

CITY OF JACKSONVILLE
2021 HEALTH PLAN COMPARISONS
Effective January 1, 2021

	UF HEALTH DIRECTCARE	BLUECARE HMO 48	BLUE OPTIONS PPO 5782		BLUECARE HD 65
	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
FREE!!! Preventative Services such as Annual Physical, Mammogram, Pap Smear, Annual at OB/GYN					
Family Physician & Specialist	\$0 CoPay	\$0 CoPay	\$0 CoPay	50%	\$0 CoPay
Medical / Surgical Care by Physican					
Family Physician	\$10 CoPay	\$25 CoPay	\$30 CoPay	DED + 50%	\$25 CoPay
Specialist	\$30 CoPay	\$35 CoPay	\$40 CoPay	DED + 50%	DED + 30%
DEDUCTIBLE					
Individual	\$250	\$300	\$750	\$1,000	\$1,500
Family	\$500	\$600	\$1,500	\$2,000	\$3,000
Out-of-Pocket Maximum (Includes Deductible, Coinsurance and Copayments)					
Individual	\$1,500 Medical + \$1,000 Pharmacy	\$2,500	\$6,000	\$9,000	\$5,000
Family	\$3,000 Medical + \$2,000 Pharmacy	\$5,000	\$12,000	\$18,000	\$10,000
Physician Services at Hospital					
Outpatient and Inpatient	DED + 20%	DED + 30%	DED + 30%	DED + 50%	DED + 30%
Medical / Surgical Care at a Facility					
Inpatient Hospital Facility (per admit); Outpatient Hospital; Facility or Ambulatory; and Surgical Center (per visit)	DED + 20%	DED + 30%	DED + 30%	DED + 50%	DED + 30%

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Emergency and Urgent Care Facility Charges (Separate physican cost share may apply)					
Emergency Room Facility (per admit)	DED + 20%	\$300 CoPay + 30%	\$300 CoPay + 30%	\$300 CoPay + 30%	DED + 30%
Urgent Care Centers	\$25 CoPay	\$30 CoPay	\$35 CoPay	DED + 50%	\$25 CoPay
Ambulance	DED + 20%	\$200 CoPay	\$200 CoPay	\$200 CoPay	DED + 30%
Diagnostic Testing (e.g, Lab, X-ray)					
Independent Clinical Laboratory	\$0 CoPay	\$0 CoPay	\$0 CoPay	DED + 50%	\$0 CoPay
Diagnostic Testing Center	\$30 CoPay	\$30 CoPay	\$35 CoPay	DED + 50%	DED + 30%
Advanced Imaging (MRI, CAT & PET)	\$100 CoPay	\$300 CoPay	\$300 CoPay	DED + 50%	DED + 30%
Outpatient Therapy (60 visits per benefits year)					
In Network Family Physician and Specialist	DED + 20%	\$35 CoPay	\$40 CoPay	DED + 50%	DED + 30%
Prescription Drugs					
RETAIL: Generic	\$10	\$10	\$10	DED + Coins	\$10
Preferred Brand	\$40	\$40	\$40	DED + Coins	\$40
Non-Preferred Brand	\$75	\$75	\$75	DED + Coins	\$75
MAIL ORDER: Generic	\$20	\$20	\$20	Not Covered	\$20
Preferred Brand	\$80	\$80	\$80	Not Covered	\$80
Non-Preferred Brand	\$150	\$150	\$150	Not Covered	\$150