Levy County BOCC Overall Increase 2.4%

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

Medical - PRM Plan BlueOptions 03748	Active Rates	Active Rates	COBRA	Reduced Retiree	Reduced Retiree
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$1,086.32	$1,112.71	$1,134.96	$804.13	$823.67
Additional for Spouse	$971.79	$995.40	$1,015.31	$680.25	$696.78
Additional for Child	$848.04	$868.64	$886.01		
Additional for Family	$1,061.63	$1,087.42	$1,109.17		

Medical - PRM Plan HMO 55					
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$988.08	$1,012.09	$1,032.33	$731.39	$749.16
Additional for Spouse	$910.11	$932.22	$950.86	$637.06	$652.54
Additional for Child	$794.29	$813.59	$829.86		
Additional for Family	$994.33	$1,018.49	$1,038.86		

Medical - PRM Plan PPO 0727					
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$958.20	$981.48	$1,001.11	$709.25	$726.48
Additional for Spouse	$909.65	$931.75	$950.39	$636.74	$652.21
Additional for Child	$793.89	$813.18	$829.44		
Additional for Family	$993.79	$1,017.93	$1,038.29		

Medical - PRM Plan BlueOptions 05168/05169					
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$931.48	$954.11	$973.19	$689.50	$706.25
Additional for Spouse	$833.25	$853.49	$870.56	$583.24	$597.41
Additional for Child	$727.14	$744.80	$759.70		
Additional for Family	$910.33	$932.45	$951.10		

Medical - PRM Plan BlueOptions 03559					
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$896.36	$918.14	$936.50	$663.47	$679.59
Additional for Spouse	$801.85	$821.33	$837.76	$561.26	$574.89
Additional for Child	$699.70	$716.70	$731.03		
Additional for Family	$875.96	$897.24	$915.18		

Medical - PRM Plan BlueOptions 05360					
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$852.76	$873.48	$890.95	$631.22	$646.55
Additional for Spouse	$762.82	$781.35	$796.98	$533.93	$546.90
Additional for Child	$665.70	$681.87	$695.51		
Additional for Family	$833.36	$853.61	$870.68		

Medical - PRM Plan BlueOptions 05180/05181					
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$828.07	$848.19	$865.15	$612.95	$627.84
Additional for Spouse	$740.74	$758.73	$773.90	$518.50	$531.09
Additional for Child	$646.42	$662.12	$675.36		
Additional for Family	$809.27	$828.93	$845.51		

Medical - PRM Plan BlueOptions 05904					
Coverage		Proposed 10/1/2021	Proposed 10/1/2021		Proposed 10/1/2021
EE		$796.97	$812.91		$589.93
Additional for Spouse		$712.93	$727.19		$499.03
Additional for Child		$622.12	$634.56		
Additional for Family		$778.86	$794.44		

Medical - PRM Plan BlueOptions 05901					
Coverage	Current	Proposed 10/1/2021	Proposed 10/1/2021	Current	Proposed 10/1/2021
EE	$753.07	$771.36	$786.79	$557.43	$570.97
Additional for Spouse	$673.66	$690.02	$703.82	$471.54	$482.99
Additional for Child	$587.84	$602.12	$614.16		
Additional for Family	$735.95	$753.83	$768.91		

Medical - PRM Plan BlueOptions 05787					
Coverage		Proposed 10/1/2021	Proposed 10/1/2021		Proposed 10/1/2021
EE		$721.37	$735.80		$533.96
Additional for Spouse		$645.30	$658.21		$451.69
Additional for Child		$563.09	$574.35		
Additional for Family		$704.97	$719.07		

Medical - PRM Plan BlueOptions 05172/05173					
Coverage		Proposed 10/1/2021	Proposed 10/1/2021		Proposed 10/1/2021
EE		$683.28	$696.95		$505.77
Additional for Spouse		$611.23	$623.45		$427.84
Additional for Child		$533.36	$544.03		
Additional for Family		$667.74	$681.09		

