CITY OF JACKSONVILLE
2020 HEALTH PLAN COMPARISONS
Effective January 1, 2020

	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	**$750**	**$300**	**$750**	**$1,000**	**$1,500**
Family	**$1,500**	**$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	**DED + 20%**	**$30 CoPay**	**$35 CoPay**	**DED + 50%**	**DED + 30%**
Advanced Imaging (MRI, MRA, PET, CT & Nuclear Medicine	**DED + 20%**	**$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-Preffered 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-Preffered Brand	**$150**	**$150**	**$150**	**Not Covered**	**$150**