

Alachua County Employees 2023 Benefit Summary

Product	BlueOptions		BlueOptions	
Plan Number	05770		05781	
Effective Date	10/1/2023		10/1/2023	
Employee Premium	Bi-Weekly	Monthly	Bi-Weekly	Monthly
Employee only	\$47.35	\$94.70	\$17.44	\$34.88
Employee + 1	\$226.31	\$452.62	\$154.80	\$309.60
Employee + 2 or More	\$319.06	\$638.12	\$218.24	\$436.48
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)			HRA Employee: \$750 HRA Emp + 1/Family: \$1,500	
In-Network	\$500/\$1,500		\$1,500/\$3,000	
Out-of-Network	\$750/\$2,500		\$3,000/\$6,000	
Coinsurance (BCBSF pays / Member pays)				
In-Network	80% / 20%		80% / 20%	
Out-of-Network	50% / 50%		50% / 50%	
Out of Pocket Maximum (Per Person/Family Aggregate)				
In-Network	\$2,500/\$5,000		\$4,000/\$8,000	
Out-of-Network	\$5,000/\$10,000		\$8,000/\$16,000	
Medical Pharmacy OOP Maximum (Per Person per calendar month)				
In-Network (Preferred/Non-Preferred)	\$200		\$200	
Out-of-Network	NA		NA	
Medical / Surgical Care by a Physician				
Virtual Visits				
In-Network Family Physician/Value Choice PCP	\$25 Copayment		DED + 20%	
In-Network Specialist/Value Choice Specialist	\$45 Copayment		DED + 20%	
Out-of-Network	Not Covered		Not Covered	
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.	
In-Network Family Physician/Value Choice PCP	\$25 Copayment		DED + 20%	
In-Network Specialist/Value Choice Specialist	\$45 Copayment		DED + 20%	
Out-of-Network	DED + 50%		DED + 50%	
Allergy Injections (Office)				
In-Network Family Physician/Value Choice PCP	\$10 Copayment		DED + 20%	
In-Network Specialist/Value Choice Specialist	\$10 Copayment		DED + 20%	
Out-of-Network	DED + 50%		DED + 50%	
Health Care Professional Administered Medications in the Office (Medical Pharmacy)				
In-Network (Preferred & Non-Preferred)	20%		20%	
Out-of-Network	DED + 50%		DED + 50%	
Convenient Care Center				
In-Network	\$25 Copayment		DED + 20%	
Out-of-Network	DED + 50%		DED + 50%	
Physician Services at Hospital				
In-Network	\$100 Copayment		DED + 20%	
Out-of-Network	\$100 Copayment		INN DED + 20%	
Radiology, Pathology and Anesthesiology Provider Services at Hospital				
In-Network	\$100 Copayment		DED + 20%	
Out-of-Network	\$100 Copayment		INN DED + 20%	
Radiology, Pathology and Anesthesiology Provider Services at ASC				
In-Network	\$45 Copayment		DED + 20%	
Out-of-Network	\$45 Copayment		INN DED + 20%	
Physician Services at Locations other than Office, Hospital and ER				
In-Network Family Physician	\$25 Copayment		DED + 20%	

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In-Network Specialist	\$45 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Preventive Services-Adult and Child Wellness Services		
Office Services		
In-Network Family Physician	\$0 Copayment	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment
Out-of-Network	50%	50%
Independent Clinical Laboratory		
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	50%	50%
Independent Diagnostic Testing Center		
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	50%	50%
Mammograms	• Includes Routine and Diagnostic Mammograms	• Includes Routine and Diagnostic Mammograms
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment
Colonoscopies		
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment
Medical / Surgical Care at a Facility		
Ambulatory Surgical Center (ASC)		
In-Network	\$150 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
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.
In-Network	Option 1: \$600 Copayment	Option 1: DED + 20%
	Option 2: \$1000 Copayment	Option 2: DED + 20%
Out-of-Network	\$3,500 Copayment	\$0 PAD + DED + 50%
Outpatient Hospital Facility (per visit) (Surgical and Non-Surgical)		
In-Network	Option 1: \$250 Copayment	Option 1: DED + 20%
	Option 2: \$300 Copayment	Option 2: DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Emergency and Urgent Care		
Emergency Room Facility (per visit)	• 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	\$300 Copayment	DED + 20%
Out-of-Network	\$300 Copayment	INN Ded + 20%
Physician Services at ER		
In-Network	\$100 Copayment	DED + 20%
Out-of-Network	\$100 Copayment	INN Ded + 20%
Urgent Care Centers		
Value Choice Urgent Care Provider	\$50 Copayment	DED+20%
In-Network	\$50 Copayment	DED + 20%
Out-of-Network	DED + \$50 Copayment	DED + 20%
Ambulance		
In-Network	DED + 20%	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 20%
Diagnostic Testing (e.g., Lab, x-ray)		
Physician Office		
In-Network Family Physician/Value Choice PCP	\$25 Copayment	DED + 20%
In-Network Specialist/Value Choice Specialist	\$45 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Independent Clinical Laboratory		
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	DED + 50%	DED + 50%
Independent Diagnostic Testing Center		
In-Network	\$50 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%

