2023 Summary Plans Comparison

Product	2023 BlueCare (Gold) HMO Gold	2023 BlueOptions (Gold) PPO Gold	2023 BlueOptions (Gold) HDHP Gold Indv	2023 BlueOptions (Gold) HDHP Gold Family
Plan Number	**47**	**03359**	**03160**	**03161**
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)				
In-Network	$600 / $1,200	$1,200 / $2,400	$2,000	$4,000/$4,000
Out-of-Network	NA / NA	$2,400 / $4,800	$4,000	$8,000/$8,000
Coinsurance (BCBSF pays / Member pays)				
In-Network	20%	20%	20%	20%
Out-of-Network	NA / NA	40%	40%	40%
Out of Pocket Maximum (Per Person/Family Aggregate)				
In-Network	$5,000 / $10,000	$6,000 / $12,000	$5,400	$7,050 / $10,800
Out-of-Network	NA / NA	$12,000 / $24,000	$10,800	$21,600/$21,600
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.			
Value Choice PCP	$0 Copayment	$0 Copayment	DED	DED
Value Choice Specialist	$20 Copayment	$20 Copayment	DED	DED
In-Network Family Physician	$45 Copayment	$50 Copayment	DED + 20%	DED + 20%
In-Network Specialist	$65 Copayment	$70 Copayment	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Convenient Care Center				
In-Network	$45 Copayment	$50 Copayment	DED + 20%	DED + 20%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%
Physician Services at Hospital				
In-Network	DED + 20%	DED + 20%	DED + 20%	DED + 20%
Out-of-Network	Not Covered	INN DED + 20%	INN DED + 20%	INN DED + 20%
Preventive Services-Adult & Child Wellness Services				
Office Services				
In-Network Family Physician	$0 Copayment	$0	$0 Copayment	$0 Copayment
In-Network Specialist	$0 Copayment	$0	$0 Copayment	$0 Copayment
Out-of-Network	Not Covered	40%	40%	40%
Medical / Surgical Care at a Facility				
Ambulatory Surgical Center (ASC)				
In-Network	$200 Copayment	$200 Copayment	DED + 20%	DED + 20%
Out-of-Network	Not Covered	Ded + 40%	DED + 40%	DED + 40%
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%
In-Network				
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%
Outpatient Hospital Facility (per visit) (Surgical)				
In-Network	$300 copay	$300 copay	DED + 20%	DED + 20%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%

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2023 Summary Plans Comparison

FCSRMC FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM

Product	2023 BlueCare (Gold) HMO Gold	2023 BlueOptions (Gold) PPO Gold	2023 BlueOptions (Gold) HDHP Gold Indv	2023 BlueOptions (Gold) HDHP Gold Family
Plan Number	**47**	**03359**	**03160**	**03161**
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%
Out-of-Network	$250 Copayment	$250 Copayment	INN DED + 20%	INN DED + 20%
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
In-Network	$65 Copayment	$70 Copayment	DED + 20%	DED + 20%
Out-of-Network	Not Covered	INN DED + $70 Copayment	DED + 20%	DED + 20%
Mental Health and Substance Dependency Services				
Physician Office				
In-Network Family Physician	$0 Copayment	$0 Copayment	DED + 20%	DED + 20%
In-Network Specialist	$0 Copayment	$0 Copayment	DED + 20%	DED + 20%
Out-of-Network	Not Covered	40%	DED + 40%	DED + 40%
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%
Out-of-Network	Not Covered	40%	DED + 40%	DED + 40%
Outpatient Hospital Facility				
In-Network	$0 Copayment	$0 Copayment	DED + 20%	DED + 20%
Out-of-Network	Not Covered	40%	DED + 40%	DED + 40%
Teladoc				
Standalone Telemedicine with Teladoc - General Medicine				
In-Network	$0	$0	Deductible	Deductible
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Standalone Telemedicine with Teladoc - Dermatology				
In-Network	$10	$10	Deductible	Deductible
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Standalone Telemedicine with Teladoc - Behavioral Health				
In-Network	$0	$0	Deductible	Deductible
Out-of-Network	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%
Rx- Specialty	$250	$250	CYD + 20%	CYD + 20%
MAIL ORDER Generic/Brand/Non-Preferred	$40/$115/$165	$40/$150/$250	CYD + 20%	CYD + 20%
Out-of-Network				
RETAIL - Generic/Brand/Non-Preferred	Not covered	50%	50%	50%
MAIL ORDER - Generic/Brand/Non-Preferred	Not Covered	50%	50%	50%
HSA Account Funding			**EE Only = $400**	**EE + 1 = $800, EE + 2 or more + $1,200**