2024 Summary of Plans Comparison

Product	BlueOptions (Gold) PPO Gold	BlueOptions(Silver) PPO Silver	BlueOptions (Silver) HDHP Silver Indv	BlueOptions (Silver) HDHP Silver Family
Plan Number	**03359**	**05774**	**05194**	**05195**
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)				
In-Network	$1,200 / $2,400	$4,000 / $8,000	$2,800	$5,600 / $5,600
Out-of-Network	$2,400 / $4,800	$8,000 / $16,000	$5,600	$11,200 / $11,200
Coinsurance (BCBSF pays / Member pays)				
In-Network	20%	30%	20%	20%
Out-of-Network	40%	50%	50%	50%
Out of Pocket Maximum (Per Person/Family Aggregate)				
In-Network	$6,000 / $12,000	$7,000 / $14,000	$7,000	$7,050 / $14,000
Out-of-Network	$12,000 / $24,000	$14,000 / $28,000	$14,000	$28,000
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	$50 Copayment	$70 Copayment	DED + 30%	DED + 30%
In-Network Specialist	$70 Copayment	$100 Copayment	DED + 30%	DED + 30%
Out-of-Network	DED + 40%	DED + 50%	DED + 50%	DED + 50%
Convenient Care Center				
In-Network	$50 Copayment	$70 Copayment	DED + 30%	DED + 30%
Out-of-Network	Ded + 40%	DED + 50%	DED + 40%	DED + 40%
Physician Services at Hospital				
In-Network	DED + 20%	DED + 30%	DED + 30%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 50%	INN DED + 50%
Preventive Services-Adult & Child Wellness Services				
Office Services				
In-Network Family Physician	$0	$0 Copayment	$0 Copayment	$0 Copayment
In-Network Specialist	$0	$0 Copayment	$0 Copayment	$0 Copayment
Out-of-Network	40%	50%	40%	40%
Medical / Surgical Care at a Facility				
Ambulatory Surgical Center (ASC)				
In-Network	$200 Copayment	$350 Copayment	DED + 30%	DED + 30%
Out-of-Network	Ded + 40%	DED + 50%	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.	• OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.		• OON only; if admitted as an Inpatient from ER, apply Inpatient Hospital INN Option 1 cost share.
In-Network	$300 per day/$1500 max	DED + 30%	DED + 30%	DED + 30%
In-Network				
Out-of-Network	DED + 40%	DED + 50%	DED + 50%	DED + 50%
Outpatient Hospital Facility (per visit) (Surgical)				
In-Network	$300 copay	DED + 30%	DED + 30%	DED + 30%, Option 2: DED + 35%
Out-of-Network	DED + 40%	DED + 50%	DED + 50%	DED + 50%

2024 Summary of Plans Comparison

Product	BlueOptions (Gold) PPO Gold	BlueOptions(Silver) PPO Silver	BlueOptions (Silver) HDHP Silver Indv	BlueOptions (Silver) HDHP Silver Family
Plan Number	**03359**	**05774**	**05194**	**05195**
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	$450 copayment	DED + 30%	DED + 30%
Out-of-Network	$250 Copayment	$450 copayment	INN DED + 30%	INN DED + 30%
Urgent Care Centers				
Value Choice Urgent Care Provider	$0 Copayment - Visits 1-2 PBP $70 Copay for remaining Visits PBP	$0 Copayment - Visits 1-2 PBP $100 Copay for remaining Visits PBP	DED	DED
In-Network	$70 Copayment	$100 Copayment	DED + 30%	DED + 30%
Out-of-Network	INN DED + $70 Copayment	$100 Copayment	INN DED + 30%	INN DED + 30%
Mental Health and Substance Dependency Services				
Physician Office				
In-Network Family Physician	$0 Copayment	$0 Copayment	DED + 30%	DED + 30%
In-Network Specialist	$0 Copayment	$0 Copayment	DED + 30%	DED + 30%
Out-of-Network	40%	50%	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	DED + 30%	DED + 30%
Out-of-Network	40%	50%	DED + 50%	DED + 50%
Outpatient Hospital Facility				
In-Network	$0 Copayment	$0	DED + 30%	DED + 30%
Out-of-Network	40%	50%	DED + 50%	DED + 50%
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/$60/$100	$15/$70/$110	CYD + 30%	CYD + 30%
Rx- Specialty	$250	$350	CYD + 30%	CYD + 30%
MAIL ORDER -Generic/Brand/Non-Preferred	$40/$150/$250	$40/$175/$275	CYD + 30%	CYD + 30%
Out-of-Network				
RETAIL -Generic/Brand/Non-Preferred	50%	50%	50%	50%
MAIL ORDER -Generic/Brand/Non-Preferred	50%	50%	50%	50%
HSA Account Funding			**EE Only = $300**	**EE + 1 = $600, EE + 2 or more + $900**