Product	BlueOptions (PPO) 03748
Cost Sharing - Member's Responsibility	
Deductible (Per Person / Family Aggregate)	\$0 / \$0
Coinsurance (BCBSF pays / Member pays)	100% / 0%
Out of Pocket Maximum (Per Person/Family Aggregate)	\$1,500 / \$3,000
Office Services	
Family Physician / Specialist	\$10/\$20 Copay
Preventive Services	
Office Services (Primary / Specialist)	\$0 Copay
Medical / Surgical Care at a Facility	
Ambulatory Surgical Center (ASC)	\$50 Copay
Inpatient Hospital Facility	
Option 1	\$250 Copay
Option 2	\$500 Copay
Outpatient Hospital Facility	
Option 1	\$100 Copay
Option 2	\$200 Copay
Emergency and Urgent Care	
Emergency Room Facility (per visit) (Surgery performed or with admit)	\$50 Copay
Urgent Care Centers	\$20 Copay
Diagnostic Testing (e.g., Lab, x-ray)	
Independent Clinical Laboratory	\$0 Copay
Independent Diagnostic Testing Center	\$50 Copay
Outpatient Hospital Facility	
Option 1	\$100 Copay
Option 2	\$200 Copay
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	
Independent Diagnostic Testing Center	\$50 Copay
Outpatient Hospital Facility	
Option 1	\$100 Copay
Option 2	\$200 Copay
Other Special Services and Locations	
Durable Medical Equipment	
Skilled Nursing Facility	DED + 0%
Home Health Care	
Hospice	
Prescription Drugs (Certain Medications subject to Prior Authorization)	
Retail - Generic/Brand/Non-Preferred/Specialty	\$10 / \$25 / \$60
Mail Order - Generic/Brand/Non-Preferred	\$20 / \$50 / \$120
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000
Hearing Aid Benefit	
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included

Medical - PRM Plan BlueOptions 03748		ACTIVE		RETIREES (REDUCED)	
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE	\$1,258.52	\$1,277.00	\$1,302.00	\$931.60	\$945.00
Additional for Spouse	\$1,125.83	\$1,142.00	\$1,164.00	\$788.08	\$799.00
Additional for Child	\$982.45	\$997.00	\$1,016.00		
Additional for Family	\$1,229.91	\$1.248.00	\$1 272 00		

2025 PRM Medical Plan Matrix 10.1.2025

Product	BlueCare (HMO) 55
Cost Sharing - Member's Responsibility	
Deductible (Per Person / Family Aggregate)	\$0/\$0
Coinsurance (BCBSF pays / Member pays)	100% / 0%
Out of Pocket Maximum (Per Person/Family Aggregate)	\$1,500 / \$3,000
Office Services	
Family Physician / Specialist	\$10/\$10 Copay
Preventive Services	
Office Services (Primary / Specialist)	\$0 Copay
Medical / Surgical Care at a Facility	
Ambulatory Surgical Center (ASC)	\$100 Copay
Inpatient Hospital Facility	
Option 1	\$250 Copay
Option 2	NA
Outpatient Hospital Facility	
Option 1	\$100 Copay
Option 2	NA
Emergency and Urgent Care	10 PM
Emergency Room Facility (per visit) (Surgery performed or with admit)	\$50 Copay
Urgent Care Centers	\$10 Copay
Diagnostic Testing (e.g., Lab, x-ray)	
Independent Clinical Laboratory	\$0 Copay
Independent Diagnostic Testing Center	\$0 Copay
Outpatient Hospital Facility	
Option 1	\$100 Copay
Option 2 Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	NA NA
Independent Diagnostic Testing Center	\$0 Copay
Outpatient Hospital Facility	
Option 1	\$100 Copay
Option 2	NA
Other Special Services and Locations	
Durable Medical Equipment	
Skilled Nursing Facility	\$0 Copay
Home Health Care	ФФ Зорыу
Hospice	
Prescription Drugs (Certain Medications subject to Prior Authorization)	
Retail - Generic/Brand/Non-Preferred/Specialty	\$5 / \$25 / \$25
Mail Order - Generic/Brand/Non-Preferred	\$10 / \$50 / \$50
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000
Hearing Aid Benefit	
\$500 for 1st ear; \$300 for 2nd ear.	Included

Medical - PRM Plan HMO 55					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE	\$1,144.71	\$1,161.00	\$1,184.00	\$847.32	\$860.00
Additional for Spouse	\$1,054.37	\$1,070.00	\$1,091.00	\$738.04	\$749.00
Additional for Child	\$920.20	\$934.00	\$952.00		
Additional for Family	\$1,151.95	\$1,169.00	\$1,192.00		

