Exhibit 4

Benefits Match-Up – a,b,c,d

(In Word format)

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| BENEFIT HIGHLIGHTS | IN-NETWORK | | OUT-OF-NETWORK | **Write “Match” or Fill In Differences** |
| --- | --- | --- | --- | --- |
| **Plan Name:** | Florida Blue Plan – BlueChoice 0727 | | |  |
| **MEDICAL** |  | | | Please note any program limitation or prior authorization programs for each type of benefit when applicable. |
| **Lifetime Maximum** | Unlimited | | |  |
| **Deductible**  Individual  Family | $500 per year  $1,000 per year | | |  |
| **Out-of-Pocket (OOP) Maximum**  Individual  Family | $2,000 per year  $4,000 per year | | |  |
| **Out-of-Pocket Info:** | Does not include any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount. | | |  |
| **Coinsurance** | 20% | | 40% |  |
| **Physician’s Services** |  | | |  |
| Primary Physician Office Visit | 80% after deductible | | 60% after deductible |  |
| Specialist Physician Office Visit | 80% after deductible | | 60% after deductible |  |
| **Preventative Health Services** |  | | |  |
| Covered Health Services include but are not limited to: |  | | |  |
| Primary Physician Office Visit | 100% | | 60% |  |
| Specialist Physician Office Visit | 100% | | 60% |  |
| **Ambulance Services** | 80% after deductible | | |  |
| **Durable Medical Equipment (DME), Prosthetics and Orthotics** | 80% after deductible | | 60% after deductible |  |
| **Emergency Room** |  | | |  |
| Facility | 80% after deductible plus Per Visit Deductible ($0) | | 80% after deductible plus Per Visit Deductible ($0) |  |
| Physician services | 80% after deductible | | 80% after deductible |  |
| **Home Health Care**  Benefits are limited as follows:  58 visits per year | 100% | | 100% |  |
| **Hospice Care** | 100% | | 100% |  |
| **Hospital – Inpatient Stay** |  | |  |  |
| Facility Fee | 80% after deductible | | 60% after deductible |  |
| Physician/Surgeon Fees | 80% after deductible | | 80% after deductible |  |
| **Lab, X-Ray and Major Diagnostics – Outpatient** | Independent Clinical Lab:  80%  Independent Diagnostic Testing Center:  80% after deductible | | Independent Clinical Lab:  60%  Independent Diagnostic Testing Center:  60% after deductible |  |
| **Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient** | 80% after deductible | | 60% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Inpatient** |  | | |  |
| Facility Services | 80% after deductible | | 60% after deductible |  |
| Physician and other health care professionals licensed to perform such services | 80% after deductible | | 80% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Outpatient** |  | | |  |
| Emergency Room | 80% after deductible | | 80% after deductible |  |
| Hospital | 80% after deductible | | 60% after deductible |  |
| Physician Services at Hospital and Emergency Room | 80% after deductible | | 80% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services – Physician and other health care professionals** |  | | |  |
| Primary physician office | 80% after deductible | | 60% after deductible |  |
| Specialist office and all other locations | 80% after deductible | | 60% after deductible |  |
| **Medical Pharmacy** |  | | |  |
| **Prescription Drugs administered by:** |  | | |  |
| Primary Physician | 80% | | 50% after deductible |  |
| Specialist Physician | 80% | | 50% after deductible |  |
| Medical Pharmacy Out-of-Pocket Maximum per covered plan participant per month | $200 | | n/a |  |
| Note: | The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share.  Immunizations, allergy injections and services covered through a pharmacy program are not considered Medical Pharmacy. | | |  |
| **Pregnancy – Maternity Services** |  | | |  |
| Office Visits | 80% after deductible | | 60% after deductible |  |
| Childbirth/Delivery Professional Services | 80% after deductible | | 80% after deductible |  |
| Childbirth/Delivery Facility Services | 80% after deductible | | 60% after deductible |  |
| **Radiologist, Pathologist and Anesthesiologist Provider Services at Hospital or Ambulatory Surgical Center** | 80% after deductible | | 60% after deductible |  |
| **Rehabilitation Services – Outpatient** |  | | |  |
| Benefits are limited to 75 visits | 80% after deductible | | 60% after deductible |  |
| **Skilled Nursing Facility**  Benefits are limited as follows:  120 days per year | 100% | | 100% |  |
| **Surgery – Outpatient** |  | | |  |
| Facility Fee | 80% after deductible | | 60% after deductible |  |
