2024 Summary of Benefits Comparison

Product	2024 BlueCare (Gold) HMO Gold	2024 BlueOptions (Gold) PPO Gold	2024 BlueOptions (Gold) HDHP Gold Indv	2024 BlueOptions (Gold) HDHP Gold Family	2024 BlueOptions (Bronze) PPO Bronze
Plan Number	**47**	**03359**	**03160**	**03161**	**05909**
Cost Sharing - Member's Responsibility					
Deductible (DED) (Per Person/Family Aggregate)					
In-Network	$600 / $1,200	$1,200 / $2,400	$2,000	$4,000	$6,000 / $12,000
Out-of-Network	NA / NA	$2,400 / $4,800	$4,000	$8,000	$12,000 / $24,000
Coinsurance (BCBSF pays / Member pays)					
In-Network	20%	20%	20%	20%	40%
Out-of-Network	NA / NA	40%	40%	40%	50%
Out of Pocket Maximum (Per Person/Family Aggregate)					
In-Network	$5,000 / $10,000	$6,000 / $12,000	$5,400	$7,050 / $10,800	$8,700 / $17,400
Out-of-Network	NA / NA	$12,000 / $24,000	$10,800	$21,600	$17,400 / $34,800
Medical / Surgical Care by a Physician					
Office Services	• Nutritional counseling for a diagnosis of diabetes is covered at $0 copayment when billed by a VCP Specialist in the office.				• Nutritional counseling for a diagnosis of diabetes is covered at $0 copayment
Value Choice PCP	$0 Copayment	$0 Copayment	DED	DED	$0 Copayment
Value Choice Specialist	$20 Copayment	$20 Copayment	DED	DED	$20 Copayment
In-Network Family Physician	$45 Copayment	$50 Copayment	DED + 20%	DED + 20%	$60 Copayment
In-Network Specialist	$65 Copayment	$70 Copayment	DED + 20%	DED + 20%	DED + 40%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%	DED + 50%
Convenient Care Center					
In-Network	$45 Copayment	$50 Copayment	DED + 20%	DED + 20%	40%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%	DED + 50%
Physician Services at Hospital					
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 20%	DED + 40%
Out-of-Network	Not Covered	INN DED + 20%	INN DED + 20%	INN DED + 20%	INN DED + 40%
Preventive Services-Adult & Child Wellness Services					
Office Services					
In-Network Family Physician	$0 Copayment	$0	$0 Copayment	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0	$0 Copayment	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	40%	40%	40%	50%
Medical / Surgical Care at a Facility					
Ambulatory Surgical Center (ASC)					
In-Network	$200 Copayment	$200 Copayment	DED + 20%	DED + 20%	DED + 40%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%	DED + 50%
Inpatient Hospital Facility (per admit)		• OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.			
In-Network	$300 per day/$1500 max	$300 per day/$1500 max	DED + 20%	DED + 20%	DED + 40%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%	DED + 50%
Outpatient Hospital Facility (per visit) (Surgical)					
In-Network	$300 copay	$300 copay	DED + 20%	DED + 20%	DED + 40%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%	DED + 50%
Emergency and Urgent Care					
Emergency Room Facility (per visit) (No surgery performed or not admitted)	• If admitted as an inpatient from ER, the hospital will submit an inpatient hospital claim instead of an ER facility claim; only inpatient facility cost share will apply.				
In-Network	$250 Copayment	$250 Copayment	DED + 20%	DED + 20%	DED + 40%
Out-of-Network	$250 Copayment	$250 Copayment	INN DED + 20%	INN DED + 20%	INN DED + 40%
Urgent Care Centers	• Out-of-Network only covered out-of-state.				
Value Choice Urgent Care Provider	$0 Copayment - Visits 1-2 PBP $65 Copay for remaining Visits PBP	$0 Copayment - Visits 1-2 PBP $70 Copay for remaining Visits PBP	DED	DED	$0 Copayment - Visits 1-2 PBP 40% for remaining Visits PBP
In-Network	$65 Copayment	$70 Copayment	DED + 20%	DED + 20%	40%
Out-of-Network	Not Covered	INN DED + $70 Copayment	DED + 20%	DED + 20%	INN DED + 40%

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Plan Number	**47**	**03359**	**03160**	**03161**	**05909**
Diagnostic Testing (e.g., Lab, x-ray)					
Physician Office	Low-dose lung cancer screening covered In-Network at $0 Copay with a limit one per year when USPSTF recommendations are met, for adults ages 50-80.				
Value Choice PCP	$0 Copayment	$0	DED	DED	$0 Copayment
Value Choice Specialist	$20 Copayment	$20 Copayment	DED	DED	$20 Copayment
In-Network Family Physician	$45 Copayment	$50 Copayment	DED + 20%	DED + 20%	40%
In-Network Specialist	$65 Copayment	$70 Copayment	DED + 20%	DED + 20%	40%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%	DED + 50%
Independent Clinical Laboratory			INN only; Waive deductible for International Normalized Ratio (INR) testing. INN only; Waive deductible for Low-density Lipoprotein (LDL) testing.		
In-Network	$0 Copayment	$0 Copayment	DED + 0%	DED + 0%	$0 Copayment
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%	DED + 50%
Independent Diagnostic Testing Center					
In-Network	$50 Copayment	$70 Copayment	DED + 20%	DED + 20%	DED + 40%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%	DED + 50%
Outpatient Hospital Facility					
In-Network	$300 Copayment	$300 Copayment	Option 1: DED + 20%	Option 1: DED + 20%	Option 1: DED + 40%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%	DED + 50%
Mental Health and Substance Dependency Services					
Physician Office					
In-Network Family Physician	$0 Copayment	$0 Copayment	DED + 20%	DED + 20%	$0 Copayment
In-Network Specialist	$0 Copayment	$0 Copayment	DED + 20%	DED + 20%	$0 Copayment
Out-of-Network	Not Covered	40%	DED + 40%	DED + 40%	50%
Inpatient Hospital Facility		OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.			
In-Network	$0 Copayment	$0 Copayment	DED + 20%	DED + 20%	$0
Out-of-Network	Not Covered	40%	DED + 40%	DED + 40%	DED + 50%
Outpatient Hospital Facility					
In-Network	$0 Copayment	$0 Copayment	DED + 20%	DED + 20%	$0
Out-of-Network	Not Covered	40%	DED + 40%	DED + 40%	DED + 50%
Teladoc					
Standalone Telemedicine with Teladoc - General Medicine					
In-Network	$0	$0	Deductible	Deductible	$0
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Standalone Telemedicine with Teladoc - Dermatology					
In-Network	$10	$10	Deductible	Deductible	$10
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Standalone Telemedicine with Teladoc - Behavioral Health					
In-Network	$0	$0	Deductible	Deductible	$0
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Drugs					
Deductible					
In-Network					
RETAIL - Generic/Brand/Non-Preferred	$15/$45/$65	$15/$60/$100	CYD + 20%	CYD + 20%	$15/CYD + 40%/CYD + 40%
Rx- Specialty	$250	$250	CYD + 20%	CYD + 20%	CYD + 40%
MAIL ORDER - Generic/Brand/Non-Preferred	$40/$115/$165	$40/$150/$250	CYD + 20%	CYD + 20%	$40/CYD + 40%/CYD + 40%
Out-of-Network					
RETAIL - Generic/Brand/Non-Preferred	Not covered	50%	50%	50%	50%
MAIL ORDER - Generic/Brand/Non-Preferred	Not Covered	50%	50%	50%	50%
HSA Account Funding			**EE Only = $400**	**EE + 1 = $800, EE + 2 or more + $1,200**	