2025 PRM Medical Plan Matrix 10.1.2025

BlueCare HMO 55

Product	BlueOptions (PPO) 03769
Cost Sharing - Member's Responsibility	
Deductible (Per Person / Family Aggregate)	\$500 / \$1,500
Coinsurance (BCBSF pays / Member pays)	80% / 20%
Out of Pocket Maximum (Per Person/Family Aggregate)	\$1,500 / \$4,500
Office Services	
Family Physician / Specialist	\$15/\$15 Copay
Preventive Services	
Office Services (Primary / Specialist)	\$0 Copay
Medical / Surgical Care at a Facility	
Ambulatory Surgical Center (ASC)	DED + 20%
Inpatient Hospital Facility	
Option 1	DED + 20%
- Option 2	NA
Outpatient Hospital Facility	
- Option 1	DED + 20%
Option 2	NA
Emergency and Urgent Care	
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 20%
Urgent Care Centers	\$15 Copay
Diagnostic Testing (e.g., Lab, x-ray)	
Independent Clinical Laboratory	20%
Independent Diagnostic Testing Center	\$15 Copay
Outpatient Hospital Facility	
Option 1	DED + 20%
Option 2	NA
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	
Independent Diagnostic Testing Center	\$15 Copay
Outpatient Hospital Facility	
Option 1	DED + 20%
Option 2	NA
Other Special Services and Locations	
Durable Medical Equipment	
Skilled Nursing Facility	DED + 20%
Home Health Care	
Hospice	
Prescription Drugs (Certain Medications subject to Prior Authorization)	
Retail - Generic/Brand/Non-Preferred/Specialty	\$5 / \$35 / \$35
Mail Order - Generic/Brand/Non-Preferred	\$10 / \$70 / \$70
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000
Hearing Aid Benefit	
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included

Medical - PRM Plan BlueOptions 03769						
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025	
EE	\$1,110.08	\$1,126.00	\$1,148.00	\$821.67	\$833.00	
Additional for Spouse	\$1,053.84	\$1,069.00	\$1,090.00	\$737.67	\$748.00	
Additional for Child	\$919.73	\$933.00	\$951.00			
Additional for Family	\$1,151.31	\$1,168.00	\$1,191.00			

Product	BlueOptions (HSA) 05168/9			
Cost Sharing - Member's Responsibility				
Deductible (Per Person / Family Aggregate)	\$1,650 / NA	\$3,300 / \$3,300		
Coinsurance (BCBSF pays / Member pays)	100% / 0%	100% / 0%		
Out of Pocket Maximum (Per Person/Family Aggregate)	\$1,650 / NA	\$3,300 / \$3,300		
Office Services				
Family Physician / Specialist	DED+0%/DED+0%	DED+0%/DED+0%		
Preventive Services				
Office Services (Primary / Specialist)	\$0 Copay	\$0 Copay		
Medical / Surgical Care at a Facility				
Ambulatory Surgical Center (ASC)	DED + 0%	DED + 0%		
Inpatient Hospital Facility				
Option 1	DED + 0%	DED + 0%		
Option 2				
Outpatient Hospital Facility				
Option 1	DED + 0%	DED + 0%		
Option 2				
Emergency and Urgent Care Emergency Room Facility (per visit) (Surgery				
performed or with admit)	DED + 0%	DED + 0%		
Urgent Care Centers				
Diagnostic Testing (e.g., Lab, x-ray)				
Independent Clinical Laboratory	DED + 0%	DED + 0%		
Independent Diagnostic Testing Center	222 - 070	0.00		
Outpatient Hospital Facility				
Option 1	DED + 0%	DED + 0%		
Option 2				
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)				
Independent Diagnostic Testing Center	DED + 0%	DED + 0%		
Outpatient Hospital Facility				
Option 1	DED + 0%	DED + 0%		
Option 2				
Other Special Services and Locations				
Durable Medical Equipment				
Skilled Nursing Facility	DED + 0%	DED + 0%		
Home Health Care				
Hospice				
Prescription Drugs (Certain Medications subject to Prior Authorization)				
Retail - Generic/Brand/Non-Preferred/Specialty	100% after INN DED	100% after INN DED		
Mail Order - Generic/Brand/Non-Preferred	100% after INN DED	100% after INN DED		
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	DED / \$3,000	DED / \$3,000		
Hearing Aid Benefit				
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included	Included		

Medical - PRM Plan BlueOptions 05168/05169

Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE	\$1,079.13	\$1,095.00	\$1,116.00	\$798.80	\$810.00
Additional for Spouse	\$965.32	\$979.00	\$998.00	\$675.69	\$685.00
Additional for Child	\$842.39	\$855.00	\$872.00		Name of the last o
Additional for Family	\$1,054.63	\$1,070.00	\$1,091.00		

2025 PRM Medical Plan Matrix 10.1.2025

BlueOptions HSA 05168-9

Product	BlueOptions (PPO) 0355		
Cost Sharing - Member's Responsibility			
Deductible (Per Person / Family Aggregate)	\$750 / \$2,250		
Coinsurance (BCBSF pays / Member pays)	80% / 20%		
Out of Pocket Maximum (Per Person/Family Aggregate)	\$3,000 / \$6,000		
Office Services			
Family Physician / Specialist	\$20/\$35 Copay		
Preventive Services			
Office Services (Primary / Specialist)	\$0 Copay		
Medical / Surgical Care at a Facility			
Ambulatory Surgical Center (ASC)	\$100 Copay		
Inpatient Hospital Facility			
Option 1	\$750 Copay		
Option 2	\$1,000 Copay		
Outpatient Hospital Facility			
Option 1	\$150 Copay		
Option 2	\$250 Copay		
Emergency and Urgent Care			
Emergency Room Facility (per visit) (Surgery performed or with admit)	\$100 Copay		
Urgent Care Centers	\$35 Copay		
Diagnostic Testing (e.g., Lab, x-ray)			
Independent Clinical Laboratory	\$0 Copay		
Independent Diagnostic Testing Center	\$50 Copay		
Outpatient Hospital Facility			
Option 1	\$150 Copay		
Option 2	\$250 Copay		
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)			
Independent Diagnostic Testing Center	\$100 Copay		
Outpatient Hospital Facility			
Option 1	\$150 Copay		
Option 2	\$250 Copay		
Other Special Services and Locations			
Durable Medical Equipment			
Skilled Nursing Facility	DED + 20%		
Home Health Care	0.00		
Hospice			
Prescription Drugs (Certain Medications subject to Prior Authorization)			
Retail - Generic/Brand/Non-Preferred/Specialty	\$10 / \$25 / \$60		
Mail Order - Generic/Brand/Non-Preferred	\$20 / \$50 / \$120		
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000		
Hearing Aid Benefit			
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included		

