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

GEHRING GROUP
INSURANCE BROKERS & CONSULTANTS

Summary of Benefits	CURRENT		RENEWAL	
Plan Structure	**Florida Blue Medicare Advantage Blue Medicare Group PPO 2 RX 1**		**Florida Blue Medicare Advantage Blue Medicare Group PPO 2 RX 1**	
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				
Diagnostic Tests & X-Rays (IDTF)	$100 / visit	40% after CYD	$100 / visit	40% after CYD
Advanced Imaging (IDTF)	$175 / visit	40% after CYD	$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
Hospital Services				
Inpatient	$250/day to max of $1,750/admit	40% after CYD	$250/day to max of $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	$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				
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				
Prescription ONLY Deductible	No Deductible	Not Covered	No Deductible	Not Covered
$0 to Catastrophic				
Preferred Generics	$10 ($0 through mail order)	Not covered	$10 ($0 through mail order)	Not covered
Non-Preferred Generics	$10 ($0 through mail order)	Not covered	$10 ($0 through 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***	
Generic	Greater of 5% or $2.95 / $3.30	Not covered	Greater of 5% or $3.30 / **$3.35**(2)	Not covered
Preferred Brand	Greater of 5% or $7.40 / $8.25	Not covered	Greater of 5% or $8.25 / **$8.35**(2)	Not covered
Non-Preferred Brand	Greater of 5% or $7.40 / $8.25	Not covered	Greater of 5% or $8.25 / **$8.35**(2)	Not covered
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	**Current**		**Renewal**	
Single	**$365.54**		**$363.97**	
Family	N/A		N/A	
% Change	**N/A**		**-0.4%**	

(1) C=Cardiac; P=Physical; S=Speech; O=Occupational (2) Minimum Cost sharing for 2018 displayed.

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Summary of Benefits	CURRENT		ALTERNATIVE # 1	
Plan Structure	**Florida Blue Medicare Advantage Blue Medicare Group PPO 2 RX 1**		**Florida Blue Medicare Advantage Blue Medicare Group PPO 2 RX 2**	
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				
Diagnostic Tests & X-Rays (IDTF)	$100 / visit	40% after CYD	$100 / visit	40% after CYD
Advanced Imaging (IDTF)	$175 / visit	40% after CYD	$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
Hospital Services				
Inpatient	$250/day to max of $1,750/admit	40% after CYD	$250/day to max of $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	$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				
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				
Prescription ONLY Deductible	No Deductible	Not Covered	**$75 (Brand Drugs Only)**	Not Covered
$0 to Catastrophic				
Preferred Generics	$10 ($0 through mail order)	Not covered	**$15** (**$8** through mail order)	Not covered
Non-Preferred Generics	$10 ($0 through mail order)	Not covered	**$15** (**$8** through 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***	
Generic	Greater of 5% or $2.95 / $3.30	Not covered	Greater of 5% or $3.30 / **$3.35**(2)	Not covered
Preferred Brand	Greater of 5% or $7.40 / $8.25	Not covered	Greater of 5% or $8.25 / **$8.35**(2)	Not covered
Non-Preferred Brand	Greater of 5% or $7.40 / $8.25	Not covered	Greater of 5% or $8.25 / **$8.35**(2)	Not covered
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	**Current**		**Alternative #1**	
Single	**$365.54**		**$326.64**	
Family	N/A		N/A	
% Change	**N/A**		**-10.6%**	

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Summary of Benefits	CURRENT		ALTERNATIVE # 2	
Plan Structure	**Florida Blue Medicare Advantage Blue Medicare Group PPO 2 RX 1**		**Florida Blue Medicare Advantage Blue Medicare Group PPO 1 RX 1**	
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	**$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				
Inpatient	$250/day to max of $1,750/admit	40% after CYD	**$150/day to max of $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 mail order)	Not covered	$10 ($0 through mail order)	Not covered
Non-Preferred Generics	$10 ($0 through mail order)	Not covered	$10 ($0 through 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***	
Generic	Greater of 5% or $2.95 / $3.30	Not covered	Greater of 5% or $3.30 / **$3.35**(2)	Not covered
Preferred Brand	Greater of 5% or $7.40 / $8.25	Not covered	Greater of 5% or $8.25 / **$8.35**(2)	Not covered
Non-Preferred Brand	Greater of 5% or $7.40 / $8.25	Not covered	Greater of 5% or $8.25 / **$8.35**(2)	Not covered
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	**Current**		**Alternative #2**	
Single	**$365.54**		**$397.46**	
Family	N/A		N/A	
% Change	**N/A**		**8.7%**	

(1) C=Cardiac; P=Physical; S=Speech; O=Occupational (2) Minimum Cost sharing for 2018 displayed.