FCSRMC
FLORIDA COLLEGE SYSTEM RISK MANAGEMENT CONSORTIUM

ACTIVE EMPLOYEE
2024 Medical Plan Comparison

DAYTONA STATE COLLEGE

	Florida Blue GOLD PPO 03359	Florida Blue SILVER PPO 05774	Florida Health Care Plans GOLD HMO TS3	Florida Health Care Plans SILVER HMO TS4
Cost Sharing - Member's Responsibility				
Deductible (DED) (Per Person/Family Aggregate)				
In-Network	$1,200 / $2,400	$4,000 / $8,000	$750 / $1,500	$3,000 / $9,000
Out-of-Network	$2,400 / $4,800	$8,000 / $16,000	N/A	N/A
Coinsurance (BCBSF pays / Member pays)				
In-Network	80% / 20%	70% / 30%	80% / 20%	80% / 20%
Out-of-Network	60% / 40%	50% / 50%	N/A	N/A
Out of Pocket Maximum (Per Person/Family Aggregate)				
In-Network	$6,000 / $12,000	$7,000 / $14,000	$5,000 / $10,000	$6,350 / $12,700
Out-of-Network	$12,000 / $24,000	N/A	N/A	N/A
Medical / Surgical Care by a Physician				
Office Services				
In-Network Family Physician	$50	$70	$30	$40
In-Network Specialist	$70	$100	$50	$65
Out-of-Network	DED + 40%	DED + 50%	N/A	N/A
Convenient Care Center - FHCP Wellness Centers ONLY				
In-Network	$50 Copayment	$70 Copayment	$10	$10
Out-of-Network	DED + 40%	DED + 50%	N/A	N/A
Physician Services at Hospital				
In-Network	DED + 20%	DED + 30%	$0	DED + 20%
Out-of-Network	INN DED + 20%	INN DED + 30%	N/A	N/A
Preventive Services (Adult & Well Child)				
Office Services				
In-Network Family Physician	$0	$0	Covered In Full	Covered In Full
In-Network Specialist	$0	$0	Covered In Full	Covered In Full
Out-of-Network	40%	50%	N/A	N/A
Medical / Surgical Care at a Facility				
Ambulatory Surgical Center (ASC)				
In-Network	$200 Copayment	$350 Copayment	$300 Copayment	$350 Copayment
Out-of-Network	DED + 40%	DED + 50%	N/A	N/A
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	$300/Day $1,500 Max	DED + 30%	$300/Day $1,500 Max	DED + 20%
Out-of-Network	DED + 40%	DED + 50%	N/A	N/A
Outpatient Hospital Facility (per visit) (Surgical)				
In-Network	$300 Copayment	DED + 30%	$500 Copay	DED + 20%
Out-of-Network	DED + 40%	DED + 50%	N/A	N/A
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	$450 Copayment	$250 Copayment	$400 Copayment
Out-of-Network	$250 Copayment	$450 Copayment	$250 Copayment	$400 Copayment
Urgent Care Centers				
In-Network	$70 Copayment	$100 Copayment	$65 Copayment	$100 Copayment
Out-of-Network	INN DED + $70 Copay	$100 Copayment	$65 Copayment	$100 Copayment
Ambulance				
In-Network			DED + 20%	DED + 20%

Comparison continued on page 2 (over)

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Mental Health & Substance Dependency Services				
Physician Office				
In-Network Family Physician	$0 Copayment	$0 Copayment	$30	$40
In-Network Specialist	$0 Copayment	$0 Copayment	$50	$65
Out-of-Network	40%	50%	N/A	N/A
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	$0 Copayment	$0 Copayment	$300 Per Day/$1,500 Max	DED + 20%
Out-of-Network	40%	50%	N/A	N/A
Outpatient Hospital Facility				
In-Network	$0 Copayment	$0 Copayment	$50 (per visit)	$65 (per visit)
Out-of-Network	40%	50%	N/A	N/A
Telemedicine				
	Teladoc - FL Blue		**Doctor On Demand - FHCP**	
In-Network	$0 General Medicine $10 Dermatology $0 Behavioral	$0 General Medicine $10 Dermatology $0 Behavioral	$0 General Medicine $0 N/A $30 Behavioral	$0 General Medicine $0 N/A $30 Behavioral
Out-of-Network	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Drugs				
In-Network				
- Retail				
Generic/(Non-Preferred Gen (FHCP)/Brand/Non-Preferred	$15 / $60 / $100	$15 / $70 / $110	$3 / $10 / $30 / $55	$3 / $10 / $30 / $55
RxSpecialty	$250	$350	$250	$250
- Mail Order				
Generic/Brand/Non-Preferred	$40 / $150 / $250	$40 / $175 / $275	$6 / $27 / $87 / $162	$6 / $27 / $87 / $162
Out-of-Network				
- Retail				
Generic/Brand/Non-Preferred	50%	50%	Not Covered	Not Covered
- Mail Order				
Generic/Brand/Non-Preferred	50%	50%	Not Covered	Not Covered
Pref Generic/Non-Preferred Gen(FHCP)/Pref Brand/Non-Preferred Brand/Specialty Rx	Preventive - Free $15 / $60 / $100 / $250	Preventive - Free $15 / $70 / $110 / $350	Not Covered	Not Covered
	Walgreens is the featured pharmacy with lower costs; may also use Publix, Winn Dixie, & Walmart. CVS owned pharmacies (Target) not in pharmacy network		Select Walgreens - see provider listing locations & limitations Pref Gen $15 / Non-Pref Gen $15 / Pref Brand $35 / Non-Pref Brand $60 / Speciality - FHCP Pharmacy Only	
Retail - Out of Network Generic/Brand/Non-Preferred	50%	50%	N/A	N/A

24-Pay per Year

	FL Blue GOLD PPO 03359		FL Blue SILVER PPO 05774		FHCP GOLD HMO TS3		FHCP SILVER HMO TS4	
	Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay
Employee	$72.40	$36.20	$33.06	$16.53	$75.10	$37.55	$33.95	$16.98
Employee & Spouse	$395.72	$197.86	$291.48	$145.74	$409.76	$204.88	$299.26	$149.63
Employee & Child(ren)	$339.04	$169.52	$249.90	$124.95	$351.26	$175.63	$256.62	$128.31
Employee & Family	$630.30	$315.15	$517.60	$258.80	$653.10	$326.55	$531.36	$265.68

18-Pay per Year

	FL Blue GOLD PPO 03359		FL Blue SILVER PPO 05774		FHCP GOLD HMO TS3		FHCP SILVER HMO TS4	
	Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay	Per Month	Per Pay
Employee	$96.54	$48.27	$44.06	$22.03	$100.14	$50.07	$45.28	$22.64
Employee & Spouse	$527.63	$263.81	$388.66	$194.33	$546.36	$273.18	$399.00	$199.50
Employee & Child(ren)	$452.06	$226.03	$333.22	$166.61	$468.36	$234.18	$342.16	$171.08
Employee & Family	$840.40	$420.20	$766.80	$383.40	$870.82	$435.41	$708.48	$354.24