Medical - PRM Plan BlueOptions 03559					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE	\$1,038.44	\$1,054.00	\$1,075.00	\$768.64	\$780.00
Additional for Spouse	\$928.95	\$942,00	\$960.00	\$650.22	\$659.00
Additional for Child	\$810.61	\$822.00	\$838.00		
Additional for Family	\$1,014.81	\$1,030.00	\$1,050.00		

Product	BlueOptions (PPO) 05360
Cost Sharing - Member's Responsibility	TREALS STORY
Deductible (Per Person / Family Aggregate)	\$1,500 / \$4,500
Coinsurance (BCBSF pays / Member pays)	80% / 20%
Out of Pocket Maximum	\$3,000 / \$6,000
(Per Person/Family Aggregate)	φο,οσο / φο,οσο
Office Services	
Family Physician / Specialist	\$25 / \$75 Copay
Preventive Services	
Office Services (Primary / Specialist)	\$0 Copay
Medical / Surgical Care at a Facility	
Ambulatory Surgical Center (ASC)	DED + 20%
Inpatient Hospital Facility	
Option 1	DED + 20%
Option 2	
Outpatient Hospital Facility	
Option 1	DED + 20%
Option 2	DLD + 2076
Emergency and Urgent Care	
Emergency Room Facility (per visit) (Surgery	DED + 20%
performed or with admit)	675 0
Urgent Care Centers	\$75 Copay
Diagnostic Testing (e.g., Lab, x-ray)	60.0
Independent Clinical Laboratory	\$0 Copay
Independent Diagnostic Testing Center	DED + 20%
Outpatient Hospital Facility	
Option 1	DED + 20%
Option 2	
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	
Independent Diagnostic Testing Center	DED + 20%
Outpatient Hospital Facility	
Option 1	DED + 20%
Option 2	
Other Special Services and Locations	
Durable Medical Equipment	
Skilled Nursing Facility	DED + 20%
Home Health Care	220 . 2070
Hospice	
Prescription Drugs (Certain Medications subject to Prior Authorization)	
Retail - Generic/Brand/Non-Preferred/Specialty	\$10 / \$35 / \$70
Mail Order - Generic/Brand/Non-Preferred	\$20 / \$70 / \$140
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000
Hearing Aid Benefit	
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included

Medical - PRM Plan BlueOptions 05360

Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE MANAGEMENT CONTRACTOR OF THE CONTRACTOR OF TH	\$987.93	\$1,002.00	\$1,022.00	\$731.27	\$742.00
Additional for Spouse	\$883.73	\$896.00	\$913.00	\$618.56	\$627.00
Additional for Child	\$771.22	\$782.00	\$797.00		
Additional for Family	\$965.46	\$979.00	\$998.00		

Product	BlueOptions HDHP (HSA) 05180/1			
Cost Sharing - Member's Responsibility				
Deductible (Per Person / Family Aggregate)	\$2,500	\$5,000		
Coinsurance (BCBSF pays / Member pays)	100% / 0%	100% / 0%		
Out of Pocket Maximum	\$2,500	\$5,000		
(Per Person/Family Aggregate)				
Office Services Family Physician / Specialist	DED+0% / DED+0%	DED+0%/DED+0%		
	DED+0% / DED+0%	DED+0%/DED+0%		
Preventive Services Office Services (Primary / Specialist)	\$0 Congy	\$0 Copay		
	\$0 Copay	30 Сорау		
Medical / Surgical Care at a Facility	DED + 09/	DED + 0%		
Ambulatory Surgical Center (ASC)	DED + 0%	DED + 0%		
Inpatient Hospital Facility				
Option 1	DED + 0%	DED + 0%		
Option 2				
Outpatient Hospital Facility				
Option 1	DED + 0%	DED + 0%		
Option 2				
Emergency and Urgent Care				
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 0%	DED + 0%		
Urgent Care Centers	DED + 0 %	DED + 0%		
Diagnostic Testing (e.g., Lab, x-ray)				
Independent Clinical Laboratory				
Independent Diagnostic Testing Center	DED + 0%	DED + 0%		
Outpatient Hospital Facility				
Option 1				
Option 2	DED + 0%	DED + 0%		
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)				
Independent Diagnostic Testing Center	DED + 0%	DED + 0%		
Outpatient Hospital Facility				
Option 1	DED + 09/	DED + 09/		
Option 2	DED + 0%	DED + 0%		
Other Special Services and Locations				
Durable Medical Equipment				
Skilled Nursing Facility	DED + 0%	DED + 0%		
Home Health Care	DED + 0%	DED + 0%		
Hospice		والمريز والمحاود أتوالا		
Prescription Drugs (Certain Medications subject to Prior Authorization)		S. S. M.		
Retail - Generic/Brand/Non-Preferred/Specialty	100% after INN DED	100% after INN DED		
Mail Order - Generic/Brand/Non-Preferred	100% after INN DED	100% after INN DED		
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	DED / \$3,000	DED / \$3,000		
Hearing Aid Benefit				
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included	Included		

