

Summary of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
Financial Features		
Deductible (DED ¹) (PBP ²) (DED is the amount the member is responsible for before Florida Blue pays)	\$1,500 per person	\$3,000 per person
Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	Not Applicable	\$500
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	\$5,000 per person	\$15,000 per person
Office Services		
Physician Office Services Primary Care Physician Specialist Convenient Care e-Office Visit	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Allergy Injections (per visit) Primary Care Physician Specialist	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	20% after Deductible	40% after Deductible
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum ³ Provider	\$200 20% after Deductible	50% after Deductible
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the <i>medical</i> benefit. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	\$0	40%
Mammograms	\$0	\$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	\$0	\$0
Emergency Medical Care		
Urgent Care Centers	20% after Deductible	20% after Deductible
Emergency Room Facility Services (per visit)	20% after Deductible	20% after Deductible ⁴

¹ DED = Deductible

² PBP = Per Benefit Period

³ In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

⁴ If admitted as an Inpatient from the Emergency Room member pays Out-of-Network DED and In-Network Emergency Room Copay.

Note: Out-of-Network services may be subject to balance billing.

Florida Blue is a trade name of Blue Cross and Blue Shield of Florida, Inc., an Independent Licensee of the Blue Cross and Blue Shield Association. Florida Blue does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

BlueOptions

For Large Groups

Health Benefit **Single Plan 05190** (HSA-Compatible)

Summary of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
Emergency Medical Care (continued)		
Ambulance Services	20% after Deductible	20% after In-Network Deductible
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Independent Clinical Lab (e.g., Blood Work)	Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays) Option 1 Option 2	20% after Deductible 25% after Deductible	40% after Deductible 40% after Deductible
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	20% after Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit) Therapy Services Option 1 Option 2 All other Services Option 1 Option 2	20% after Deductible 25% after Deductible 20% after Deductible 25% after Deductible	40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit) Option 1 Option 2	20% after Deductible 25% after Deductible	\$500 PAD, then 40% after Deductible ⁴ \$500 PAD, then 40% after Deductible ⁴
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit) Option 1 and Option 2	20% after Deductible	20% after In-Network Deductible ⁴
Outpatient Hospitalization Facility Service (per visit) Option 1 and Option 2	20% after Deductible	40% after Deductible
Emergency Room Facility Services (per visit)	20% after Deductible	20% after In-Network Deductible
Provider Services at Hospital and ER Primary Care Physician / Specialist	20% after Deductible	20% after In-Network Deductible
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Outpatient Office Visit Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Other Provider Services		
Provider Services at Hospital and ER	20% after Deductible	20% after In-Network Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	20% after Deductible	20% after In-Network Deductible
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible

BlueOptions

For Large Groups

Health Benefit **Single** Plan 05190 (HSA-Compatible)

Summary of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
Other Special Services (continued)		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	20% after Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit) Option 1	20% after Deductible	40% after Deductible
Option 2	25% after Deductible	40% after Deductible
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	40% after Deductible
Home Health Care	20% after Deductible	40% after Deductible
Skilled Nursing Facility	20% after Deductible	40% after Deductible
Hospice	20% after Deductible	40% after Deductible

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services **you need to get an approval** from Florida Blue before your service or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	21 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

BlueScript Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them. Important Note: Your health plan may include prescription drug coverage that only provides coverage at Exclusive Pharmacies except for emergency situations.

Access to Our Strong Networks

NetworkBlueSM is the Preferred Provider Network designated as "In-Network" for BlueOptions. While In-Network providers remain the best value, members are still **protected from balance billing** if they go Out-of-Network to someone who is part of our Traditional Provider Network. You may also receive **out-of-state coverage through the BlueCard[®]** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

BlueOptions

For Large Groups

Health Benefit **Single** Plan 05190 (HSA-Compatible)

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, Florida Blue does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at floridablue.com.

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

Summary of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
Financial Features		
Deductible (NEM DED ¹) (PBP ²) (DED is the amount the member is responsible for before Florida Blue pays)	\$3,000 per person \$6,000 per family ¹	\$6,000 per person \$6,000 per family
Out-of-Network Inpatient Hospital Facility Services Per Admission Deductible (PAD)	Not Applicable	\$500
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (EM OOP ³) (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	\$6,850 per person \$10,000 per family ³	\$15,000 per person \$15,000 per family
Office Services		
Physician Office Services Primary Care Physician Specialist Convenient Care e-Office Visit	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible 40% after Deductible 40% after Deductible
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Allergy Injections (per visit) Primary Care Physician Specialist	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	20% after Deductible	40% after Deductible
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum ⁴ Provider	\$200 20% after Deductible	50% after Deductible
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the <i>medical</i> benefit. Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	\$0	40%
Mammograms	\$0	\$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	\$0	\$0
Emergency Medical Care		
Urgent Care Centers	20% after Deductible	20% after Deductible
Emergency Room Facility Services (per visit)	20% after Deductible	20% after Deductible ⁵

¹ NEM DED = Deductible is Non-Embedded: Deductible is shared for all individuals on the family plan.