ACTIVE EMPLOYEE RATES	INCREASE FROM PRIOR YEAR	2.40%	4.50%			EMPLOYEE PAID - PER PAY PERIOD			
		LISTS "CURRENT" PREM EE @988.08		AMT +/-	% +/-			AMT +/-	% +/-
	Medical - PRM Plan HMO 55 (HMO 05)								
	Coverage	**10/1/2021**	**10/1/2020**			**10/1/2021**	**10/1/2020**		
Medical - PRM Plan HMO 55 (HMO 05)	EE	1012.09	1018.03	-5.94	-0.00587	70.07	70.48	-0.41	-0.00585
Medical - PRM Plan HMO 55 (HMO 05)	Additional for Spouse	932.22	910.7	21.52	0.023085	500.32	490.80	9.52	0.019028
Medical - PRM Plan HMO 55 (HMO 05)	Additional for Child	813.59	794.67	18.92	0.023255	445.57	437.25	8.32	0.018673
Medical - PRM Plan HMO 55 (HMO 05)	Additional for Family	1018.49	994.87	23.62	0.023191	540.14	529.65	10.49	0.019421
	Medical - PRM Plan HMO 59 (HMO 042)								
	Coverage								
Medical - PRM Plan HMO 59 (HMO 042)	EE	not offering HMO 59 FOR 2021	988.08						
Medical - PRM Plan HMO 59 (HMO 042)	Additional for Spouse		910.11						
Medical - PRM Plan HMO 59 (HMO 042)	Additional for Child		794.29						
Medical - PRM Plan HMO 59 (HMO 042)	Additional for Family		994.33						
	Medical - PRM Plan PPO 0727								
	Coverage								
Medical - PRM Plan PPO 0727	EE	981.48	958.2	23.28	0.023719	67.95	66.34	1.61	0.023694
Medical - PRM Plan PPO 0727	Additional for Spouse	931.75	909.65	22.1	0.023719	497.99	486.18	11.81	0.023715
Medical - PRM Plan PPO 0727	Additional for Child	813.18	793.89	19.29	0.023722	443.26	432.75	10.51	0.023711
Medical - PRM Plan PPO 0727	Additional for Family	1017.93	993.79	24.14	0.023715	537.76	525.01	12.75	0.023709
	Medical - PRM Plan BlueOptions 03559								
	Coverage	LISTS "CURRENT" PREM WRONG							
Medical - PRM Plan BlueOptions 03559	EE	918.14	920.55	-2.41	-0.00262	63.56	63.73	-0.17	-0.00267
Medical - PRM Plan BlueOptions 03559	Additional for Spouse	821.33	823.47	-2.14	-0.00261	442.64	443.79	-1.15	-0.0026
Medical - PRM Plan BlueOptions 03559	Additional for Child	716.7	718.59	-1.89	-0.00264	394.35	395.39	-1.04	-0.00264
Medical - PRM Plan BlueOptions 03559	Additional for Family	897.24	899.6	-2.36	-0.00263	477.67	478.93	-1.26	-0.00264
	Medical - PRM Plan BlueOptions 05901								
	Coverage								
Medical - PRM Plan BlueOptions 05901	EE	771.36	753.07	18.29	0.023711	53.40	52.14	1.26	0.023596
Medical - PRM Plan BlueOptions 05901	Additional for Spouse	690.02	673.66	16.36	0.023709	371.87	363.06	8.81	0.023691
Medical - PRM Plan BlueOptions 05901	Additional for Child	602.12	587.84	14.28	0.023716	331.30	323.45	7.85	0.023695
Medical - PRM Plan BlueOptions 05901	Additional for Family	753.83	735.95	17.88	0.023719	401.32	391.80	9.52	0.023722

BlueCare

For Public Risk Management Groups
2021-2022 Plan 55

Florida Blue HMO

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED is the amount the member is responsible for before Florida Blue HMO pays)	$0	Not covered
Coinsurance (Coinsurance is the percentage the member pays for services)	0%	Not covered
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$1,500 per person $3,000 per family	Not covered
Office Services		
Physician Office Services - Including Virtual Visits		
Primary Care Physician	$10 Copay	Not covered
Specialist	$10 Copay	Not covered
Convenient Care	$10 Copay	Not covered
Teladoc - General Medicine, Dermatology & Behavioral Health	$0 visits 1-4 then $10 Copay	N/A
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$10 Copay	Not covered
Specialist	$10 Copay	Not covered
Allergy Injections (per visit)		
Primary Care Physician	$5 Copay	Not covered
Specialist	$5 Copay	Not covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$0	Not covered
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	Not covered
Mammograms	$0	Not covered
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	Not covered
Emergency Medical Care		
Urgent Care Centers	$10 Copay	Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$50 Copay	$50 Copay
Ambulance Services	$0	$0
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$0	Not covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$0	Not covered
Independent Clinical Lab (e.g., Blood Work)	$0	Not covered
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	$100 Copay	Not covered

