

Levy County BOCC

Overall Increase

4.5%

Sample Group Health Rates - \$1,000,000 Surplus Release

Medical - PRM Plan BlueOptions 03748

Coverage	Active Rates		COBRA	Reduced Retiree	
	Current	Proposed 10/1/2020		Current	Proposed 10/1/2020
EE	\$1,039.55	\$1,086.32	\$1,108.05	\$769.51	\$804.13
Additional for Spouse	\$929.95	\$971.79	\$991.23	\$650.96	\$680.25
Additional for Child	\$811.53	\$848.04	\$865.00		
Additional for Family	\$1,015.92	\$1,061.63	\$1,082.86		

Medical - PRM Plan HMO 55

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$974.20	\$1,018.03	\$1,038.39	\$718.78	\$751.12
Additional for Spouse	\$871.49	\$910.70	\$928.91	\$610.01	\$637.46
Additional for Child	\$760.45	\$794.67	\$810.56		
Additional for Family	\$952.03	\$994.87	\$1,014.77		

Medical - PRM Plan HMO 59

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$945.54	\$988.08	\$1,007.84	\$699.90	\$731.39
Additional for Spouse	\$870.92	\$910.11	\$928.31	\$609.63	\$637.06
Additional for Child	\$760.09	\$794.29	\$810.18		
Additional for Family	\$951.52	\$994.33	\$1,014.22		

Medical - PRM Plan PPO 0727

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$916.94	\$958.20	\$977.36	\$678.71	\$709.25
Additional for Spouse	\$870.48	\$909.65	\$927.84	\$609.33	\$636.74
Additional for Child	\$759.71	\$793.89	\$809.77		
Additional for Family	\$951.00	\$993.79	\$1,013.67		

Medical - PRM Plan BlueOptions 05168/05169

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$891.37	\$931.48	\$950.11	\$659.81	\$689.50
Additional for Spouse	\$797.37	\$833.25	\$849.92	\$558.13	\$583.24
Additional for Child	\$695.83	\$727.14	\$741.68		
Additional for Family	\$871.13	\$910.33	\$928.54		

Medical - PRM Plan BlueOptions 03559

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$880.91	\$920.55	\$938.96	\$652.09	\$681.43
Additional for Spouse	\$788.01	\$823.47	\$839.94	\$551.60	\$576.42
Additional for Child	\$687.65	\$718.59	\$732.96		
Additional for Family	\$860.87	\$899.60	\$917.59		

Medical - PRM Plan BlueOptions 03359

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$857.77	\$896.36	\$914.29	\$634.90	\$663.47
Additional for Spouse	\$767.33	\$801.85	\$817.89	\$537.10	\$561.26
Additional for Child	\$669.57	\$699.70	\$713.69		
Additional for Family	\$838.24	\$875.96	\$893.48		

Medical - PRM Plan BlueOptions 05360

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$816.04	\$852.76	\$869.82	\$604.04	\$631.22
Additional for Spouse	\$729.98	\$762.82	\$778.08	\$510.94	\$533.93
Additional for Child	\$637.04	\$665.70	\$679.01		
Additional for Family	\$797.48	\$833.36	\$850.03		

Medical - PRM Plan BlueOptions 05180/05181

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$792.42	\$828.07	\$844.63	\$586.56	\$612.95
Additional for Spouse	\$708.85	\$740.74	\$755.55	\$496.18	\$518.50
Additional for Child	\$618.59	\$646.42	\$659.35		
Additional for Family	\$774.43	\$809.27	\$825.46		

Medical - PRM Plan BlueOptions 05901

Coverage	Current	Proposed 10/1/2020	Proposed 10/1/2020	Current	Proposed 10/1/2020
EE	\$720.65	\$753.07	\$768.13	\$533.43	\$557.43
Additional for Spouse	\$644.66	\$673.66	\$687.13	\$451.24	\$471.54
Additional for Child	\$562.53	\$587.84	\$599.60		
Additional for Family	\$704.26	\$735.95	\$750.67		