² PBP = Per Benefit Period

³ EM OOP = Out-of-Pocket Maximum is Embedded: A covered family member's out-of-pocket costs are capped at the individual out-of-pocket maximum amount on the family plan.

⁴ In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

⁵ If admitted as an Inpatient from the Emergency Room member pays Out-of-Network DED and In-Network Emergency Room Coinsurance.

Note: Out-of-Network services may be subject to balance billing.

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BlueOptions

For Large Groups

Health Benefit **Family** Plan 05191 (HSA-Compatible)

Summary of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
Emergency Medical Care (continued)		
Ambulance Services	20% after Deductible	20% after In-Network Deductible
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	20% after Deductible	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	20% after Deductible	40% after Deductible
Independent Clinical Lab (e.g., Blood Work)	Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)		
Option 1	20% after Deductible	40% after Deductible
Option 2	25% after Deductible	40% after Deductible
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	20% after Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit)		
Therapy Services Option 1	20% after Deductible	40% after Deductible
Option 2	25% after Deductible	40% after Deductible
All other Services Option 1	20% after Deductible	40% after Deductible
Option 2	25% after Deductible	40% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit)		
Option 1	20% after Deductible	\$500 PAD, then 40% after Deductible ⁵
Option 2	25% after Deductible	\$500 PAD, then 40% after Deductible ⁵
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)		
Option 1 and Option 2	20% after Deductible	20% after In-Network Deductible ⁵
Outpatient Hospitalization Facility Service (per visit)		
Option 1 and Option 2	20% after Deductible	40% after Deductible
Emergency Room Facility Services (per visit)	20% after Deductible	20% after In-Network Deductible
Provider Services at Hospital and ER		
Primary Care Physician / Specialist	20% after Deductible	20% after In-Network Deductible
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Outpatient Office Visit		
Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Other Provider Services		
Provider Services at Hospital and ER	20% after Deductible	20% after In-Network Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	20% after Deductible	20% after In-Network Deductible
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician	20% after Deductible	40% after Deductible
Specialist	20% after Deductible	40% after Deductible

BlueOptions

For Large Groups

Health Benefit **Family** Plan 05191 (HSA-Compatible)

Summary of Benefits for Covered Services	Amount Member Pays	
	In-Network	Out-of-Network
Other Special Services (continued)		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	20% after Deductible	40% after Deductible
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Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	21 Days PBP
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Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
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BlueOptions

For Large Groups

Health Benefit **Family** Plan 05191 (HSA-Compatible)

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, Florida Blue does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at floridablue.com.

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BlueScript Pharmacy Benefits - \$10/\$50/\$80 after In-Network Deductible

For BlueOptions Plans (Mail Order Available)

The BlueOptions® health benefit plan your employer is offering you is paired with our BlueScript® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain prescription drugs at a location convenient to you.

You may also be able to receive more savings on prescription drugs by purchasing your drugs through the mail order program.

See table to the right for your specific plan details.

Advantages of our Pharmacy Program

With our BlueScript Pharmacy Program, you'll receive coverage for Preferred Generic, Preferred Brand Name, and Non-Preferred Prescription Drugs, as well as self-administered injectables and specialty medications. You have easy access to Participating Pharmacies throughout Florida and to National Network Pharmacies with over 60,000 locations.

Save When Purchasing Your Prescription Drugs

You can reduce your out-of-pocket costs by purchasing Covered Prescription Drugs listed on our Preferred Medication List. These prescription drugs should cost you less than prescription drugs not on the list.

Generic Prescription Drugs

You pay a lower cost for Generic Prescription Drugs that appear on the Preferred Medication List. If you request a Brand Name Prescription Drug when a Generic is available, you will be responsible for:

1. The copayment applicable to Brand Name Prescription Drugs;
2. The difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated on the BlueOptions pharmacy Program Schedule of Benefits.

More Convenient Than Ever

Take your prescriptions to a participating pharmacy to have them filled. Or, if you are taking a prescription medication on an ongoing basis, you have a couple of convenient options:

1. Your doctor can prescribe a 3-month supply and you can have it filled at select participating retail pharmacies. A 3-month out-of-pocket cost (copay, coinsurance, and/or deductible) applies.
2. For additional savings, fill prescriptions via our home delivery program. This program allows covered members taking prescription drugs to receive up to a 3-month supply for one Home Delivery Copayment, after Pharmacy Deductible, if applicable. Prescription drugs ordered through this program are provided by Alliance Rx Walgreens Prime.

	In-Network	Out-of-Network	Mail Order* (90 days)
Pharmacy Deductible	In-Network Deductible		
Generic			
Preferred Generic Drugs	\$10 after In-Network Deductible	50% after In-Network Deductible	\$25 after In-Network Deductible
Condition Care Rx (high blood pressure, high cholesterol, diabetes)	\$10 copay	50% after In-Network Deductible	\$25 copay
Brand Name			
Preferred Drugs	\$50 after In-Network Deductible	50% after In-Network Deductible	\$125 after In-Network Deductible
Condition Care Rx (high blood pressure, high cholesterol, diabetes)	\$50 copay	50% after In-Network Deductible	\$125 copay
Brand Name			
Non-Preferred Drugs	\$80 after In-Network Deductible	50% after In-Network Deductible	\$200 after In-Network Deductible
Oral Chemotherapy Drugs	\$10 after In-Network Deductible	50% after In-Network Deductible	\$25 after In-Network Deductible

*Specialty drugs are not available through home delivery.

