BlueChoice: No Maximum

#### Outpatient Hospital (per visit)
- **In-Network**
  - BlueCare: $325
  - BlueChoice: DED + 20%
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: DED + 30%

#### Therapy at Outpatient Hospital
- **In-Network**
  - BlueCare: $25
  - BlueChoice: DED + 20%
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: DED + 30%

### MENTAL HEALTH AND SUBSTANCE ABUSE

#### Inpatient Hospitalization
- **In-Network**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: 30% (No DED)

#### Outpatient Hospitalization (per visit)
- **In-Network**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: 30% (No DED)

#### Provider Services at Hospital and ER
- **In-Network Family Physician or Specialist**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network Provider**
  - BlueCare: Not Covered
  - BlueChoice: $0

#### Physician Office Visit
- **In-Network Family Physician or Specialist**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network Provider**
  - BlueCare: Not Covered
  - BlueChoice: $0

#### Emergency Room Facility Services (per visit)
- **In-Network**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network**
  - BlueCare: $0
  - BlueChoice: $0

#### Provider Services at Locations other than Hospital and ER
- **In-Network Family Physician**
  - BlueCare: $0
  - BlueChoice: $0
- **In-Network Specialist**
  - BlueCare: $0
  - BlueChoice: $0
- **Out-of-Network Provider**
  - BlueCare: Not Covered
  - BlueChoice: 30% (No DED)

### OTHER SPECIAL SERVICES AND LOCATIONS

#### Advanced Imaging Services in Physician’s Office
- **In-Network Family Physician**
  - BlueCare: $20 X-rays; $50 All Other
  - BlueChoice: $25 FP
- **In-Network Specialist**
  - BlueCare: $20 X-rays; $50 All Other
  - BlueChoice: $25 SP
- **Out-of-Network**
  - BlueCare: Not Covered
  - BlueChoice: DED + 30%
<table>
<thead>
<tr>
<th>COST SHARING</th>
<th>BlueCare 042</th>
<th>BlueChoice 0727</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Birth Center</strong></td>
<td>In-Network: Not Covered</td>
<td>Out-of-Network: DED + 20% DED + 30%</td>
</tr>
<tr>
<td><strong>Diabetic Equipment and Supplies</strong></td>
<td>In-Network: $25 Not Covered</td>
<td>Out-of-Network: DED + 20% DED + 30%</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment, Prosthetics, Orthotics BPM</strong></td>
<td>In-Network: Enteral Formulas: $2,500 All Other: No Maximum Motorized Wheelchair: $500 All Other: $25 Not Covered</td>
<td>Out-of-Network: DED + 30%</td>
</tr>
<tr>
<td><strong>Home Health Care BPM</strong></td>
<td>In-Network: No Maximum $0</td>
<td>Out-of-Network: DED + 20% DED + 30%</td>
</tr>
<tr>
<td><strong>Hospice LTM</strong></td>
<td>In-Network: No Maximum $0</td>
<td>Out-of-Network: DED + 20% DED + 30%</td>
</tr>
<tr>
<td><strong>Outpatient Therapy and Spinal Manipulations BPM</strong></td>
<td>In-Network: No Maximum</td>
<td>Out-of-Network: 35 Visits (Max of 26 Spinal Manips also Applies)</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility BPM</strong></td>
<td>In-Network: 30 Days $0</td>
<td>Out-of-Network: DED + 20% DED + 30%</td>
</tr>
</tbody>
</table>

### PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>In-Network</th>
<th>BlueCare 042</th>
<th>BlueChoice 0727</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail (30 days)</td>
<td>Generic/Preferred Brand/Non-Preferred</td>
<td>$7 / $50 / $80</td>
</tr>
<tr>
<td>Mail Order (90 days)</td>
<td>Generic/Preferred Brand/Non-Preferred</td>
<td>$20 / $125 / $200</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>Retail (30 days)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mail Order (90 days)</td>
<td>Generic/Preferred Brand/Non-Preferred</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Medical Pharmacy (Provider-Administered Rx)</strong></td>
<td>In-Network: See Location of Service NA</td>
<td>Out-of-Network: $200 Monthly OOP Max 20% (No DED) DED + 50%</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility BPM</strong></td>
<td>In-Network: No Maximum</td>
<td>Out-of-Network: DED + 20% DED + 30%</td>
</tr>
</tbody>
</table>

* Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.

** (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida’s Benefit Booklet and Schedule of Benefits; their terms prevail.