Indian River County Retiree Medicare Advantage Renewal Evaluation Effective Date: October 1, 2017

GEHRING GROUP & CONSULTANTS

Summary of Benefits	CURRENT		RENEWAL		
	Florida Blue Med	icare Advantage	Florida Blue Med	icare Advantage	
Plan Structure	Blue Medicare G	roup PPO 2 RX 1	Blue Medicare Gi	<u> </u>	
Network Name	PPO	Out of Network	PPO	Out of Network	
Lifetime Maximum	Unlimited		Unlimited		
Calendar Year Deductible (CYD)					
Individual	No deductible	\$2,000	No deductible	\$2,000	
Family	N/A	N/A	N/A	N/A	
Annual Out-of-Pocket Maximum	. , ,	,	,		
Individual	\$2,000	\$4,000	\$2,000	\$4,000	
Family	N/A	N/A	N/A	N/A	
Physician Services	.,,,,		.,,	,	
Primary Care Office Visit	\$35 / visit	40% after CYD	\$35 / visit	40% after CYD	
Specialist Office Visit	\$50 / visit	40% after CYD	\$50 / visit	40% after CYD	
Chiropractic Services	\$20 / visit	40% after CYD	\$20 / visit	40% after CYD	
Preventive Services	No charge	40% Coinsurance	No charge	40% Coinsurance	
Lab & Radiology Services	No charge	40% comsurance	No charge	4070 Comsulation	
Diagnostic Tests & X-Rays (IDTF)	\$100 / visit	40% after CYD	\$100 / visit	40% after CYD	
Advanced Imaging (IDTF)	\$175 / visit	40% after CYD	\$100 / Visit \$175 / visit	40% after CYD	
Lab Services (Independent)	No charge	40% after CYD	No charge	40% after CYD	
Laboratory Provider	Quest Diagnostics	N/A	Quest Diagnostics	N/A	
•	Quest Diagnostics	N/A	Quest Diagnostics	IN/A	
Hospital Services	\$250/day to max of		\$250/day to max of		
Inpatient	\$1,750/admit	40% after CYD	\$1,750/admit	40% after CYD	
Outpatient	\$250/visit	40% after CYD	\$250/visit	40% after CYD	
Physician Services at Facility	No charge	No charge	No charge	No charge	
Outpatient Advanced Imaging	\$250 / visit	40% after CYD	\$250 / visit	40% after CYD	
Emergency Room	\$75 / visit	\$75 / visit	\$250 / Visit \$75 / visit	\$75 / visit	
Urgent Care	\$50 / visit	\$50 / visit	\$50 / visit	\$50 / visit	
Ambulance	\$150 / occurrence	\$150 / occurrence	\$150 / occurrence	\$150 / occurrence	
Outpatient Rehabilitation	\$1507 occurrence	J130 / Occurrence	\$1307 occurrence	\$150 / Occurrence	
Facility Charge	\$40	40% after CYD	\$40	40% after CYD	
Annual Maximum Visits	\$1,940 Max - P,S / \$1,940 Max - O		\$1,980 Max - P,S / \$1,980 Max - O		
Services Included ⁽¹⁾	C, P, S, O		C, P, S, O		
Durable Medical Equipment	\$0-20%/item			40% after CYD	
Prescription Drugs	\$6 20% Rem	1070 ditei 012	φο 2070/ item	1070 ditei eib	
Prescription ONLY Deductible	No Deductible	Not Covered	No Deductible	Not Covered	
\$0 to Catastrophic	no beautime		, no beautione	1100 0010100	
•	\$10 (\$0 through		\$10 (\$0 through		
Preferred Generics	mail order)	Not covered	mail order)	Not covered	
N	\$10 (\$0 through		\$10 (\$0 through		
Non-Preferred Generics	mail order)	Not covered	mail order)	Not covered	
Preferred Brand	\$40	Not covered	\$40	Not covered	
Non-Preferred Brand	\$70	Not covered	\$70	Not covered	
Specialty Drugs	25%	Not covered	25%	Not covered	
Mail Order (90 day supply)	2x	Not covered	2x	Not covered	
Catastrophic	2016 > = \$4,850/ 2017 >= \$4,950		2017 > = \$4,950/ 2018 >= \$5,000		
	Greater of 5% or		Greater of 5% or		
Generic	\$2.95 / \$3.30	Not covered	\$3.30 / \$3.35 ⁽²⁾	Not covered	
	Greater of 5% or		Greater of 5% or		
Preferred Brand	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
	Greater of 5% or		Greater of 5% or		
Non-Preferred Brand	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
	Greater of 5% or		Greater of 5% or		
Specialty Drugs	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
Monthly Premium	\$7.40 / \$6.25	rent	36.23 / 36.33 Rene	wal	
Single	\$365		\$363		
	N/A		N/A		
Family	N/	′ A	N/	A	

Indian River County Retiree Medicare Advantage Renewal Evaluation Effective Date: October 1, 2017