Medical - PRM Plan BlueOptions 05180/05181

Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE	\$959.34	\$973.00	\$992.00	\$710.11	\$720.00
Additional for Spouse	\$858.14	\$871.00	\$888.00	\$600.68	\$609.00
Additional for Child	\$748.88	\$760.00	\$775.00	the State of the	
Additional for Family	\$937.54	\$951.00	\$970.00		

PRM Medical Plan Matrix 2025-2026	
Product	BlueOptions (PPO) 05904
Cost Sharing - Member's Responsibility	
Deductible (Per Person / Family Aggregate)	\$2,500 /\$5,000
Coinsurance (BCBSF pays / Member pays)	80% / 20%
Out of Pocket Maximum (Per Person/Family Aggregate)	\$6,000 / \$12,000
Office Services	
Family Physician / Specialist	\$35 / \$75 Copay
Preventive Services	
Office Services (Primary / Specialist)	\$0 Copay
Medical / Surgical Care at a Facility	
Ambulatory Surgical Center (ASC)	DED + 20%
Inpatient Hospital Facility	
Option 1	DED + 20%
Option 2	BEB - 2070
Outpatient Hospital Facility	
Option 1	DED + 20%
Option 2	525 2070
Emergency and Urgent Care	
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 20%
Urgent Care Centers	\$75 Copay
Diagnostic Testing (e.g., Lab, x-ray)	
Independent Clinical Laboratory	\$0 Copay
Independent Diagnostic Testing Center	\$50 Copay
Outpatient Hospital Facility	
Option 1	\$250 Copay
Option 2	DED + 20%
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	
Independent Diagnostic Testing Center	DED + 20%
Outpatient Hospital Facility	
Option 1	DED + 20%
Option 2	DEB - 20%
Other Special Services and Locations	
Durable Medical Equipment	
Skilled Nursing Facility	DED + 20%
Home Health Care	525 . 20/0
Hospice	
Prescription Drugs (Certain Medications subject to Prior Authorization)	
Retail - Generic/Brand/Non-Preferred/Specialty	\$10 / \$50 / \$80 / \$120
Mail Order - Generic/Brand/Non-Preferred	\$20 / \$100 / \$160
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000
Hearing Aid Benefit	
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included

Medical - PRM Plan BlueOptions 05904

Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE .	\$901.39	\$914.00	\$932.00	\$667.23	\$677.00
Additional for Spouse	\$806.34	\$818.00	\$834.00	\$564.42	\$572.00
Additional for Child	\$703.64	\$714.00	\$728.00		
Additional for Family	\$880.92	\$894.00	\$911.00	N CONTRACTOR	

Product	BlueOptions (PPO) 05901
Cost Sharing - Member's Responsibility	
Deductible (Per Person / Family Aggregate)	\$2,000 / NA
Coinsurance (BCBSF pays / Member pays)	50% / 50%
Out of Pocket Maximum (Per Person/Family Aggregate)	\$6,350 / \$12,800
Office Services	
Family Physician / Specialist	\$35 / \$75 Copay
Preventive Services	
Office Services (Primary / Specialist)	\$0 Copay
Medical / Surgical Care at a Facility	
Ambulatory Surgical Center (ASC)	DED + 50%
Inpatient Hospital Facility	
Option 1	\$2,000 Copay
Option 2	\$3,000 Copay
Outpatient Hospital Facility	
) Option 1	\$300 Copay
Option 2	\$400 Copay
Emergency and Urgent Care	
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 50%
Urgent Care Centers	\$75 Copay
Diagnostic Testing (e.g., Lab, x-ray)	
Independent Clinical Laboratory	\$0 Copay
Independent Diagnostic Testing Center	\$50 Copay
Outpatient Hospital Facility	
Option 1	\$300 Copay
Option 2	\$400 Copay
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	
Independent Diagnostic Testing Center	\$200 Copay
Outpatient Hospital Facility	
Option 1	\$300 Copay
Option 2	\$400 Copay
Other Special Services and Locations Durable Medical Equipment	
Skilled Nursing Facility	DED + 50%
Home Health Care	DED + 50%
Hospice	
Prescription Drugs (Certain Medications subject to Prior Authorization)	
Retail - Generic/Brand/Non-Preferred/Specialty	\$10 / \$60 / \$100 / \$120
Mail Order - Generic/Brand/Non-Preferred	\$30 / \$180 / \$300
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000
Hearing Aid Benefit	ADD 100 100 100 100 100 100 100 100 100 1
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included

