Florida Blue

In the pursuit of health®

Indian River County BOCC #90000
2018 BlueMedicare Group PPO (Employer PPO) Health Benefits

Benefits	BlueMedicare Group PPO Plan 2
Premium (per member, per month)	$316.55 for PPO2Rx1 ~~$292.43 for PPO2Rx2~~
Annual Deductible	$0 In-Network / $2,000 Out-of-Network
Out-of Pocket Maximum (based on plan year)	$2,000 In-Network / $4,000 Out-of-Network In-Network out-of-pocket maximum accumulates toward Out-of-Network out-of-pocket maximum
Physician Office	
Primary Care (per visit)	In-Network $35 Copayment Out-of-Network Deductible & 40% Coinsurance
Specialist Care (per visit)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Convenient Care Center	In-Network / Out-of-Network $50 Copayment
Podiatry Services (per visit) (routine foot care up to 6 visits per year)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Chiropractic Services (per visit) For each Medicare-covered visit (manual manipulation of the spine to correct subluxation)	In-Network $20 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Mental Health Care (per visit) For individual or group therapy (including partial hospitalization)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Substance Abuse Care (per visit)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance
Part B drugs (including chemotherapy)	In-Network 20% coinsurance Out-of-Network Deductible & 40% Coinsurance
Allergy Injections	In-Network $10 Copayment Out-of-Network Deductible & 40% Coinsurance

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Other Services	
Outpatient Surgery	In-Network • $250 Copayment for each outpatient hospital facility visit • $175 Copayment for each visit to an ambulatory surgical center Out-of-Network Deductible & 40% Coinsurance In-Network / Out-of-Network • $0 Copayment for physician services
Diagnostic Tests, X-Rays	
Office	In-Network • PCP $35 Copayment • Specialist $50 Copayment Out-of-Network Deductible & 40% Coinsurance
IDTF	In-Network $100 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance
Lab Services	
Independent Clinical Lab	In-Network $0 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital All Locations	In-Network $30 Copayment Out-of-Network Deductible & 40% Coinsurance
Advanced Imaging (MRI, MRA, CT Scan, PET Scan and Nuclear Medicine):	
Office	In-Network $175 Copayment Out-of-Network Deductible & 40% Coinsurance
IDTF	In-Network $175 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance

Benefits	BlueMedicare Group PPO Plan 2
Outpatient Hospital Services (per visit): Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac Rehab (including intensive cardiac rehab)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance $1,980 Physical and Speech Therapy Annual Benefit Maximum. This limit is for 2017 and subject to change by Medicare in 2018. $1,980 Occupational Therapy Annual Benefit Maximum. This limit is for 2017 and subject to change by Medicare in 2018.
Pulmonary Rehab	In-Network $30 Copayment Out-of-Network Deductible & 40% Coinsurance
Radiation Therapy	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Dialysis	In-Network / Out-of-Network 20% Coinsurance
Lab Only	In-Network $30 Copayment Out-of-Network Deductible & 40% Coinsurance
All Other Diagnostic Tests, X-Rays, Advanced Imaging, etc.	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance
Urgently Needed Care (This is not emergency care, and in most cases is out-of-the-service area.)	In-Network / Out-of-Network $50 Copayment
Emergency Services (Including Worldwide Coverage)	In-Network / Out-of-Network $75 Copayment
Dental, Hearing and Vision (Medicare-Covered)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Home Health	In-Network / Out-of-Network $0 Copayment
Ambulance	In-Network / Out-of-Network $150 Copayment for Medicare-covered ambulance services

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Outpatient Medical Services and Supplies	
Durable Medical Equipment/Diabetic Supplies Diabetic Supplies (glucose meters, test strips and lancets) *Note: needles, syringes and insulin for self-injection are covered under your Part D benefit*	In-Network $0 Copayment Out-of-Network Deductible & 40% Coinsurance
Equipment: Plan-Approved Electric Customized Wheelchairs, Electric Scooters	In-Network 20% Coinsurance Out-of-Network Deductible & 40% Coinsurance
All Other Medicare-Covered Durable Medical Equipment	In-Network $0 Copayment Out-of-Network Deductible & 40% Coinsurance
Prosthetic Devices	In-Network $0 Copayment for Medicare-covered items Out-of-Network Deductible & 40% Coinsurance
Outpatient Rehabilitation Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac Rehab (including intensive cardiac rehab)	$1,980 Physical and Speech Therapy Annual Benefit Maximum. This limit is for 2017 and subject to change by Medicare in 2018. $1,980 Occupational Therapy Annual Benefit Maximum. This limit is for 2017 and subject to change by Medicare in 2018.
Office or Freestanding Facility Services	In-Network $40 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital Services	In-Network $40 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Pulmonary Rehab	In-Network $30 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Dialysis	In-Network/Out-of-Network 20% Coinsurance
Inpatient Care	
Inpatient Hospital Care (including substance abuse treatment)	In-Network • $250 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • After the 7th day, the plan pays 100% of covered expenses per stay Out-of-Network Deductible & 40% Coinsurance