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Summary of Benefits	CURRENT		ALTERNATIVE # 1		
·	Florida Blue Med	licare Advantage	Florida Blue Med	icare Advantage	
Plan Structure	Blue Medicare G	roup PPO 2 RX 1	Blue Medicare G	<u> </u>	
Network Name	PPO	Out of Network	PPO	Out of Network	
Lifetime Maximum	Unlimited		Unlimited		
Calendar Year Deductible (CYD)	5 minited				
Individual	No deductible	\$2,000	No deductible	\$2,000	
Family	N/A	N/A	N/A	N/A	
Annual Out-of-Pocket Maximum	.,,				
Individual	\$2,000	\$4,000	\$2,000	\$4,000	
Family	N/A	N/A	N/A	N/A	
Physician Services	.,,,,		,		
Primary Care Office Visit	\$35 / visit	40% after CYD	\$35 / visit	40% after CYD	
Specialist Office Visit	\$50 / visit	40% after CYD	\$50 / visit	40% after CYD	
Chiropractic Services	\$20 / visit	40% after CYD	\$30 / visit \$20 / visit	40% after CYD	
Preventive Services	No charge	40% Coinsurance	No charge	40% Coinsurance	
Lab & Radiology Services	No charge	40% Comparance	ivo charge	40% Comsulation	
Diagnostic Tests & X-Rays (IDTF)	\$100 / visit	40% after CYD	\$100 / visit	40% after CYD	
Advanced Imaging (IDTF)	\$100 / visit \$175 / visit	40% after CYD	\$100 / visit \$175 / visit	40% after CYD	
Lab Services (Independent)	No charge	40% after CYD	No charge	40% after CYD	
Laboratory Provider	Quest Diagnostics	N/A	!	N/A	
Hospital Services	Quest Diagnostics	IV/A	Quest Diagnostics	IV/ A	
inospitai sei vites	\$250/day to max of		\$250/day to max of		
Inpatient	\$1,750/admit	40% after CYD	\$1,750/admit	40% after CYD	
Outpatient	\$250/visit	40% after CYD	\$250/visit	40% after CYD	
Physician Services at Facility	No charge	No charge	No charge	No charge	
Outpatient Advanced Imaging	\$250 / visit	40% after CYD	\$250 / visit	40% after CYD	
Emergency Room	\$250 / Visit \$75 / visit	\$75 / visit	\$250 / visit \$75 / visit	\$75 / visit	
Urgent Care	\$50 / visit	\$50 / visit	\$50 / visit	\$50 / visit	
Ambulance	\$150 / occurrence	\$150 / occurrence	\$150 / occurrence	\$150 / occurrence	
Outpatient Rehabilitation	\$1507 occurrence	3130 / Occurrence	\$1507 occurrence	\$150 / Occurrence	
Facility Charge	\$40	40% after CYD	\$40	40% after CYD	
Annual Maximum Visits	\$1,940 Max - P,S / \$1,940 Max - O		\$1,980 Max - P,S / \$1,980 Max - O		
Services Included ⁽¹⁾	C, P, S, O		C, P, S, O		
Durable Medical Equipment	\$0-20%/item	40% after CYD	\$0-20%/item 40% after CYD		
Prescription Drugs	\$ 2070/ ite	ion alter and	\$ 2070, Item	10/0 01101 012	
Prescription ONLY Deductible	No Deductible	Not Covered	\$75 (Brand Drugs Only)	Not Covered	
\$0 to Catastrophic			, in the same of t		
•	\$10 (\$0 through		\$15 (\$8 through		
Preferred Generics	mail order)	Not covered	mail order)	Not covered	
N 5 () 6	\$10 (\$0 through		\$15 (\$8 through		
Non-Preferred Generics	mail order)	Not covered	mail order)	Not covered	
Preferred Brand	\$40	Not covered	\$45	Not covered	
Non-Preferred Brand	\$70	Not covered	\$85	Not covered	
Specialty Drugs	25%	Not covered	25%	Not covered	
Mail Order (90 day supply)	2x	Not covered	3x	Not covered	
Catastrophic	2016 > = \$4,850/ 2017 >= \$4,950		2017 > = \$4,950/ 2018 >= \$5,000		
	Greater of 5% or		Greater of 5% or		
Generic	\$2.95 / \$3.30	Not covered	\$3.30 / \$3.35 ⁽²⁾	Not covered	
	Greater of 5% or		Greater of 5% or		
Preferred Brand	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
	Greater of 5% or		Greater of 5% or		
Non-Preferred Brand	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
	Greater of 5% or		Greater of 5% or		
Specialty Drugs	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
Monthly Premium		rent		tive #1	
	<u>Current</u> \$365.54		Alternative #1 \$326.64		
-	\$369	5.54	\$326	5.64	
Single Family	\$365 N/		\$326 N/		

Indian River County Retiree Medicare Advantage Renewal Evaluation Effective Date: October 1, 2017