Medical - PRM Plan BlueOptions 05901

Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE	\$872.43	\$885.00	\$902.00	\$645.78	\$655.00
Additional for Spouse	\$780.44	\$792.00	\$807.00	\$546.27	\$554.00
Additional for Child	\$681.01	\$691.00	\$704.00		
Additional for Family	\$852.61	\$865.00	\$882.00		

Product	BlueOptions (PPO) 05787
Cost Sharing - Member's Responsibility	
Deductible (Per Person / Family Aggregate)	\$7,350 / \$14,700
Coinsurance (BCBSF pays / Member pays)	100% / 0%
Out of Pocket Maximum (Per Person/Family Aggregate)	\$7,350 / \$14,700
Office Services	
Family Physician / Specialist	\$45 / \$90 Copay
Preventive Services	
Office Services (Primary / Specialist)	\$0 Copay
Medical / Surgical Care at a Facility	
Ambulatory Surgical Center (ASC)	DED + 0%
Inpatient Hospital Facility	
Option 1	DED + 0%
Option 2	DED - 070
Outpatient Hospital Facility	
Option 1	DED + 0%
Option 2	DED + 0/0
Emergency and Urgent Care	
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 0%
Urgent Care Centers	\$90 Copay
Diagnostic Testing (e.g., Lab, x-ray)	是 不是
Independent Clinical Laboratory	\$0 Copay
Independent Diagnostic Testing Center	\$75 Copay
Outpatient Hospital Facility	
Option 1	DED + 0%
Option 2	DEB 1 0%
Ádvanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)	
Independent Diagnostic Testing Center	DED + 0%
Outpatient Hospital Facility	
Option 1	DED + 0%
Option 2	Miles Islanda
Other Special Services and Locations	
Durable Medical Equipment	
Skilled Nursing Facility	DED + 0%
Home Health Care	0.0
Hospice	
Prescription Drugs (Certain Medications subject to Prior Authorization)	
Retail - Generic/Brand/Non-Preferred/Specialty	\$10 / \$60 / \$100 /\$120
Mail Order - Generic/Brand/Non-Preferred	\$30 / \$180 / \$300
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000
Hearing Aid Benefit	
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included

Medical - PRM Plan BlueOptions 05787

Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
EE WALLESTON OF THE STATE OF TH	\$815.90	\$828.00	\$844.00	\$603.92	\$612.00
Additional for Spouse	\$729.85	\$740.00	\$754.00	\$510.88	\$518.00
Additional for Child	\$636.87	\$646.00	\$658.00		
Additional for Family	\$797.34	\$809.00	\$825.00		

Product	BlueOptions HDHP (HSA) 05172/3			
Cost Sharing - Member's Responsibility				
Deductible (Per Person / Family Aggregate)	\$5,000 / NA	\$5,000 / \$10,000		
Coinsurance (BCBSF pays / Member pays)	90% / 10%	90% / 10%		
Out of Pocket Maximum (Per Person/Family Aggregate)	\$6,850 / NA	\$6,850 / \$13,700		
Office Services				
Family Physician / Specialist	DED+10%/DED+10%	DED+10% DED+10%		
Preventive Services				
Office Services (Primary / Specialist)	\$0 Copay	\$0 Copay		
Medical / Surgical Care at a Facility				
Ambulatory Surgical Center (ASC)	DED + 10%	DED + 10%		
npatient Hospital Facility				
Option 1	DED - 409/	DED + 10%		
Option 2	DED + 10%	DED + 10%		
Outpatient Hospital Facility				
Option 1	DED + 109/	DED + 10%		
Option 2	DED + 10%	DED + 10%		
Emergency and Urgent Care				
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 10%	DED + 10%		
Urgent Care Centers				
Diagnostic Testing (e.g., Lab, x-ray)				
ndependent Clinical Laboratory	DED + 0%	DED + 0%		
ndependent Diagnostic Testing Center	DED + 10%	DED + 10%		
Outpatient Hospital Facility				
Option 1 Option 2	DED + 10%	DED + 10%		
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)				
Independent Diagnostic Testing Center	DED + 10%	DED + 10%		
Outpatient Hospital Facility				
Option 1	DED . 100/	250 . 10%		
Option 2	DED + 10%	DED + 10%		
Other Special Services and Locations				
Durable Medical Equipment				
Skilled Nursing Facility	DED + 10%	DED + 10%		
Home Health Care	DED + 10%	DED + 10%		
Hospice				
Prescription Drugs (Certain Medications subject to Prior Authorization)				
Retail - Generic/Brand/Non-Preferred/Specialty	10% after INN DED	10% after INN DED		
Mail Order - Generic/Brand/Non-Preferred	10% after INN DED	10% after INN DED		
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	30% / \$3,000	30% / \$3,000		
Hearing Aid Benefit				
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included	Included		

Medical - PRM Plan BlueOptions 05172/05173

Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/2025
	\$772.81	\$784.00	\$799.00	\$572.04	\$580.00
Additional for Spouse	\$691.32	\$701.00	\$715.00	\$483.91	\$491.00
Additional for Child	\$603.25	\$612.00	\$624.00		THE RESERVE
Additional for Family	\$755.24	\$766.00	\$781.00		