| Physician/Surgeon Fees | 80% after deductible | | Ambulatory Surgical Center:  60%  Hospital:  80% after deductible |  |
| **Urgent Care** | 80% after deductible | | 80% after deductible |  |
| **Pharmacy Program** | **Participating Pharmacy** | **Non-Participating Pharmacy** | |  |
| **Tier 1 purchased at:**  Retail Pharmacy – For up to 31 day supply | $5 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $5 | 50% | |  |
| Mail Order – For up to a 90 day supply | $10 | 50% | |  |
| **Tier 2 purchased at:**  Retail Pharmacy – For up to 31 day supply | $30 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $30 | 50% | |  |
| Mail Order – For up to a 90 day supply | $60 | 50% | |  |
| **Tier 3 purchased at:**  Retail Pharmacy – For up to 31 day supply | $60 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $60 | 50% | |  |
| Mail Order – For up to a 90 day supply | $120 | 50% | |  |

| BENEFIT HIGHLIGHTS | IN-NETWORK | | OUT-OF-NETWORK | **Write “Match” or Fill In Differences** |
| --- | --- | --- | --- | --- |
| **Plan Name:** | Florida Blue Plan – BlueChoice 03359 | | |  |
| **MEDICAL** |  | | | Please note any program limitation or prior authorization programs for each type of benefit when applicable. |
| **Lifetime Maximum** | Unlimited | | |  |
| **Deductible**  Individual / Family Maximum | $1,000 per person /  $3,000 per family | | $2,000 per person /  $6,000 per family |  |
| **Deductible Info:** | Deductibles accumulate separately In and Out of Network. | | |  |
| **Out-of-Pocket (OOP) Maximum**  Individual / Family Maximum | $3,000 per person /  $6,000 per family | | $5,000 per person /  $10,000 per family |  |
| **Coinsurance** | 20% | | 40% |  |
| **Physician’s Services** |  | | |  |
| Primary Physician Office Visit | $25 copay | | 60% after deductible |  |
| Specialist Physician Office Visit | 80% after deductible | | 60% after deductible |  |
| **Preventative Health Services** |  | | |  |
| Covered Health Services include but are not limited to: |  | | |  |
| Primary Physician Office Visit | 100% | | 60% |  |
| Specialist Physician Office Visit | 100% | | 60% |  |
| **Ambulance Services** | 80% after In-Network deductible | | |  |
| **Durable Medical Equipment (DME), Prosthetics and Orthotics** | 80% after deductible | | 60% after deductible |  |
| **Emergency Room** |  | | |  |
| Facility | $200 copay  (waived if admitted) | | $200 copay |  |
| Physician and other health care professional services | 80% after deductible | | 80% after In-Network deductible |  |
| **Home Health Care**  Benefits are limited as follows:  20 visits per year | 80% after deductible | | 60% after deductible |  |
| **Hospice Care** | 80% after deductible | | 60% after deductible |  |
| **Hospital – Inpatient Stay** |  | | |  |
| Facility Services (per admission) | Option 1:  $750 copay  Option 2:  $1,000 copay | | 60% after deductible |  |
| Physician and other health care professional services | 80% after deductible | | 80% after In-Network deductible |  |
| **Lab, X-Ray and Major Diagnostics – Outpatient** | Independent Clinical Lab:  100%  Independent Diagnostic Testing Center:  $50 copay | | 60% after deductible |  |
| **Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient** | $125 copay | | 60% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Inpatient** |  | | |  |
| Facility Services | Option 1: $750 copay  Option 2: $1,000 copay | | Option 1: 60% after deductible  Option 2: 60% after deductible |  |
| Physician and other health care professionals licensed to perform such services | 80% after deductible | | 80% after In-Network deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Outpatient** |  | | |  |
| Emergency Room (per visit deductible) (PVD) | $100 copay plus $50 PVD | | $100 copay plus $50 PVD |  |
| Hospital | Option 1: $150 copay  Option 2: $250 copay | | Option 1: 60% after deductible  Option 2: 60% after deductible |  |
| Physician Services at Hospital and Emergency Room | 80% after deductible | | 80% after In-Network deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services – Physician and other health care professionals** |  | | |  |
| Primary physician office | $25 copay | | 60% after deductible |  |
| Specialist office and all other locations | 80% after deductible | | 60% after deductible |  |
| **Medical Pharmacy** |  | | |  |
| **Prescription Drugs administered by:** |  | | |  |
| Primary Physician | 80% | | 50% after deductible |  |