Summary of Benefits for Covered Services	BlueChoice	BlueCare	BlueCare	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions
Per Benefit Period (BPM)	0727	55	59	03748	03359	05360	05901	HSA-Compatible 05168/05169	HSA-Compatible 05180/05181	
Emergency Medical Care										
Urgent Care Centers (UCC)										
In-Network	\$15	\$10	\$35	\$20	\$35	\$75	\$75	DED	DED	
Out-of-Network	\$15	\$10	\$35	\$20	\$35	\$75	\$75	DED	DED	
Emergency Room Facility Services (per visit)										
In-Network	20% after DED	\$50	\$50	\$50	\$100	20% after DED	50% after DED	DED	DED	
Out-of-Network	20% after DED	\$50	\$50	\$50	\$100	20% after DED	50% after DED	DED	DED	
Ambulance Services										
In-Network	20% after DED	\$0	\$0	DED	20% after DED	20% after In-NWk DED	50% after DED	DED	DED	
Out-of-Network	20% after In-Network DED	\$0	\$0	In-Network DED	20% after DED	20% after In-NWk DED	50% after In-NWk DED	In-NWk DED	In-NWk DED	
Outpatient Diagnostic Services										
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays)(includes Provider Services)										
In-Network - Diagnostic Services (ecopr. AIS)	\$15	\$0	\$0	\$50	\$100	20% after DED	\$50	DED	DED	
In-Network - Advanced Imaging Services (AIS)(MRI, MRA, PET, CT, Nuclear Med.)	\$15	\$0	\$0	\$50	\$100	20% after DED	\$200	DED	DED	
Out-of-Network	40% after DED	Not Covered	Not Covered	40% after DED	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Independent Clinical Lab (e.g. Blood Work)										
In-Network	20%	\$0	\$0	\$0	\$0	\$0	\$0	DED	DED	
Out-of-Network	40%	Not Covered	Not Covered	40% after DED	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays)										
In-Network	20% after DED	\$100	\$200	Option 1 - \$100 Option 2 - \$200	Option 1 - \$200 Option 2 - \$300	Option 1 - 20% after DED Option 2 - 20% after DED	Option 1 - \$300 Option 2 - \$400	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED	
Out-of-Network	40% after DED	Not Covered	Not Covered	\$300	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Hospital/Surgical										
Ambulatory Surgical Center Facility (ASC)										
In-Network	20% after DED	\$100	\$200	\$50	\$100	20% after DED	50% after DED	DED	DED	
Out-of-Network	40% after DED	Not Covered	Not Covered	40% after DED	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Outpatient Hospital Facility Services (per visit)										
In-Network	20% after DED	\$5	\$5	Option 1 - \$100 Option 2 - \$200	Option 1 - \$20 Option 2 - \$35	Option 1 - \$45 Option 2 - \$60	Option 1 - \$30 Option 2 - \$50	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED	
Out-of-Network	40% after DED	Not Covered	Not Covered	\$300	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
All other Services										
In-Network	20% after DED	\$100	\$200	Option 1 - \$100 Option 2 - \$200	Option 1 - \$200 Option 2 - \$300	Option 1 - 20% after DED Option 2 - 20% after DED	Option 1 - \$300 Option 2 - \$400	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED	
Out-of-Network	40% after DED	Not Covered	Not Covered	\$300	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Inpatient Hospital Facility and Rehabilitation Services (per admit)										
In-Network	20% after DED	\$250	\$150 (day), \$750 maximum	Option 1 - \$250 Option 2 - \$500	Option 1 - \$750 Option 2 - \$1,000	Option 1 - 20% after DED Option 2 - 20% after DED	Option 1 - \$2,000 Option 2 - \$3,000	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED	
Out-of-Network	\$300 PAD, then 40% after DED	Not Covered	Not Covered	\$750	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Mental Health/Substance Dependency										
Inpatient Hospitalization Facility Services (per admit)										
In-Network	20% after DED	\$250	\$150 (day), \$750 maximum	Option 1 - \$250 Option 2 - \$500	Option 1 - \$750 Option 2 - \$1,250	Option 1 - 20% after DED Option 2 - 20% after DED	Option 1 - \$2,000 Option 2 - \$3,000	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED	
Out-of-Network	\$300 PAD, then 40% after DED	Not Covered	Not Covered	\$750	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Outpatient Hospitalization Facility Service (per visit)										
In-Network	20% after DED	\$10	\$200	Option 1 - \$100 Option 2 - \$200	Option 1 - \$35 Option 2 - \$50	Option 1 - 20% after DED Option 2 - 20% after DED	Option 1 - \$300 Option 2 - \$400	Option 1 - DED Option 2 - DED	Option 1 - DED Option 2 - DED	
Out-of-Network	40% after DED	Not Covered	Not Covered	\$300	40% after DED	40% after DED	50% after DED	20% after DED	20% after DED	
Emergency Room Facility Services (per visit)										
In-Network	20% after DED	\$50	\$50	\$50	\$100	20% after DED	50% after DED	DED	DED	
Out-of-Network	20% after DED	\$50	\$50	\$50	\$100	20% after In-NWk DED	50% after DED	In-NWk DED	In-NWk DED	

