

 BlueCross BlueShield of Florida <small>An Independent Licensee of the Blue Cross and Blue Shield Association</small>	Blue Choice 117 (PPO)	Blue Options 3360 (PPO)	Blue Care 40 (HMO - Florida Only)
PREMIUMS PER PAYCHECK - 24/20 CHECKS	24-PAYCHECKS / 20-PAYCHECKS	24-PAYCHECKS / 20-PAYCHECKS	24-PAYCHECKS / 20-PAYCHECKS
Employee - Board Contributions \$174.23 / \$209.07	\$50 / \$60	\$23.63 / \$28.35	\$5.25 / \$6.30
Employee + 1 - Board Contributions \$205.52 / \$246.62	\$150 / \$180	\$105 / \$126	\$78.75 / \$94.50
Employee + 2 - Board Contributions \$369.73 / \$443.67 or more	\$250 / \$300	\$118.13 / \$141.75	\$91.88 / \$110.25
Calendar Year Deductible (CYD)			Must Use Network Providers
In-Network (per person / family):	\$1,000 / \$2,000	\$1,250 / \$2,500	\$250 / \$500
Out-of-Network (per person / family):	\$2,000 / \$4,000	\$2,500 / \$5,000	N/A
Coinsurance (Amount owed after CYD met)			Must Use Network Providers
In-Network:	20% of BCBS allowable charges	20% of BCBS allowable charges	20% of BCBS allowable charges
Out-of-Network (subject to balance billing):	50% of BCBS allowable charges	50% of BCBS allowable charges	N/A
Out-of-Pocket Maximum			Must Use Network Providers
In-Network:	\$2,500 / \$5,000	\$3,500 / \$7,000 (Everything but prescription co-pays applies to Max Out-of-Pocket)	\$4,500 / \$9,000 (Everything but prescription co-pays applies to Max Out-of-Pocket)
Out-of-Network:	\$5,000 / \$10,000	\$7,000 / \$14,000 (Everything but prescription co-pays applies to Max Out-of-Pocket)	N/A
Preventive Health (per frequency schedule) - Calendar Year Deductible (CYD) Waived Using In-Network Providers			Must Use Network Providers
Mammograms:	Paid 100%	Paid 100%	Paid 100%
Well Child (through age 16):	Paid 100%	Paid 100%	Paid 100%
Adult Wellness - age 17 and older:	Paid 100% In-Network	Paid 100% In-Network	Paid 100%
Unlimited in-network –per Wellness Schedule	Out-of-Network: \$150 Max + Coinsurance	Out-of-Network: \$150 Max + Coinsurance	
Colonoscopy: (Age 50+) When claims submitted as Preventive Screening	Services paid 100% In-Network	Services paid 100% In-Network	Services paid 100% In-Network
Colonoscopy: When claims submitted as Diagnostic Screening	Services paid in full, less \$100 Copay In-Network	Services paid in full, less \$100 Copay In-Network	Services paid in full, less \$100 Copay In-Network
Office Services			Must Use Network Providers
In-Network Family Physician	CYD + Coinsurance	\$25 Copayment (CYD not applied)	\$30 Copayment (CYD not applied)
In-Network Specialist:	CYD + Coinsurance	\$50 Copayment (CYD not applied)	\$60 Copayment (CYD not applied)
In-Network Chiropractor	CYD + Coinsurance	\$50 Copayment (CYD not applied)	\$60 Copayment (CYD not applied)
Out-of-Network Providers:	CYD + Coinsurance	CYD + Coinsurance	Out-of-Network Not Covered
In-Network e-Office Visit Family Physician:	CYD + Coinsurance	\$10 Copayment (CYD not applied)	\$10 Copayment (CYD not applied)
In-Network e-Office Visit Specialist:	CYD + Coinsurance	\$10 Copayment (CYD not applied)	\$10 Copayment (CYD not applied)
Out-of-Network e-Office Visit:	CYD + Coinsurance	CYD + Coinsurance	Out-of-Network Not Covered
In-Network Family Physician Advanced Imaging	CYD + Coinsurance	\$25 Copayment (CYD not applied)	\$0 X-ray; \$25 Diagnostic Testing
In-Network Specialist Advanced Imaging	CYD + Coinsurance	\$50 Copayment (CYD not applied)	\$0 X-ray; \$50 Diagnostic Testing
Out-of-Network Providers Advanced Imaging	CYD + Coinsurance	CYD + Coinsurance	Out-of-Network Not Covered
Allergy Injection In-Network:	CYD + Coinsurance	\$10 Copayment (CYD not applied)	\$10 Copayment (CYD not applied)