| Specialist Physician | 80% | | 50% after deductible |  |
| Medical Pharmacy Out-of-Pocket Maximum per covered plan participant per month | $200 | | n/a |  |
| Note: | The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share.  Immunizations, allergy injections and services covered through a pharmacy program are not considered Medical Pharmacy. | | |  |
| **Pregnancy – Maternity Services** |  | | |  |
| Office Visits | 80% after deductible | | 60% after deductible |  |
| Childbirth/Delivery Professional Services | 80% after deductible | | 80% after in-Network deductible |  |
| Childbirth/Delivery Facility Services | $750 copay | | 60% after deductible |  |
| **Radiologist, Pathologist and Anesthesiologist Provider Services at Hospital or Ambulatory Surgical Center** | 80% after deductible | | 80% after In-Network deductible |  |
| **Rehabilitation Services – Outpatient** |  | | |  |
| Benefits are limited to 35 visits | 80% after deductible | | 60% after deductible |  |
| **Skilled Nursing Facility**  Benefits are limited as follows:  60 days per year | 80% after deductible | | 60% after deductible |  |
| **Surgery – Outpatient** |  | | |  |
| Facility Fee | Ambulatory Surgical Center:  $100 copay  Hospital:  Option 1: $150 copay  Option 2: $250 copay | | Ambulatory Surgical Center:  60% after deductible  Hospital:  60% after deductible |  |
| Physician/Surgeon Fees | 80% after deductible | | Ambulatory Surgical Center:  60% after deductible  Hospital:  80% after In-Network deductible |  |
| **Urgent Care** | 80% after deductible | | 80% after deductible |  |
| **Pharmacy Program** | **Participating Pharmacy** | **Non-Participating Pharmacy** | |  |
| **Tier 1 purchased at:**  Retail Pharmacy – For up to 31 day supply | $10 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $10 | 50% | |  |
| Mail Order – For up to a 90 day supply | $20 | 50% | |  |
| **Tier 2 purchased at:**  Retail Pharmacy – For up to 31 day supply | $30 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $30 | 50% | |  |
| Mail Order – For up to a 90 day supply | $60 | 50% | |  |
| **Tier 3 purchased at:**  Retail Pharmacy – For up to 31 day supply | $60 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $60 | 50% | |  |
| Mail Order – For up to a 90 day supply | $120 | 50% | |  |

| BENEFIT HIGHLIGHTS | IN-NETWORK | | OUT-OF-NETWORK | **Write “Match” or Fill In Differences** |
| --- | --- | --- | --- | --- |
| **Plan Name:** | Florida Blue Plan – BlueChoice 0117 | | |  |
| **MEDICAL** |  | | | Please note any program limitation or prior authorization programs for each type of benefit when applicable. |
| **Lifetime Maximum** | Unlimited | | |  |
| **Deductible**  Individual  Family | $1,500 per year  $4,500 per year | | |  |
| **Out-of-Pocket (OOP) Maximum**  Individual  Family | $5,000 per year  $13,200 per year | | |  |
| **Out-of-Pocket Info:** | Does not include any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount. | | |  |
| **Coinsurance** | 30% | | 50% |  |
| **Physician’s Services** |  | | |  |
| Primary Physician Office Visit | 70% after deductible | | 50% after deductible |  |
| Specialist Physician Office Visit | 70% after deductible | | 50% after deductible |  |
| **Preventative Health Services** |  | | |  |
| Covered Health Services include but are not limited to: |  | | |  |
| Primary Physician Office Visit | 100% | | 50% |  |
| Specialist Physician Office Visit | 100% | | 50% |  |
| **Ambulance Services** | 70% after deductible | | |  |
| **Durable Medical Equipment (DME), Prosthetics and Orthotics** | 70% after deductible | | 50% after deductible |  |
| **Emergency Room** |  | | |  |
| Facility | 70% after deductible and Per Visit Deductible ($50) | | 70% after deductible and Per Visit Deductible ($50) |  |
| Physician services | 70% after deductible | | 70% after deductible |  |
| **Home Health Care**  Benefits are limited as follows:  10 visits per year | 70% after deductible | | 50% after deductible |  |
| **Hospice Care** | 70% after deductible | | 50% after deductible |  |
| **Hospital – Inpatient Stay** |  | |  |  |
| Facility Fee | 70% after deductible plus per admission deductible ($150) | | 50% after deductible plus per admission deductible ($300) |  |
| Physician/Surgeon Fees | 70% after deductible | | 70% after deductible |  |
| **Lab, X-Ray and Major Diagnostics – Outpatient** | 70% after deductible | | 50% after deductible |  |