Summary of Benefits for Covered Services	BlueChoice	BlueCare	BlueCare	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions	BlueOptions
Per Benefit Period (BPM)	0727	55	59	03748	06359	03359	05380	06501	05380	06501	05380	06501
Provider Services at Hospital												
Primary Care Physician / Specialist	20% after DED 40% after DED	\$0 Not Covered	Not Covered	\$0 \$0	20% after DED 40% after in-NWk DED	20% after DED 71% after in-NWk DED	20% after DED 40% after in-NWk DED	\$0 50% after in-NWk DED	20% after DED 40% after in-NWk DED	DED In-NWk DED	DED In-NWk DED	DED In-NWk DED
Out-of-Network												
Provider Services at ER	20% after DED 20% after DED	\$0 \$0	\$0	\$0 \$0	20% after DED 40% after in-NWk DED	20% after DED 71% after in-NWk DED	20% after DED 40% after in-NWk DED	\$0 50% after in-NWk DED	20% after DED 40% after in-NWk DED	DED In-NWk DED	DED In-NWk DED	DED In-NWk DED
Primary Care Physician / Specialist												
Out-of-Network												
Provider Services at Locations other than Hospital and ER	\$0 40% after DED	Not Covered	Not Covered	\$10 PCP / \$20 Spec. 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	50% after DED 50% after DED	20% after DED 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
Primary Care Physician / Specialist												
Out-of-Network												
Outpatient Office Visit	\$15 40% after DED	\$10 Not Covered	\$15 / \$35 Not Covered	\$10 PCP / \$20 Spec. 40% after DED	\$20 40% after DED	\$30 PCP/\$35 Spec. 40% after DED	\$25 PCP/\$35 Spec. 40% after DED	\$35 / \$75 50% after DED	\$25 PCP/\$35 Spec. 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
Primary Care Physician / Specialist												
Out-of-Network												
Other Provider Services												
Provider Services at Hospital												
In-Network	20% after DED 20% after DED	\$0 Not Covered	Not Covered	\$0 40% after DED	20% after DED 20% after in-NWk DED	20% after DED 20% after in-NWk DED	20% after DED 20% after in-NWk DED	50% after DED 50% after DED	20% after DED 20% after in-NWk DED	DED In-NWk DED	DED In-NWk DED	DED In-NWk DED
Out-of-Network												
Provider Services at ER	20% after DED 20% after DED	\$0 \$0	\$0	\$0 \$0	20% after DED 20% after in-NWk DED	20% after DED 71% after in-NWk DED	20% after DED 40% after in-NWk DED	50% after DED 50% after DED	20% after DED 40% after in-NWk DED	DED In-NWk DED	DED In-NWk DED	DED In-NWk DED
In-Network												
Out-of-Network												
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)												
In-Network	20% after DED 40% after DED	\$0 Not Covered	Not Covered	\$20 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	50% after DED 50% after DED	20% after DED 40% after DED	DED In-NWk DED	DED In-NWk DED	DED In-NWk DED
Out-of-Network												
Provider Services at Locations other than Office, Hospital and ER	20% after DED 40% after DED	\$0 Not Covered	Not Covered	\$10 PCP / \$20 Spec. 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	50% after DED 50% after DED	20% after DED 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
Primary Care Physician / Specialist												
Out-of-Network												
Other Specialist Services												
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations												