2025 PRM Medical Plan Matrix 10.1.2025

Levy, County of

Overall Increase

1.50%

2025-2026

Medical - PRM Plan BlueOptions 03748		ACTIVE	COBRA		EES (REDUCED)
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
	\$1,258.52	\$1,277.00	\$1,302.00	\$931.60	\$945.00
dditional for Spouse	\$1,125.83	\$1,142.00	\$1,164.00	\$788.08	\$799.00
dditional for Child	\$982.45	\$997.00	\$1,016.00		
dditional for Family	\$1,229.91	\$1,248.00	\$1,272.00		
ledical - PRM Plan HMO 55					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
	\$1,144.71	\$1,161.00	\$1,184.00	\$847.32	\$860.00
dditional for Spouse	\$1,054.37	\$1,070.00	\$1,091.00	\$738.04	\$749.00
dditional for Child	\$920.20	\$934.00	\$952.00	TERMINE TO THE	
dditional for Family	\$1,151.95	\$1,169.00	\$1,192.00		
1edical - PRM Plan BlueOptions 03769					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/20
	\$1,110.08	\$1,126.00	\$1,148.00	\$821.67	\$833.00
dditional for Spouse	\$1,053.84	\$1,069.00	\$1,090.00	\$737.67	\$748.00
dditional for Child	\$919.73	\$933.00	\$951.00		
dditional for Family	\$1,151.31	\$1,168.00	\$1,191.00		
edical - PRM Plan BlueOptions 05168/05169					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
corcinge	\$1,079.13	\$1,095.00	\$1,116.00	\$798.80	\$810.00
dditional for Spouse	\$965.32	\$979.00	\$998.00	\$675.69	\$685.00
dditional for Child	\$842.39	\$855.00	\$872.00	2075.09	\$085.00
dditional for Child	\$1,054.63	\$1,070.00	\$1,091.00		
Soldend for Farmy	\$1,054.05	\$1,070.00	\$1,091.00		
ledical - PRM Plan BlueOptions 03559				December 198	
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
	\$1,038.44	\$1,054.00	\$1,075.00	\$768.64	\$780.00
dditional for Spouse	\$928.95	\$942.00	\$960.00	\$650.22	\$659.00
dditional for Child	\$810.61	\$822.00	\$838.00	ÇOSO.ZZ	\$055.00
dditional for Family	\$1,014.81	\$1,030.00	\$1,050.00		
Nedical - PRM Plan BlueOptions 05360					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
	\$987.93	\$1,002.00	\$1,022.00	\$731.27	\$742.00
dditional for Spouse	\$883.73	\$896.00	\$913.00	\$618.56	\$627.00
dditional for Child	\$771.22	\$782.00	\$797.00		
dditional for Family	\$965.46	\$979.00	\$998.00		
Medical - PRM Plan BlueOptions 05180/05181					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
	\$959.34	\$973.00	\$992.00	\$710.11	\$720.00
dditional for Spouse	\$858.14	\$871.00	\$888.00	\$600.68	\$609.00
dditional for Child	\$748.88	\$760.00	\$775.00		
dditional for Family	\$937.54	\$951.00	\$970.00		SINE STATE
ledical - PRM Plan BlueOptions 05904					
		V	T		
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
11:	\$901.39	\$914.00	\$932.00	\$667.23 .	\$677.00
dditional for Spouse	\$806.34	\$818.00	\$834.00	\$564.42	\$572.00
dditional for Child	\$703.64	\$714.00	\$728.00		
ditional for Family	\$880.92	\$894.00	\$911.00		
ledical - PRM Plan BlueOptions 05901					
Cougrage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Correct	Dropperd 40/4 /gos
Coverage	Current \$872.43	\$885.00	Proposed 10/1/2025 \$902.00	Current \$645.78	Proposed 10/1/202 \$655.00
dditional for Spouse	\$780.44	\$792.00	\$807.00	\$545.78	\$554.00
dditional for Child	\$681.01	\$691.00	\$704.00	3340.21	\$334.00
ditional for Family	\$852.61	\$865.00	\$882.00		
	V025.01	4303.00	V002,00		
ledical - PRM Plan BlueOptions 05787					
Coverage	Current	Proposed 10/1/2025	Proposed 10/1/2025	Current	Proposed 10/1/202
	\$815.90	\$828.00	\$844.00	\$603.92	\$612.00
	\$729.85	\$740.00	\$754.00	\$510.88	\$518.00
dditional for Spouse	\$725.03				
	\$636.87	\$646.00	\$658.00		
dditional for Child			\$658.00 \$825.00		
dditional for Child dditional for Family	\$636.87	\$646.00			
dditional for Child dditional for Family ledical - PRM Plan BlueOptions 05172/05173	\$636.87 \$797.34	\$646.00 \$809.00	\$825.00	Current	Proposed 10/1/20:
dditional for Child dditional for Family ledical - PRM Plan BlueOptions 05172/05173 Coverage	\$636.87 \$797.34 Current	\$646.00 \$809.00 Proposed 10/1/2025	\$825.00 Proposed 10/1/2025	Current \$572.04	
	\$636.87 \$797.34 Current \$772.81	\$646.00 \$809.00 Proposed 10/1/2025 \$784.00	\$825.00 Proposed 10/1/2025 \$799.00	\$572.04	Proposed 10/1/202 \$580.00 \$491.00
dditional for Child dditional for Family ledical - PRM Plan BlueOptions 05172/05173 Coverage E dditional for Spouse	\$636.87 \$797.34 Current \$772.81 \$691.32	\$646.00 \$809.00 Proposed 10/1/2025 \$784.00 \$701.00	\$825.00 Proposed 10/1/2025 \$799.00 \$715.00		
dditional for Child dditional for Family 1edical - PRM Plan BlueOptions 05172/05173 Coverage	\$636.87 \$797.34 Current \$772.81	\$646.00 \$809.00 Proposed 10/1/2025 \$784.00	\$825.00 Proposed 10/1/2025 \$799.00	\$572.04	\$580.00