| **Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient** | 70% after deductible | | 50% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Inpatient** |  | | |  |
| Facility Services | 70% after deductible plus per admission deductible ($150) | | 50% after deductible plus per admission deductible ($300) |  |
| Physician and other health care professionals licensed to perform such services | 70% after deductible | | 70% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Outpatient** |  | | |  |
| Emergency Room | 70% after deductible plus per visit deductible ($50) | | 70% after deductible plus per visit deductible ($50) |  |
| Hospital | 70% after deductible | | 50% after deductible |  |
| Physician Services at Hospital and Emergency Room | 70% after deductible | | 70% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services – Physician and other health care professionals** |  | | |  |
| Primary physician office | 70% after deductible | | 50% after deductible |  |
| Specialist office and all other locations | 70% after deductible | | 50% after deductible |  |
| **Medical Pharmacy** |  | | |  |
| **Prescription Drugs administered by:** |  | | |  |
| Primary Physician | 70% | | 50% after deductible |  |
| Specialist Physician | 70% | | 50% after deductible |  |
| Medical Pharmacy Out-of-Pocket Maximum per covered plan participant per month | $200 | | n/a |  |
| Note: | The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share.  Immunizations, allergy injections and services covered through a pharmacy program are not considered Medical Pharmacy. | | |  |
| **Pregnancy – Maternity Services** |  | | |  |
| Office Visits | 70% after deductible | | 50% after deductible |  |
| Childbirth/Delivery Professional Services | 70% after deductible | | 70% after deductible |  |
| Childbirth/Delivery Facility Services | 70% after deductible plus per admission deductible ($150) | | 50% after deductible plus per admission deductible ($300) |  |
| **Radiologist, Pathologist and Anesthesiologist Provider Services at Hospital or Ambulatory Surgical Center** | 70% after deductible | | 50% after deductible |  |
| **Rehabilitation Services – Outpatient** |  | | |  |
| Benefits are limited to 15 visits | 70% after deductible | | 50% after deductible |  |
| **Skilled Nursing Facility**  Benefits are limited as follows:  60 days per year | 70% after deductible | | 50% after deductible |  |
| **Surgery – Outpatient** |  | | |  |
| Facility Fee | 70% after deductible | | 50% after deductible |  |
| Physician/Surgeon Fees | 70% after deductible | | Ambulatory Surgical Center:  50% after deductible  Hospital:  70% after deductible |  |
| **Urgent Care** | 70% after deductible | | 70% after deductible |  |
| **Pharmacy Program** | **Participating Pharmacy** | **Non-Participating Pharmacy** | |  |
| **Tier 1 purchased at:**  Retail Pharmacy – For up to 31 day supply | 30% after deductible | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | 30% after deductible | 50% | |  |
| Mail Order – For up to a 90 day supply | $14 | 50% | |  |
| **Tier 2 purchased at:**  Retail Pharmacy – For up to 31 day supply | 30% after deductible | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | 30% after deductible | 50% | |  |
| Mail Order – For up to a 90 day supply | $40 | 50% | |  |
| **Tier 3 purchased at:**  Retail Pharmacy – For up to 31 day supply | 30% after deductible | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | 30% after deductible | 50% | |  |
| Mail Order – For up to a 90 day supply | 100% | 50% | |  |

| BENEFIT HIGHLIGHTS | IN-NETWORK | | OUT-OF-NETWORK | **Write “Match” or Fill In Differences** |
| --- | --- | --- | --- | --- |
| **Plan Name:** | Florida Blue Plan – BlueChoice 05901 | | |  |
| **MEDICAL** |  | | | Please note any program limitation or prior authorization programs for each type of benefit when applicable. |
| **Lifetime Maximum** | Unlimited | | |  |
| **Deductible**  Individual / Family Maximum | $2,000 per person /  n/a per family | | $6,000 per person /  n/a per family |  |
| **Deductible Info:** | Deductibles accumulate separately In and Out of Network. | | |  |
| **Out-of-Pocket (OOP) Maximum**  Individual / Family Maximum | $6,350 per person /  $12,700 per family | | $30,000 per person /  $30,000 per family |  |
| **Coinsurance** | 50% | | 50% |  |
| **Physician’s Services** |  | | |  |
| Primary Physician Office Visit | $35 copay | | 50% after deductible |  |
| Specialist Physician Office Visit | $75 copay | | 50% after deductible |  |
| **Preventative Health Services** |  | | |  |