BlueCare

For Public Risk Management Groups
2021-2022 Plan 55

Florida Blue
HMO

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$100 Copay	Not covered
Outpatient Hospital Facility Services (per visit)		
Therapy Services	$5 Copay	Not covered
All other Services	$100 Copay	Not covered
Inpatient Hospital Facility and Rehabilitation Services (per admit)	$250 Copay	Not covered
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)	$250 Copay	Not covered
Outpatient Hospitalization Facility Service (per visit)	$10 Copay	Not covered
Emergency Room Facility Services (per visit)	$50 Copay	$50
Provider Services at Hospital		
Primary Care Physician / Specialist	$0	Not covered
Provider Services at ER		
Primary Care Physician / Specialist	$0	$0
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	$0	Not covered
Outpatient Office Visit		
Primary Care Physician / Specialist	$10 Copay	Not covered
Other Provider Services		
Provider Services at Hospital	$0	Not covered
Provider Services at ER	$0	$0
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	$0	Not covered
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician	$0	Not covered
Specialist	$0	Not covered
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$10 Copay	Not covered
Outpatient Hospital Facility Services (per visit)	$5 Copay	Not covered
Durable Medical Equipment, Prosthetics and Orthotics		
Motorized Wheelchair	$0	Not covered
All Other	$0	Not covered
Home Health Care	$0	Not covered

BlueCare

For Public Risk Management Groups
2021-2022 Plan 55

Florida Blue HMO

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services (continued)		
Skilled Nursing Facility	$0	Not covered
Hospice	$0	Not covered

Preauthorization for select services: Members don't need a referral to see a participating specialist, however authorizations are required for certain services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment. Ensure members know that **before an appointment** they should visit floridablue.com/Authorization or call the toll-free number on their member ID card to see if a prior authorization is required.

Benefit Maximums	
Home Health Care	No Maximum
Inpatient Rehabilitation Therapy	No Maximum
Outpatient Therapy	62 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	90 Days PBP

Prescription Drug Coverage	In-Network	Out of Network
Retail (30 days) (generic/preferred brand/non-preferred brand)	$5/$25/$25	Not Covered
Mail Order (90 days) (generic/preferred brand/non-preferred brand)	$10/$50/$50	Not Covered

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy

This summary is only a partial description of the many benefits and services covered by Florida Blue HMO, an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue HMO BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueChoice
For Public Risk Management Groups
2021-2022 Plan 0727

Florida Blue

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED is the amount the member is responsible for before Florida Blue pays)	$500 per person $1,500 per family	Combined with In-Network
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$1,500 per person $4,500 per family	Combined with In-Network
Office Services		
Physician Office Services - Including Virtual Visits		
Primary Care Physician	$15 Copay	40% after Deductible
Specialist	$15 Copay	40% after Deductible
Convenient Care	$15 Copay	40% after Deductible
Teladoc - General Medicine, Dermatology & Behavioral Health	$0 visits 1-4 then $15 Copay	N/A
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$15 Copay	40% after Deductible
Specialist	$15 Copay	40% after Deductible
Allergy Injections (per visit)		
Primary Care Physician	$5 Copay	40% after Deductible
Specialist	$5 Copay	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$15 Copay	40% after Deductible
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	40%
Mammograms	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	40%
Emergency Medical Care		
Urgent Care Centers	$15 Copay	$15 Copay
Emergency Room Facility Services (per visit)	20% after Deductible	20% after Deductible
Ambulance Services	20% after Deductible	20% after Deductible
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$15 Copay	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$15 Copay	40% after Deductible
Independent Clinical Lab (e.g., Blood Work)	20%	40%
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)	20% after Deductible	40% after Deductible