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Hospital Services			Must Use Network Providers
Inpatient In-Network:	\$200 PAD + CYD + Coinsurance	\$250 PAD + CYD + Coinsurance	\$300 Copay + Coinsurance
Inpatient Out-of-Network:	\$400 PAD + CYD + Coinsurance	\$500 PAD + CYD + Coinsurance	Out-of-Network Not Covered
Outpatient In-Network - Therapy Services:	CYD + Coinsurance	CYD + Coinsurance	\$30 Copayment (CYD not applied)
Outpatient In-Network - All other Services:	CYD + Coinsurance	CYD + Coinsurance	CYD + Coinsurance
Outpatient Out-of-Network: Therapy Services / All Other Services:	CYD + Coinsurance	CYD + Coinsurance	Out-of-Network Not Covered
Emergency Room - In-Network:	\$200 Copay + CYD + Coinsurance (\$200 Copay waived if admitted)	\$250 Copay + CYD + Coinsurance (\$250 Copay waived if admitted)	\$100 Copay + Coinsurance (\$100 Copay waived if admitted)
Emergency Room - Out-of-Network:	\$400 Copay + CYD + Coinsurance (\$400 Copay waived if admitted)	\$500 Copay + CYD + Coinsurance (\$500 Copay waived if admitted)	\$100 Copay + Coinsurance (\$100 Copay waived if admitted)
Provider Services at Hospital / ER:	CYD + Coins In and Out-of-Network	CYD + Coins In- and Out-of-Network	\$0 In-Network; Out-of-Network Not Covered
Urgent Care Centers In-Network:	CYD + Coinsurance	\$50 Copayment (CYD not applied)	\$75 Copayment (CYD not applied)
Urgent Care Centers Out-of-Network:	CYD + Coinsurance	CYD + Coinsurance	Out-of-Network Not Covered
Other			Must Use Network Providers
Independent Clinical Labs: Quest Diagnostics is the only in-network provider	CYD + Coinsurance	\$0 Co-Payment In-Network (CYD not applied) CYD + Coinsurance Out-of-Network	\$0 Co-Payment In-Network (CYD not applied)
Independent Diagnostic Testing Facility:	CYD + Coinsurance	CYD + Coinsurance (X-ray & AIS) In- and Out-of-Network	\$0 Copay for X-rays; Applicable Provider Copay for Diagnostic Testing
Contraceptive Injections:	CYD + Coinsurance	Copay <u>or</u> CYD + Coins In-Network; CYD + Coins Out-of-Network	Not Covered
Prosthetics & Orthotics:	CYD + Coinsurance	CYD + Coinsurance In- and Out-of-Network	\$0 Copay In-Network
Durable Medical Equipment:	CYD + Coinsurance	CYD + Coinsurance In- and Out-of-Network	CYD + Coinsurance; \$500 Copay + Coins. for Motorized Wheelchair
Ambulance Services:	CYD + In-Network Coinsurance	CYD + In-Network Coins up to \$5,000 Per Day Combined Ground & Air/Water Max	CYD + Coinsurance
Ambulatory Surgical Center:	CYD + Coinsurance	CYD + Coinsurance	CYD + Coinsurance
Radiology, Pathology & Anesthesiology Provider Services (Ambulatory Surgical Center):	CYD + In-Network Coinsurance	CYD + In-Network Coinsurance	\$0 In-Network; Out-of-Network Not Covered
Provider Services at Locations Other than Office, Hospital and ER:	CYD + Coinsurance	CYD + Coinsurance	\$0 In-Network; Out-of-Network Not Covered
Benefit Maximums			Must Use Network Providers
Substance Dependency and Mental Health	No Maximum	No Maximum	No Maximum
Home Health Care:	\$10,000 CYM	\$10,000 CYM	Unlimited; \$0 Copay
Skilled Nursing Facility:	90 Days CYM	90 Days CYM	30 Days CYM; \$0 Copay
Outpatient Therapy:	\$2,500 CYM	\$2,500 CYM	Authorization Required
Spinal Manipulations:	52 CYM	52 CYM	52 CYM
Hospice:	No Maximum	No Maximum	Unlimited; \$0 Copay
Lifetime Maximum:	\$5,000,000	\$5,000,000	Unlimited

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To locate a BlueCross BlueShield network provider in Florida: www.bcbsfl.com

Blue Choice 117 Select " <u>Blue Choice PPO</u> " Plan Directory	Blue Options 3360 Select " <u>BlueOptions (Network Blue)</u> " Plan Directory	Blue Care 40 Select " <u>Blue Care (HMO)</u> " Plan Directory
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or call

BlueCross BlueShield of Florida Customer Service
(877) 352-2583

PHARMACY BENEFITS (Administered by Walgreens)

Prescriptions — 30 Days or Less			
Generic	\$4	\$4	\$4
Preferred	\$25	\$25	\$25
Non-Preferred	\$50	\$50	\$50
*Mandatory 90 on maintenance prescriptions	Member pays full cost of 4th 30-day retail fill	Member pays full cost of 4th 30-day retail fill	Member pays full cost of 4th 30-day retail fill

***Mandatory 90 Copay on 4th Fill of Maintenance Medications**

The first prescription fill and two refills of a maintenance medication may be obtained in 30-day quantities. After that, you are required to obtain your fourth and subsequent fills as 90-day quantities through a Walgreens community retail pharmacy or Walgreens Mail Service pharmacy.

Prescriptions — 90-Day Supply			
Generic	\$8	\$8	\$8
Preferred	\$50	\$50	\$50
Non-Preferred	\$100	\$100	\$100
Step Therapy Program			
	OTC Prilosec (Acid Reflux)	OTC Prilosec (Acid Reflux)	OTC Prilosec (Acid Reflux)
	SSRI (Anti-Depression)	SSRI (Anti-Depression)	SSRI (Anti-Depression)

Walgreens Customer Service
800-207-2568

GLOSSARY OF ACRONYMS:

CYD - Calendar Year Deductible	LTM - Lifetime Maximum	IP - Inpatient	OTC - Over the Counter
CYM - Calendar Year Maximum	AIS - Advanced Imaging Services	OP - Outpatient	SSRI - Selective Serotonin Reuptake Inhibitors
PAD - Per Admission Deductible			