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Outpatient Hospital Facility		
In-Network	Option 1 & 2: DED + 20%	Option 1 & 2: DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)		
Physician Office		
In-Network Family Physician/Value Choice PCP	\$200 Copayment	DED + 20%
In-Network Specialist/Value Choice Specialist	\$200 Copayment	DED + 50%
Out-of-Network	DED + 50%	DED + 50%
Independent Diagnostic Testing Center		
In-Network/Value Choice Provider	\$200 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Outpatient Hospital Facility		
In-Network	Option 1 & 2: DED + 20%	Option 1 & 2: DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Outpatient Therapy		
Physician Office		
Value Choice PCP & Specialist	\$25 Copayment	DED + 20%
In-Network Family Physician & Specialist	\$25 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Outpatient Rehabilitation Facility		
In-Network	\$25 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Outpatient Hospital Facility		
In-Network	Option 1: \$45 Copayment	DED + 20%
	Option 2: \$60 Copayment	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Mental Health Services & Substance Dependency Services		
Virtual Visits	• Includes coverage for both Virtual Mental Health and Virtual Substance Dependency Services.	• Includes coverage for both Virtual Mental Health and Virtual Substance Dependency Services.
In-Network Family Physician	\$0 Copayment	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment
Out-of-Network	Not Covered	Not Covered
Physician Office		
In-Network Family Physician	\$0 Copayment	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment
Out-of-Network	50%	50%
Inpatient Hospital Facility	• 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	Option 1: \$0 Copayment	Option 1: \$0 Copayment
	Option 2: \$0 Copayment	Option 2: \$0 Copayment
Out-of-Network	\$500 Copayment	50%
Outpatient Hospital Facility		
In-Network	Option 1: \$0 Copayment	Option 1: \$0 Copayment
	Option 2: \$0 Copayment	Option 2: \$0 Copayment
Out-of-Network	50%	50%
Emergency Room Facility(per visit)		
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment
Physician Services at Hospital		
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment
Physician Services at ER		
In-Network	\$0 Copayment	\$0 Copayment
Out-of-Network	\$0 Copayment	\$0 Copayment
Physician Services at Locations other than Office, Hospital and ER		
In-Network Family Physician	\$0 Copayment	\$0 Copayment
In-Network Specialist	\$0 Copayment	\$0 Copayment
Out-of-Network	50%	50%
Other Special Services and Locations		

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Durable Medical Equipment/Skilled Nursing Facility/Home Health Care/Hospice/Birthing or Dialysis Centers/Diabetic Equipment & Supplies		
In-Network	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Health Care Professional Administered Medications in Home Setting (Medical Pharmacy)		
In-Network (Preferred & Non-Preferred)	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%
Benefit Maximums		
Home Health Care		
Home Health Care Combined (INN & OON)	20 Visits PBP	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP	30 Days PBP
Outpatient Therapy & Spinal Manipulations	35 Visits PBP	35 Visits PBP
Skilled Nursing Facility	60 Days PBP	60 Days PBP
Spinal Manipulations	26 PBP	26 PBP
Prescription Drugs		
Deductible	\$100 Brand only	\$1,500/\$3,000
In-Network		(deductible inclusive of RX and medical)
- Retail		
Generic/Brand/Non-Preferred	\$10/\$50/\$80	\$10/\$50/\$80 after deductible
- Mail Order		
Generic/Brand/Non-Preferred	\$25/\$125/\$200	\$25/\$125/\$200 after deductible
Out-of-Network		
Retail and Mail Order		
Generic/Brand/Non-Preferred	50%	50%

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