BlueChoice

Florida Blue

For Public Risk Management Groups
2021-2022 Plan 0727

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	20% after Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit) Therapy Services All other Services	 20% after Deductible 20% after Deductible	 40% after Deductible 40% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit)	20% after Deductible	$300 PAD, then 40% after Deductible
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)	20% after Deductible	$300 PAD, then 40% after Deductible
Outpatient Hospitalization Facility Service (per visit)	20% after Deductible	40% after Deductible
Emergency Room Facility Services (per visit)	20% after Deductible	20% after Deductible
Provider Services at Hospital Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Provider Services at ER Primary Care Physician / Specialist	20% after Deductible	20% after Deductible
Provider Services at locations other than Office, Hospital and ER Primary Care Physician / Specialist	$0	40% after Deductible
Outpatient Office Visit Primary Care Physician / Specialist	$15 Copay	40% after Deductible
Other Provider Services		
Provider Services at Hospital and ER	20% after Deductible	20% after Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	20% after Deductible	40% after Deductible
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	 20% after Deductible 20% after Deductible	 40% after Deductible 40% after Deductible
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations Outpatient Rehabilitation Therapy Center Outpatient Hospital Facility Services (per visit)	 20% after Deductible 20% after Deductible	 40% after Deductible 40% after Deductible
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	40% after Deductible
Home Health Care	20% after Deductible	40% after Deductible
Skilled Nursing Facility	20% after Deductible	40% after Deductible

BlueChoice

Florida Blue

For Public Risk Management Groups
2021-2022 Plan 0727

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services (continued)		
Hospice	20% after Deductible	40% after Deductible

Benefit Maximums	
Home Health Care	20 Visits PBP
Outpatient Therapy	54 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Prescription Drug Coverage	In-Network	Out of Network
Retail (30 days) (generic/preferred brand/non-preferred brand)	$5/$35/$35	50% of allowance
Mail Order (90 days) (generic/preferred brand/non-preferred brand)	$10/$70/$70	50% of allowance

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services **you need to get an approval** from Florida Blue before your service or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

This is not an insurance contract or Certificate of Coverage. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueChoice Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueOptions

Florida Blue

For Public Risk Management Groups
2021-2022 Plan 03559

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED is the amount the member is responsible for before Florida Blue pays)	$750 per person $2,250 per family	Combined with In-Network
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$3,000 per person $6,000 per family	Combined with In-Network
Office Services		
Physician Office Services - Including Virtual Visits		
Primary Care Physician	$20 Copay	40% after Deductible
Specialist	$35 Copay	40% after Deductible
Convenient Care	$20 Copay	40% after Deductible
Teladoc - General Medicine, Dermatology & Behavioral Health	$0 visits 1-4 then $20 Copay	N/A
Maternity (Cost Share for initial visit only)		
Primary Care Physician	$20 Copay	40% after Deductible
Specialist	$35 Copay	40% after Deductible
Allergy Injections (per visit)		
Primary Care Physician	$10 Copay	40% after Deductible
Specialist	$10 Copay	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$20 PCP/ $35 Spec	40% after Deductible
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	40%
Mammograms	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	$0
Emergency Medical Care		
Urgent Care Centers	$35 Copay	$35 Copay
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$100 Copay	$100 Copay
Ambulance Services	20% after Deductible	20% after In-Ntwk Ded
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$50 Copay	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$100 Copay	40% after Deductible
Independent Clinical Lab (e.g., Blood Work)	$0	40% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)		
Option 1	$150 Copay	40% after Deductible
Option 2	$250 Copay	40% after Deductible

BlueOptions

Florida Blue

For Public Risk Management Groups
2021-2022 Plan 03559

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$100 Copay	40% after Deductible
Outpatient Hospital Facility Services (per visit) Therapy Services Option 1 Option 2 All other Services Option 1 Option 2	 $150 Copay $250 Copay $150 Copay $250 Copay	 $350 Copay $350 Copay
Inpatient Hospital Facility and Rehabilitation Services (per admit) Option 1 Option 2	 $750 Copay $1000 Copay	 $2000 Copay
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit) Option 1 Option 2	 $750 Copay $1000 Copay	 $2000 Copay
Outpatient Hospitalization Facility Service (per visit) Option 1 Option 2	 $150 Copay $250 Copay	 $350 Copay
Emergency Room Facility Services (per visit)	$100 Copay + 20%	$100 Copay + 40%
Provider Services at Hospital and ER Primary Care Physician Specialist	 20% after Deductible 20% after Deductible	 20% after In-Ntwk Ded
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	 20% after Deductible 20% after Deductible	 40% after Deductible
Outpatient Office Visit Primary Care Physician Specialist	 $20 Copay $20 Copay	 40% after Deductible
Other Provider Services		
Provider Services at Hospital Primary Care Physician Specialist	 20% after Deductible 20% after Deductible	 20% after In-Ntwk Ded 20% after In-Ntwk Ded
Provider Services at ER	20% after Deductible 20% after Deductible	20% after In-Ntwk Ded 20% after In-Ntwk Ded
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	20% after Deductible	20% after Deductible
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician Specialist	 20% after Deductible 20% after Deductible	 40% after Deductible 40% after Deductible

