Exhibit 4

Benefits Match-Up – a,b,c,d

(In Word format)

If not already received, please email Laura Rybka at lrybka@siver.com for a copy of this file in Word format

| 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**IndividualFamily | $500 per year$1,000 per year |  |
| **Out-of-Pocket (OOP) Maximum**IndividualFamily  | $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** | **ParticipatingPharmacy** | **Non-ParticipatingPharmacy** |  |
| **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 copayOption 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 copayOption 2: $1,000 copay | Option 1: 60% after deductibleOption 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 copayOption 2: $250 copay | Option 1: 60% after deductibleOption 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 copayHospital:Option 1: $150 copayOption 2: $250 copay | Ambulatory Surgical Center:60% after deductibleHospital:60% after deductible |  |
| Physician/Surgeon Fees | 80% after deductible | Ambulatory Surgical Center:60% after deductibleHospital:80% after In-Network deductible |  |
| **Urgent Care**  | 80% after deductible | 80% after deductible |  |
| **Pharmacy Program** | **ParticipatingPharmacy** | **Non-ParticipatingPharmacy** |  |
| **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**IndividualFamily | $1,500 per year$4,500 per year |  |
| **Out-of-Pocket (OOP) Maximum**IndividualFamily  | $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 deductibleHospital:70% after deductible |  |
| **Urgent Care**  | 70% after deductible | 70% after deductible |  |
| **Pharmacy Program** | **ParticipatingPharmacy** | **Non-ParticipatingPharmacy** |  |
| **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 copayOption 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 deductibleHospital:Option 1: $300 copayOption 2: $400 copay | Ambulatory Surgical Center:50% after deductibleHospital:50% after deductible |  |
| Physician/Surgeon Fees | 50% after deductible | Ambulatory Surgical Center:50% after deductibleHospital:50% after In-Network deductible |  |
| **Urgent Care**  | 50% after deductible | 50% after deductible |  |
| **Pharmacy Program** | **ParticipatingPharmacy** | **Non-ParticipatingPharmacy** |  |
| **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% |  |