Note: Condition Care Rx is available In-Network – Waive DED, regular copay applies.

Vaccines at the Pharmacy

Certain vaccines which are covered under your Wellness Benefits can be administered by Pharmacists that are certified.

Contraceptive Coverage

Generic oral contraceptives and diaphragms are covered under your pharmacy benefit and are available at no cost to you. These

contraceptives must be prescribed and obtained by a participating pharmacy.

Diabetic Supplies

Diabetic supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/or syringes and needles are covered under your pharmacy benefit. Diabetic supplies require a prescription and can be obtained from a participating pharmacy.

Medication Guide

The Preferred Medication List, which is part of the Medication Guide, is available online at floridablue.com. Changes in the formulary can occur over time and the most up-to-date listing can always be found by viewing the Medication Guide online or by calling the customer service number listed on your member ID card. For the hearing impaired, call Florida TTY Relay Services 711. The Medication Guide also identifies specialty drugs, and drugs requiring prior authorization. When reviewing the Preferred Medication List with your doctor, ask your provider to consider a prescription drug from the Preferred Medication List, particularly a Preferred Generic Prescription Drug.

Pharmacy Options Affect Your Out-of-Pocket

There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled—retail pharmacies and specialty pharmacies. To save the most money, before you get a prescription filled you should confirm which pharmacy is considered 'in-network' for that particular medication.

- **Retail Pharmacy Network**

Non-specialty 'Generic' medications and 'Brand Name' medications listed on the Medication Guide can be filled at these pharmacies at a lower cost to you than other pharmacies in your area. If you go to a non-participating pharmacy, your prescription will cost you more.

- **Specialty Pharmacy Network**

We have identified certain drugs as 'specialty drugs' due to requirements such as special handling, storage, training, distribution, and management of the therapy. These drugs are listed as a 'Specialty Drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy. These pharmacies are different than the retail pharmacies and are identified in both the Provider Directory and the Medication Guide. Using an in-network Specialty Pharmacy to provide these Specialty Drugs lowers the amount you pay for these medications.

- **Non-Participating Pharmacy**

Choosing a non-participating pharmacy will cost you more money. You may have to pay the full cost of the medication and then file a claim to be reimbursed. Our payment will be based on our Non-Participating Pharmacy Allowance minus your deductible and/or coinsurance. You will be responsible for the deductible and/or coinsurance and the difference between our allowance and the cost of the medication.

- **The National Pharmacy Network**

The National Pharmacy Network includes more than 50,000 chain and Independent Pharmacies across the United States.

The National Network Pharmacies are available to our members traveling or residing outside of Florida. Simply present your member ID card at time of purchase.

Utilization Management/Responsible Rx Programs

Prior Coverage Authorization

Drugs selected for Prior Coverage Authorization (PA) may require that specific clinical criteria be met before the drugs will be covered under your pharmacy benefit. The list of drugs requiring Prior Authorization is located in the Medication Guide and is designated with a "PA" following the product name. Florida Blue reserves the right to change the drugs that require PA at any time and for any reason.

Responsible Quantity

Drugs included in this program allow a maximum quantity per time period. Quantity limits are typically developed based upon FDA-approved drug labeling and nationally recognized therapeutic clinical guidelines. The list of drugs that have quantity limits are designated in the Formulary List with a "QL" following the product name. Florida Blue reserves the right to change the Drugs and the quantity limits subject to the Responsible Quantity Program at any time and for any reason. In cases where a larger quantity of a Responsible Quantity Drug is medically required, your doctor or health care provider can request an override. Responsible Quantity override forms are available at floridablue.com.

Responsible Steps

Drugs included in this program require that you try another designated prerequisite drug first before a drug listed in the Responsible Steps Medication Chart will be covered. If due to medical reasons you cannot use the prerequisite drug and require the Responsible Steps Medication, your doctor or health care provider may request prior authorization for an override. If the override request is approved, coverage will be provided for the Responsible Steps Medication. These medications are designated in the Formulary List with "RS" following the product name. Medications included in the Responsible Steps Program are listed in the Medication Guide. Florida Blue reserves the right to change the drugs subject to the Responsible Steps Program at any time and for any reason.

Drugs that are Not Covered

Your Pharmacy benefit may not cover select medications. The Medication Guide contains a list of non-covered drugs. Some reasons a medication may not be covered are:

- The drug has been shown to have excessive adverse effects and/or safer alternatives are available.
- The drug has a preferred formulary alternative.

Prescription Discounts

With the BlueSaver® prescription savings card program, you will receive special discounted pricing on non-covered prescription medications when you show your BlueSaver ID card at select participating pharmacies. This card provides savings for you or any of your covered family members on medications that are not covered under your BlueScript pharmacy benefit. The BlueSaver savings program is not an insurance product or part of your health benefit plan.

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