BlueOptions

Florida Blue

For Public Risk Management Groups
2021-2022 Plan 03559

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$35 Copay	40% after Deductible
Outpatient Hospital Facility Services (per visit) Option 1	$150 Copay	$350 Copay
Option 2	$250 Copay	
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	40% after Deductible

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Prescription Drug Coverage	In-Network	Out of Network
Retail (30 days) (generic/preferred brand/non-preferred brand)	$10/$25/$60	50% of allowance
Mail Order (90 days) (generic/preferred brand/non-preferred brand)	$20/$50/$120	50% of allowance

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Additional Benefits and Features

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Florida Blue

BlueOptions

For Public Risk Management Groups
2020-2021 Plan 05901

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED is the amount the member is responsible for before Florida Blue pays)	$2,000 per person N/A per family	$6,000 per person N/A per family
Coinsurance (Coinsurance is the percentage the member pays for services)	50% of the allowed amount	50% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$6,350 per person $12,700 per family	$12,800 per person $25,600 per family
Office Services		
Physician Office Services Primary Care Physician Specialist Convenient Care Teladoc	 $35 Copay $75 Copay $35 Copay $35 Copay	 50% after Deductible 50% after Deductible 50% after Deductible N/A
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	 $35 Copay $75 Copay	 50% after Deductible 50% after Deductible
Allergy Injections (per visit) Primary Care Physician Specialist	 $10 Copay $10 Copay	 50% after Deductible 50% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	50% after Deductible	50% after Deductible
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0	50%
Mammograms	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	$0
Emergency Medical Care		
Urgent Care Centers	$75 Copay	$75 Copay
Emergency Room Facility Services (per visit) (copayment waived if admitted)	50% after Deductible	50% after In-Ntwk Deductible
Ambulance Services	50% after Deductible	50% after In-Ntwk Deductible
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	 $50 Copay $200 Copay	 50% after Deductible 50% after Deductible
Independent Clinical Lab (e.g., Blood Work)	$0	50% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays) Option 1 Option 2	 $300 Copay $400 Copay	 50% after Deductible 50% after Deductible

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Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	50% after Deductible	50% after Deductible
Outpatient Hospital Facility Services (per visit)		
Therapy Services Option 1	$80 Copay	50% after Deductible
Option 2	$90 Copay	50% after Deductible
All other Services Option 1	$300 Copay	50% after Deductible
Option 2	$400 Copay	50% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit)		
Option 1	$2000 Copay	50% after Deductible
Option 2	$3000 Copay	50% after Deductible
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)		
Option 1	$2000 Copay	50%
Option 2	$3000 Copay	
Outpatient Hospitalization Facility Service (per visit)		
Option 1	$300 Copay	50%
Option 2	$400 Copay	
Emergency Room Facility Services (per visit)	50% after Deductible	50% after In-Network Deductible
Provider Services at Hospital and ER		
Primary Care Physician	$0	$0
Specialist	$0	$0
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician	50% after Deductible	50% after Deductible
Specialist	50% after Deductible	
Outpatient Office Visit		
Primary Care Physician	$35 Copay	50%
Specialist	$75 Copay	
Other Provider Services		
Provider Services at Hospital		
Primary Care Physician	50% after Deductible	50% after Deductible
Specialist	50% after Deductible	50% after Deductible
Provider Services at ER (Primary Care Physician & Specialist)	50% after Deductible	50% after In-Network Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	50% after Deductible	50% after In-Network Deductible
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician	50% after Deductible	50% after Deductible
Specialist	50% after Deductible	50% after Deductible

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Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	$75 Copay	50% after Deductible
Outpatient Hospital Facility Services (per visit) Option 1	$80 Copay	50% after Deductible
Option 2	$90 Copay	50% after Deductible
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	50% after Deductible

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Prescription Drug Coverage	In-Network	Out of Network
Retail (30 days) (generic/preferred brand/non-preferred brand)	$10/$60/$100	50% of allowance
Mail Order (90 days) (generic/preferred brand/non-preferred brand)	$30/$180/$300	50% of allowance

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services **you need to get an approval** from Florida Blue before your service or you'll have to **pay the entire cost** for the service. **Before an appointment**, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

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