

COBRA EMPLOYEE 2023 Medical Plan Comparison



**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

COBRA ENROLLES

COBRA Enrollee Only
COBRA Enrollee + Spouse
COBRA Enrollee + Child(ren)
COBRA Enrollee + Family

FL Blue GOLD PPO 03359	FL Blue SILVER PPO 05774	FHCP GOLD HMO TS3	FHCP SILVER HMO TS4
Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium
\$698.70	\$637.50	\$678.02	\$640.56
\$1,467.78	\$1,339.26	\$1,421.88	\$1,344.36
\$1,257.66	\$1,147.50	\$1,218.90	\$1,152.60
\$2,026.74	\$1,849.26	\$1,964.52	\$1,856.40