GEHRING GROUP

INSURANCE BROKERS

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& CONSULTANTS

Summary of Benefits	CUR	RENT	ALTERNA	TIVE # 2	
·	Florida Blue Med	licare Advantage	Florida Blue Med	icare Advantage	
Plan Structure	Blue Medicare Group PPO 2 RX 1		Blue Medicare Group PPO 1 RX 1		
Network Name	PPO	Out of Network	PPO	Out of Network	
Lifetime Maximum	Unlir	nited	Unlimited		
Calendar Year Deductible (CYD)					
Individual	No deductible	\$2,000	No deductible	\$1,000	
Family	N/A	N/A	N/A	N/A	
Annual Out-of-Pocket Maximum					
Individual	\$2,000	\$4,000	\$1,000	\$3,000	
Family	N/A	N/A	N/A	N/A	
Physician Services			'		
Primary Care Office Visit	\$35 / visit	40% after CYD	\$10 / visit	20% after CYD	
Specialist Office Visit	\$50 / visit	40% after CYD	\$30 / visit	20% after CYD	
Chiropractic Services	\$20 / visit	40% after CYD	\$20 / visit	20% after CYD	
Preventive Services	No charge	40% Coinsurance	No charge	20% Coinsurance	
Lab & Radiology Services			,		
Diagnostic Tests & X-Rays (IDTF)	\$100 / visit	40% after CYD	\$50 / visit	20% after CYD	
Advanced Imaging (IDTF)	\$175 / visit	40% after CYD	\$125 / visit	20% after CYD	
Lab Services (Independent)	No charge	40% after CYD	No charge	20% after CYD	
Laboratory Provider	Quest Diagnostics	N/A	Quest Diagnostics	N/A	
Hospital Services					
Innationt	\$250/day to max of	40% after CYD	\$150/day to max of	20% after CYD	
Inpatient	\$1,750/admit	40% after CYD	\$1,050/admit	20% after CYD	
Outpatient	\$250/visit	40% after CYD	\$150/visit	20% after CYD	
Physician Services at Facility	No charge	No charge	No charge	No charge	
Outpatient Advanced Imaging	\$250 / visit	40% after CYD	\$150 / visit	20% after CYD	
Emergency Room	\$75 / visit	\$75 / visit	\$75 / visit	\$75 / visit	
Urgent Care	\$50 / visit	\$50 / visit	\$30 / visit	\$30 / visit	
Ambulance	\$150 / occurrence	\$150 / occurrence	\$150 / occurrence	\$150 / occurrence	
Outpatient Rehabilitation					
Facility Charge	\$40	40% after CYD	\$30	20% after CYD	
Annual Maximum Visits	\$1,940 Max - P,S / \$1,940 Max - O		\$1,980 Max - P,S / \$1,980 Max - O		
Services Included ⁽¹⁾		C, P, S, O		C, P, S, O	
Durable Medical Equipment	\$0-20%/item	40% after CYD	\$0-20%/item	20% after CYD	
Prescription Drugs					
Prescription ONLY Deductible	No Deductible	Not Covered	No Deductible	Not Covered	
\$0 to Catastrophic					
Preferred Generics	\$10 (\$0 through	Not covered	\$10 (\$0 through	Not covered	
	mail order)		mail order)		
Non-Preferred Generics	\$10 (\$0 through	Not covered	\$10 (\$0 through	Not covered	
Preferred Brand	mail order) \$40	Not covered	mail order) \$40	Not covered	
Non-Preferred Brand	\$40 \$70	Not covered Not covered	\$40 \$70	Not covered Not covered	
Specialty Drugs	25%	Not covered Not covered	\$70 25%	Not covered Not covered	
Mail Order (90 day supply)	25% 2x	Not covered Not covered	25% 2x	Not covered Not covered	
· · · · · · · · · · · · · · · · · · ·	2016 > = \$4,850		2017 > = \$4,950/		
Catastrophic	2016 > = \$4,850/ Greater of 5% or	2011 /- بالم	2017 > = \$4,950/ Greater of 5% or	2010 /- 33 ,000	
Generic	\$2.95 / \$3.30	Not covered	\$3.30 / \$3.35 ⁽²⁾	Not covered	
	\$2.95 / \$3.30 Greater of 5% or		\$3.30 / \$3.35 ' Greater of 5% or		
Preferred Brand	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
	\$7.40 / \$8.25 Greater of 5% or		\$8.25 / \$8.35 7 Greater of 5% or		
Non-Preferred Brand	\$7.40 / \$8.25	Not covered	\$8.25 / \$8.35 ⁽²⁾	Not covered	
			l i		
Specialty Drugs	Greater of 5% or \$7.40 / \$8.25	Not covered	Greater of 5% or \$8.25 / \$8.35 ⁽²⁾	Not covered	
Monthly Premium	The state of the s	rent	Alterna		
Single	\$365.54		\$397.46		
Family	N/A		N/A		
% Change	N,	/A	8.7	%	