Benefits	BlueMedicare Group PPO Plan 2
Inpatient Mental Health Care	In-Network • $250 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • $0 Copayment each day for day(s) 8-90 for a Medicare-covered stay in a network hospital • 190-day lifetime limit in a psychiatric hospital Out-of-Network Deductible & 40% Coinsurance
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In-Network • $0 Copayment each day for days 1-20 per benefit period • $100 Copayment each day for days 21-100 per benefit period • There is a limit of 100 days for each benefit period • 3-day prior hospital stay is not required Out-of-Network Deductible & 40% Coinsurance
Hospice	Member must receive care from a Medicare-certified hospice
Preventive Services	
Annual Screening Mammograms (for women with Medicare, age 40 and older)	In-Network $0 Copayment for Medicare-covered screening mammograms Out-of-Network 40% Coinsurance
Pap Smears and Pelvic Exams (for women with Medicare)	In-Network • $0 Copayment per pap smear • $0 Copayment per pelvic exam Out-of-Network 40% Coinsurance
Bone Mass Measurement (for people with Medicare who are at risk)	In-Network $0 Copayment for each Medicare-covered bone mass measurement Out-of-Network 40% Coinsurance
Colorectal Screening Exams (for people with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered colorectal screening exams Out-of-Network 40% Coinsurance
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered prostate cancer screening exams Out-of-Network 40% Coinsurance

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Vaccines (Medicare-covered)	In-Network • $0 Copayment for influenza vaccine • $0 Copayment for pneumococcal vaccine • $0 Copayment for hepatitis B vaccine Out-of-Network 40% Coinsurance
Supplemental Benefit	
Fitness	Free membership through SilverSneakers

BlueMedicare Group PPO out-of-pocket maximum includes all covered health services member cost share rendered in/out of network on a Plan Year basis. Supplemental services and Part D costs are not applied to out-of-pocket maximum.

Medicare Part B - the premium provided under this plan excludes the Medicare Part B premium payments. (Members must continue to pay the Medicare Part B premium unless paid by Medicaid or another third party.)

Florida Blue is a PPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Florida Blue

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Indian River County BOCC #90000
2018 BlueMedicare Group Rx (Employer PDP)

Benefits	BlueMedicare Group Rx Option 1
Premium	~~Included in PPO1Rx1~~ Included in PPO2Rx1
Annual Deductible	$0
Retail	**31-day Supply**
Tier 1 - Preferred Generics	$10 Copayment
Tier 2 - Generics	$10 Copayment
Tier 3 - Preferred Brand	$40 Copayment
Tier 4 - Non-Preferred Brand	$70 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Mail Order	**90-day Supply with Mail Order**
Tier 1 - Preferred Generics	$0 Copayment
Tier 2 - Generics	$0 Copayment
Tier 3 - Preferred Brand	$80 Copayment
Tier 4 - Non-Preferred Brand	$140 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance (31-day supply only)
Gap	**31-day Supply**
Tier 1 - Preferred Generics	$10 Copayment
Tier 2 - Generics	$10 Copayment
Tier 3 - Preferred Brand	$40 Copayment
Tier 4 - Non-Preferred Brand	$70 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Catastrophic	$3.35 Copayment for generic drugs $8.35 Copayment for brand drugs

Florida Blue is an Rx (PDP) Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Prescription drug copayments do not accumulate towards the health Plan Year out-of-pocket maximum.

Part D Creditable Coverage – The enrolling member may incur Part D late enrollment penalties as defined and set by CMS in accordance with Part D guidelines if prior creditable coverage cannot be proven.