Indian River County Health Plan Options - 2A, 2B, 3B
Effective October 1, 2020

Product	BlueOptions		BlueOptions			
Plan Number	Premier Gold Plan 03559	Premier Silver Plan 05302	Gold Option 2a	Silver Option 2a		
Actuarial Value	88.2%	79.6%	86.2%	77.8%	87.4%	79.1%
Savings % by Plan	N/A	N/A	-2.3%	-2.3%	-0.9%	-0.6%
Projected Claims	$24,255,000		$23,705,000		$24,042,000	
Savings $	N/A		-$550,000		-$213,000	
Savings % Total	N/A		-2.3%		-0.9%	
Cost Sharing Member's Responsibility Calendar Year Deductible (DED)	Single/Family	Single/Family	Single/Family	Single/Family	Single/Family	Single/Family
In-Network (INN)	$400/$800	$800/$1,600	$1,500/$3,000	$2,500/$5,000	$600/$1,200	$1,000/$2,000
Out-of-Network	$800/$1,600	$1,600/$3,200	$3,000/$6,000	$5,000/$10,000	$1,200/$2,400	$2,000/$4,000
Coinsurance (Member pays after Calendar Year DED)						
In-Network	20%	30%	20%	30%	20%	30%
Out-of-Network	30%	40%	30%	40%	30%	40%
Calendar Year Out of Pocket Maximum	Single/Family	Single/Family	Single/Family	Single/Family		
In-Network	$3,000/$6,000	$6,000/$12,000	$3,000/$6,000	$6,000/$12,000	$3,000/$6,000	$6,000/$12,000
Out-of-Network	$4,000/$8,000	$8,000/$16,000	$4,000/$8,000	$8,000/$16,000	$4,000/$8,000	$8,000/$16,000
Medical/Surgical Care by a Physician						
Office Services						
In-Network Family Physician	$25 Copayment	$35 Copayment	$25 Copayment	$35 Copayment	$30 Copayment	$40 Copayment
In-Network Specialist	$45 Copayment	$60 Copayment	$45 Copayment	$60 Copayment	$50 Copayment	$65 Copayment
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Allergy Injections (Office)						
In-Network Family Physician	$5 Copayment	$5 Copayment	$5 Copayment	$5 Copayment	$5 Copayment	$5 Copayment
In-Network Specialist	$5 Copayment	$5 Copayment	$5 Copayment	$5 Copayment	$5 Copayment	$5 Copayment
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Convenient Care Center						
In-Network	$25 Copayment	$35 Copayment	$25 Copayment	$35 Copayment	$30 Copayment	$40 Copayment
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Inpatient Hospital Facility (per admin)						
In-Network	PAD $200 + DED + 20% PAD $400 + DED + 30%	PAD $500 + DED + 30% PAD $1,000 + DED + 40%	PAD $200 + DED + 20% PAD $400 + DED + 30%	PAD $500 + DED + 30% PAD $1,000 + DED + 40%	PAD $200 + DED + 20% PAD $400 + DED + 30%	PAD $500 + DED + 30% PAD $1,000 + DED + 40%
Physician Services at Hospital						
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 30%	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 30%
Radiology, Pathology, and Anesthesiology Provider Services at Hospital						
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 30%	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 30%
Services						
Office Services						
In-Network Family Physician/Specialist	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Out-of-Network	30%	40%	30%	40%	30%	40%
Non Hospital Services Freestanding Facility						
Clinical Lab (Blood Work): Quest**						
In-Network	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
X rays (Independent Diagnostic Center)						
In-Network	$15 Copayment	$25 Copayment	$15 Copayment	$25 Copayment	$15 Copayment	$25 Copayment
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Outpatient Hospital Facility (per visit) (Surgical)						
In-Network	Option 1: DED + 20%	Option 1: DED + 30%	Option 1: DED + 20%	Option 1: DED + 30%	Option 1: DED + 20%	Option 1: DED + 30%
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Emergency and Urgent Care						
Emergency Room Facility (per visit)						
In-Network	$250 Copayment + DED + 20% (Copayment Waived if Admitted)	$500 Copayment + DED + 30% (Copayment Waived if Admitted)	$250 Copayment + DED + 20% (Copayment Waived if Admitted)	$500 Copayment + DED + 30% (Copayment Waived if Admitted)	$250 Copayment + DED + 20% (Copayment Waived if Admitted)	$500 Copayment + DED + 30% (Copayment Waived if Admitted)
Out-of-Network	$250 Copayment + INN DED + 20%	$500 Copayment + INN DED + 30%	$250 Copayment + INN DED + 20%	$500 Copayment + INN DED + 30%	$250 Copayment + INN DED + 20%	$500 Copayment + INN DED + 30%
Urgent Care Centers						
In-Network	$25 Copayment	$35 Copayment	$25 Copayment	$35 Copayment	$30 Copayment	$40 Copayment
Out-of-Network	$25 Copayment	$35 Copayment	$25 Copayment	$35 Copayment	$30 Copayment	$40 Copayment
Ambulance						
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 30%	DED + 20%	DED + 30%
Out-of-Network	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 30%	INN DED + 20%	INN DED + 30%
Advanced Imaging (MRI, MRA, PET, CT & Nuclear Medicine)						
Physician Office						
In-Network Family Physician or Specialist	$200 Copayment	30%	$200 Copayment	30%	$200 Copayment	30%
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Independent Diagnostic Testing Center						
In-Network	$200 Copayment	30%	$200 Copayment	30%	$200 Copayment	30%
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Outpatient Hospital Facility						
In-Network	DED + 20%	DED + 30%	DED + 20%	DED + 30%	DED + 20%	DED + 30%
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%