Product	BlueOptions HDHP (HSA) 05180/1		BlueOptions (PPO) 05904	BlueOptions (PPO) 05901	BlueOptions (PPO) 05787	BlueOptions HDHP (HSA) 05172/3	
Cost Sharing - Member's Responsibility							
Deductible (Per Person / Family Aggregate)	\$2,500	\$5,000	\$2,500 /\$5,000	\$2,000 / NA	\$7,350 / \$14,700	\$5,000 / NA	\$5,000 / \$10,000
Coinsurance (BCBSF pays / Member pays)	100% / 0%	100% / 0%	80% / 20%	50% / 50%	100% / 0%	90% / 10%	90% / 10%
Out of Pocket Maximum (Per Person/Family Aggregate)	\$2,500	\$5,000	\$6,000 / \$12,000	\$6,350 / \$12,800	\$7,350 / \$14,700	\$6,850 / NA	\$6,850 / \$13,700
Office Services Family Physician / Specialist	DED+0% / DED+0%	DED+0%/DED+0%	\$35 / \$75 Copay	\$35 / \$75 Copay	\$45 / \$90 Copay	DED+10%/DED+10%	DED+10% DED+10%
Preventive Services					A PROPERTY SERVICE LEVEL		DES YASTIMO VE
Office Services (Primary / Specialist)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
Medical / Surgical Care at a Facility		5500		ALCOHOLD TO THE RESERVE			Stable of the state of the stat
Ambulatory Surgical Center (ASC)	DED + 0%	DED + 0%	DED + 20%	DED + 50%	DED + 0%	DED + 10%	DED + 10%
Inpatient Hospital Facility							
Option 1 Option 2	DED + 0%	DED + 0%	DED + 20%	\$2,000 Copay \$3,000 Copay	DED + 0%	DED + 10%	DED + 10%
Outpatient Hospital Facility							
Option 1	DED + 0%	DED + 0%	DED + 20%	\$300 Copay	DED + 0%	DED + 10%	DED + 10%
Option 2	DED + 0%	DED + 0%	DED + 20%	\$400 Copay	DED + 0%	DED + 10%	DED + 10%
Emergency and Urgent Care							Web State of the S
Emergency Room Facility (per visit) (Surgery performed or with admit)	DED + 0%	DED + 0%	DED + 20%	DED + 50%	DED + 0%	DED + 10%	DED + 10%
Urgent Care Centers			\$75 Copay	\$75 Copay	\$90 Copay		
Diagnostic Testing (e.g., Lab, x-ray)							
Independent Clinical Laboratory	DED + 0%	DED + 0%	\$0 Copay	\$0 Copay	\$0 Copay	DED + 0%	DED + 0%
Independent Diagnostic Testing Center	A		\$50 Copay	\$50 Copay	\$75 Copay	DED + 10%	DED + 10%
Outpatient Hospital Facility							
Option 1	DED + 0%	DED + 0%	\$250 Copay	\$300 Copay	DED + 0%	DED + 10%	DED + 10%
Option 2			DED + 20%	\$400 Copay			
Advanced Imaging (AIS) (MRI, MRA, PET, CT & Nuclear Medicine)							
Independent Diagnostic Testing Center	DED + 0%	DED + 0%	DED + 20%	\$200 Copay	DED + 0%	DED + 10%	DED + 10%
Outpatient Hospital Facility							
Option 1	DED + 0%	DED + 0%	DED + 20%	\$300 Copay	DED + 0%	DED + 10%	DED + 10%
Option 2				\$400 Copay			
Other Special Services and Locations				NAME OF TAXABLE OF			
Durable Medical Equipment Skilled Nursing Facility							
Home Health Care	DED + 0%	DED + 0%	DED + 20%	DED + 50%	DED + 0%	DED + 10%	DED + 10%
Hospice						National Nation	
Prescription Drugs (Certain Medications subject to Prior Authorization)							
Retail - Generic/Brand/Non-Preferred/Specialty	100% after INN DED	100% after INN DED	\$10 / \$50 / \$80 / \$120	\$10/\$60/\$100/\$120	\$10 / \$60 / \$100 /\$120	10% after INN DED	10% after INN DED
Mail Order - Generic/Brand/Non-Preferred	100% after INN DED	100% after INN DED	\$20 / \$100 / \$160	\$30 / \$180 / \$300	\$30 / \$180 / \$300	10% after INN DED	10% after INN DED
Oral Weight Loss Medications - Coinsurance/Annual Plan Paid Maximum	DED / \$3,000	DED / \$3,000	30% / \$3,000	30% / \$3,000	30% / \$3,000	30% / \$3,000	30% / \$3,000
Hearing Aid Benefit							
\$500 for 1st ear; \$300 for 2nd ear. One every 36 months.	Included	Included	Included	Included	Included	Included	Included

