2024 Summary Plans Comparison

Product	BlueCare (Gold) HMO Gold	BlueOptions (Gold) PPO Gold	BlueOptions (Gold) HDHP Gold Indv	BlueOptions (Gold) HDHP Gold Family	BlueOptions(Silver) PPO Silver
Plan Number	**47**	**03359**	**03160**	**03161**	**05774**
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	$4,000 / $8,000
Out-of-Network	NA / NA	$2,400 / $4,800	$4,000	$8,000/$8,000	$8,000 / $16,000
Coinsurance (BCBSF pays / Member pays)					
In-Network	20%	20%	20%	20%	30%
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	$7,000 / $14,000
Out-of-Network	NA / NA	$12,000 / $24,000	$10,800	$21,600/$21,600	$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.				• 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	$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%	$70 Copayment
In-Network Specialist	$65 Copayment	$70 Copayment	DED + 20%	DED + 20%	$100 Copayment
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%	$70 Copayment
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 + 30%
Out-of-Network	Not Covered	INN DED + 20%	INN DED + 20%	INN DED + 20%	INN DED + 30%
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%	$350 Copayment
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 + 30%
In-Network					
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 + 30%
Out-of-Network	Not Covered	DED + 40%	DED + 40%	DED + 40%	DED + 50%

2024 Summary Plans Comparison

Product	BlueCare (Gold) HMO Gold	BlueOptions (Gold) PPO Gold	BlueOptions (Gold) HDHP Gold Indv	BlueOptions (Gold) HDHP Gold Family	BlueOptions(Silver) PPO Silver
Plan Number	**47**	**03359**	**03160**	**03161**	**05774**
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.				• 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%	$450 copayment
Out-of-Network	$250 Copayment	$250 Copayment	INN DED + 20%	INN DED + 20%	$450 copayment
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 $100 Copay for remaining Visits PBP
In-Network	$65 Copayment	$70 Copayment	DED + 20%	DED + 20%	$100 Copayment
Out-of-Network	Not Covered	INN DED + $70 Copayment	DED + 20%	DED + 20%	$100 Copayment
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%	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%	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/$70/$110
Rx- Specialty	$250	$250	CYD + 20%	CYD + 20%	$350
MAIL ORDER Generic/Brand/Non-Preferred	$40/$115/$165	$40/$150/$250	CYD + 20%	CYD + 20%	$40/$175/$275
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**	