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Savings $	N/A		-$550,000		-$213,000	
Savings % Total	N/A		-2.3%		-0.9%	
Mental Health/ Alcohol & Substance Abuse Services						
Inpatient / Outpatient Hospital Facility	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)	PAD (Per Admission Deductible)
In-Network	PAD $200 + DED + 20%	$500 PAD + DED + 30%	PAD $200 + DED + 20%	$500 PAD + DED + 30%	PAD $200 + DED + 20%	$500 PAD + DED + 30%
Out-of-Network	PAD $400 + DED + 30%	$1,000 PAD + DED + 40%	PAD $400 + DED + 30%	$1,000 PAD + DED + 40%	PAD $400 + DED + 30%	$1,000 PAD + DED + 40%
Specialist Visits						
In-Network	$45 Copayment	$60 Copayment	$45 Copayment	$60 Copayment	$45 Copayment	$60 Copayment
Out-of-Network	DED + 30%	DED + 40%	DED + 30%	DED + 40%	DED + 30%	DED + 40%
Prescription Drugs (RX Administered through RX Benefits)						
1X Calendar Year Deductible Per Person	N/A	$100 (must be met before Copays apply)	N/A	$100 (must be met before Copays apply)	N/A	$100 (must be met before Copays apply)
Generic	$10 Copayment	$5 Copayment	$10 Copayment	$5 Copayment	$10 Copayment	$5 Copayment
Preferred Brand Name	$35 Copayment	$50 Copayment	$50 Copayment	$65 Copayment	$50 Copayment	$65 Copayment
Non-Preferred Brand Name	$50 Copayment	$70 Copayment	$65 Copayment	$85 Copayment	$75 Copayment	$95 Copayment
Mail Order Drug (90-Day Supply)	Express Script 2x Retail Copayment	Express Script 2x Retail Copayment	Express Script 2x Retail Copayment	Express Script 2x Retail Copayment	Express Script 2x Retail Copayment	Express Script 2x Retail Copayment
Maintenance Medication	2x Copayment at Covered Pharmacies	2x Copayment at Covered Pharmacies	2x Copayment at Covered Pharmacies	2x Copayment at Covered Pharmacies	2x Copayment at Covered Pharmacies	2x Copayment at Covered Pharmacies

Plan References: *Out of Network Balance Billing: For information regarding Out of Network Balance Billing that may be charged by an out-of-network provider, please refer to the Out-of-network Benefits section on the Summary of Coverage document. **Quest Diagnostics is the preferred lab for bloodwork through Florida Blue. When using a lab other than Quest, please be sure