Product	BlueOptions (PPO) 03748	BlueCare (HMO) 55	BlueOptions (PPO) 03769	BlueOptions (HSA) 05168/9		BlueOptions (PPO) 03559	BlueOptions (PPO) 05360
ost Sharing - Member's Responsibility							
Deductible (Per Person / Family Aggregate)	\$0 / \$0	\$0 / \$0	\$500 / \$1,500	\$1,650 / NA	\$3,300 / \$3,300	\$750 / \$2,250	\$1,500 / \$4,500
Coinsurance (BCBSF pays / Member pays)	100% / 0%	100% / 0%	80% / 20%	100% / 0%	100% / 0%	80% / 20%	80% / 20%
out of Pocket Maximum Per Person/Family Aggregate)	\$1,500 / \$3,000	\$1,500 / \$3,000	\$1,500 / \$4,500	\$1,650 / NA	\$3,300 / \$3,300	\$3,000 / \$6,000	\$3,000 / \$6,000
ffice Services							
Family Physician / Specialist	\$10/\$20 Copay	\$10/\$10 Copay	\$15/\$15 Copay	DED+0%/DED+0%	DED+0%/DED+0%	\$20/\$35 Copay	\$25 / \$75 Copay
reventive Services							
ffice Services (Primary / Specialist)	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
edical / Surgical Care at a Facility					452 MARIO (1944-1953)		SAME IN COLUMN
mbulatory Surgical Center (ASC)	\$50 Copay	\$100 Copay	DED + 20%	DED + 0%	DED + 0%	\$100 Copay	DED + 20%
patient Hospital Facility							
Option 1	\$250 Copay	\$250 Copay	DED + 20%	DED + 0%	DED + 0%	\$750 Copay	DED + 20%
Option 2	\$500 Copay	NA	NA			\$1,000 Copay	000.2070
utpatient Hospital Facility							
Option 1	\$100 Copay	\$100 Copay	DED + 20%	DED + 0%	DED + 0%	\$150 Copay	DED + 20%
Option 2	\$200 Copay	NA	NA			\$250 Copay	
mergency and Urgent Care							
nergency Room Facility (per visit) (Surgery performed with admit)	\$50 Copay	\$50 Copay	DED + 20%	DED + 0%	DED + 0%	\$100 Copay	DED + 20%
gent Care Centers	\$20 Copay	\$10 Copay	\$15 Copay			\$35 Copay	\$75 Copay
agnostic Testing (e.g., Lab, x-ray)							THE RESERVE TO THE RE
dependent Clinical Laboratory	\$0 Copay	\$0 Copay	20%	DED + 0%	DED + 0%	\$0 Copay	\$0 Copay
dependent Diagnostic Testing Center	\$50 Copay	\$0 Copay	\$15 Copay			\$50 Copay	DED + 20%
utpatient Hospital Facility							
Option 1 Option 2	\$100 Copay \$200 Copay	\$100 Copay NA	DED + 20% NA	DED + 0%	DED + 0%	\$150 Copay	DED + 20%
dvanced Imaging (AIS) (MRI, MRA, PET, CT &	\$200 Copay	NA NA	NA NA			\$250 Copay	
uclear Medicine) dependent Diagnostic Testing Center	\$50 Copay	\$0 Copay	\$15 Copay	DED + 0%	DED + 0%	\$100 Copay	DED + 20%
utpatient Hospital Facility	эээ сорау	эо сорау	313 Copay	DED + 0%	DED + 0%	\$100 Copay	DED + 20%
Option 1	\$100 Copay	\$100 Copay	DED + 20%			\$150 Copay	
Option 2	\$200 Copay	NA NA	NA NA	DED + 0%	DED + 0%	\$250 Copay	DED + 20%
ther Special Services and Locations		the beautiful to be the second					ATTENDATE AND IDEALS
urable Medical Equipment							
killed Nursing Facility	DED + 0%	\$0 Copay	DED + 20%	DED + 0%	DED + 0%	DED + 20%	DED + 20%
ome Health Care	525 . 670	Фо Сора	DED + 20%	BEB 1 0%	0.0.00	DED + 20/6	DED + 20%
ospice							
escription Drugs (Certain Medications subject to Prior athorization)							
etail - Generic/Brand/Non-Preferred/Specialty	\$10 / \$25 / \$60	\$5 / \$25 / \$25	\$5 / \$35 / \$35	100% after INN DED	100% after INN DED	\$10 / \$25 / \$60	\$10 / \$35 / \$70
ail Order - Generic/Brand/Non-Preferred	\$20 / \$50 / \$120	\$10 / \$50 / \$50	\$10/\$70/\$70	100% after INN DED	100% after INN DED	\$20 / \$50 / \$120	\$20 / \$70 / \$140
ral Weight Loss Medications - Coinsurance/Annual an Paid Maximum	30% / \$3,000	30% / \$3,000	30% / \$3,000	DED / \$3,000	DED / \$3,000	30% / \$3,000	30% / \$3,000
earing Aid Benefit						Section 1	
500 for 1st ear; \$300 for 2nd ear. ne every 36 months.	Included	Included	Included	Included	Included	Included	Included