Outpatient Rehabilitation Therapy Center	20% after DED 40% after DED	\$10 Not Covered	\$35 Not Covered	\$20 40% after DED Option 1 - \$100 Option 2 - \$200 \$300	\$35 40% after DED Option 1 - \$150 Option 2 - \$250 \$350	\$35 40% after DED Option 1 - \$20 Option 2 - \$35 40% after DED	\$50 40% after DED Option 1 - \$45 Option 2 - \$60 40% after DED	\$75 50% after DED Option 1 - \$80 Option 2 - \$90 50% after DED	DED 20% after DED Option 1 - DED Option 2 - DED 20% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
Out-of-Network												
Outpatient Hospital Facility Services (per visit)	20% after DED 20% after DED	\$5 Not Covered	\$5 Not Covered	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	50% after DED 50% after DED	20% after DED 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
Out-of-Network												
Durable Medical Equipment, Prosthetics, Orthotics												
In-Network	20% after DED 40% after DED	\$0 Not Covered	Not Covered	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	50% after DED 50% after DED	20% after DED 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
Out-of-Network												
Home Health Care	20% after DED 20% after DED	\$0 No Maximum	Not Covered	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	50% after DED 50% after DED	20% after DED 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
In-Network												
Out-of-Network												
Hospice LTM	20% after DED 40% after DED	\$0 Not Covered	Not Covered	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	20% after DED 40% after DED	50% after DED 50% after DED	20% after DED 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
In-Network												
Out-of-Network												
Outpatient Therapy and Spinal Manipulations BPM	54 Visits (Includes up to 26 Spinal Manipulations) 60 Days 20% after DED 40% after DED	90 Days \$0 Not Covered	62 visits. Auth Req for Therapy 90 Days \$0 Not Covered	35 Visits (Includes up to 26 Spinal Manipulations) 60 Days Deductible 40% after DED	35 Visits (Includes up to 26 Spinal Manipulations) 60 Days Deductible 40% after DED	35 Visits (Includes up to 26 Spinal Manipulations) 60 Days Deductible 40% after DED	35 Visits (Includes up to 26 Spinal Manipulations) 60 Days Deductible 40% after DED	35 Visits (Includes up to 26 Spinal Manipulations) 60 Days Deductible 40% after DED	35 Visits (Includes up to 26 Spinal Manipulations) 60 Days Deductible 40% after DED	DED 20% after DED	DED 20% after DED	DED 20% after DED
In-Network												
Out-of-Network												
Skilled Nursing Facility BPM												
In-Network												
Out-of-Network												
Prescription Drug Coverage												
Retail (30 Days)												
Generic/Preferred Brand/Non-Preferred Brand	\$5 / \$35 / \$35 50% of Allowance	\$5 / \$25 / \$25 Not Covered	\$10 / \$25 / \$60 50% of allowance	\$10 / \$25 / \$60 50% of allowance	\$10 / \$25 / \$60 50% of allowance	\$10 / \$25 / \$60 50% of allowance	\$10 / \$25 / \$60 50% of allowance	\$10 / \$60 / \$100 50% of allowance	\$10 / \$25 / \$60 50% of allowance	DED 50% after in-NWk DED	DED 50% after in-NWk DED	DED 50% after in-NWk DED
In-Network												
Out-of-Network												
Mail Order (90 Days)												
Generic/Preferred Brand/Non-Preferred Brand	\$10 / \$70 / \$70 50% of Allowance	\$10 / \$50 / \$50 Not Covered	\$20 / \$50 / \$120 Not Covered	\$20 / \$50 / \$120 50% of allowance	\$20 / \$50 / \$120 50% of allowance	\$20 / \$50 / \$120 50% of allowance	\$20 / \$50 / \$120 50% of allowance	\$30 / \$180 / \$300 50% of allowance	\$20 / \$70 / \$140 50% of allowance	DED 50% after in-NWk DED	DED 50% after in-NWk DED	DED 50% after in-NWk DED
In-Network												
Out-of-Network												