| Covered Health Services include but are not limited to: |  | | |  |
| Primary Physician Office Visit | 100% | | 50% |  |
| Specialist Physician Office Visit | 100% | | 50% |  |
| **Ambulance Services** | 50% after In-Network deductible | | |  |
| **Durable Medical Equipment (DME), Prosthetics and Orthotics** | 50% after deductible | | 50% after deductible |  |
| **Emergency Room** |  | | |  |
| Facility | 50% after deductible | | 50% after deductible |  |
| Physician and other health care professional services | 50% after deductible | | 50% after In-Network deductible |  |
| **Home Health Care**  Benefits are limited as follows:  10 visits per year | 50% after deductible | | 50% after deductible |  |
| **Hospice Care** | 50% after deductible | | 50% after deductible |  |
| **Hospital – Inpatient Stay** |  | | |  |
| Facility Services (per admission) | Option 1:  $2,000 copay  Option 2:  $3,000 copay | | 50% after deductible |  |
| Physician and other health care professional services | 50% after deductible | | 50% after In-Network deductible |  |
| **Lab, X-Ray and Major Diagnostics – Outpatient** | Independent Clinical Lab:  100%  Independent Diagnostic Testing Center:  $50 copay | | 50% after deductible |  |
| **Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient** | $200 copay | | 50% after deductible |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Inpatient** |  | | |  |
| Facility Services | 100% | | 50% |  |
| Physician and other health care professionals licensed to perform such services | 100% | | 100% |  |
| **Mental Health and Substance Dependency Care and Treatment Services - Outpatient** |  | | |  |
| Emergency Room | 100% | | 100% |  |
| Hospital | 100% | | 50% |  |
| Physician Services at Hospital and Emergency Room | 100% | | 100% |  |
| **Mental Health and Substance Dependency Care and Treatment Services – Physician and other health care professionals** |  | | |  |
| Primary physician office | 100% | | 50% |  |
| Specialist office and all other locations | 100% | | 50% |  |
| **Medical Pharmacy** |  | | |  |
| **Prescription Drugs administered by:** |  | | |  |
| Primary Physician | 80% | | 50% after deductible |  |
| Specialist Physician | 80% | | 50% after deductible |  |
| Medical Pharmacy Out-of-Pocket Maximum per covered plan participant per month | $200 | | n/a |  |
| Note: | The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share.  Immunizations, allergy injections and services covered through a pharmacy program are not considered Medical Pharmacy. | | |  |
| **Pregnancy – Maternity Services** |  | | |  |
| Office Visits | $75 copay | | 50% after deductible |  |
| Childbirth/Delivery Professional Services | 50% after deductible | | 50% after in-Network deductible |  |
| Childbirth/Delivery Facility Services | $2,000 copay | | 50% after deductible |  |
| **Radiologist, Pathologist and Anesthesiologist Provider Services at Hospital or Ambulatory Surgical Center** | 50% after deductible | | 50% after In-Network deductible |  |
| **Rehabilitation Services – Outpatient** |  | | |  |
| Benefits are limited to 25 visits | $75 copay | | 50% after deductible |  |
| **Skilled Nursing Facility**  Benefits are limited as follows:  60 days per year | 50% after deductible | | 50% after deductible |  |
| **Surgery – Outpatient** |  | | |  |
| Facility Fee | Ambulatory Surgical Center:  50% after deductible  Hospital:  Option 1: $300 copay  Option 2: $400 copay | | Ambulatory Surgical Center:  50% after deductible  Hospital:  50% after deductible |  |
| Physician/Surgeon Fees | 50% after deductible | | Ambulatory Surgical Center:  50% after deductible  Hospital:  50% after In-Network deductible |  |
| **Urgent Care** | 50% after deductible | | 50% after deductible |  |
| **Pharmacy Program** | **Participating Pharmacy** | **Non-Participating Pharmacy** | |  |
| **Tier 1 purchased at:**  Retail Pharmacy – For up to 31 day supply | $15 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $15 | 50% | |  |
| Mail Order – For up to a 90 day supply | $40 | 50% | |  |
| **Tier 2 purchased at:**  Retail Pharmacy – For up to 31 day supply | $50 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $50 | 50% | |  |
| Mail Order – For up to a 90 day supply | $125 | 50% | |  |
| **Tier 3 purchased at:**  Retail Pharmacy – For up to 31 day supply | $80 | 50% | |  |
| Specialty Pharmacy – For up to 31 day supply | $80 | 50% | |  |
| Mail Order – For up to a 90 day supply | $200 | 50% | |  |