ATTACHMENT "A"

Miami-Dade Blue Health Plan

Low Cost Comprehensive Health Insurance Product

Key Points

Revised: 1-2-09

- Unique Health Insurance Product Never Before Available – *Combines Low Cost Premiums + Comprehensiveness + Cost-Saving Strategies*
  - Low Premium = $110 for 35 yr old male/$122 for 35 yr old female (approximate median age of uninsured MDC population)
  - "Allowance" for Office-Based Primary & Specialty (old-style indemnity – keeps costs down for greatest service utilization)
  - 90/10% (BCBSF/member) split for hospital-related care (low cost share, post deductible/max out-of-pocket – when its needed most)
- High Value
  - $50 -- Allowance pays all but small co-pay (estimated: $10-$20) of average discounted routine physician visit
  - $2,500 – Maximum Annual Out-of-Pocket
  - $5 million -- Lifetime Maximum Benefit
- Accessibility and Sustainability
  - Broad network includes: traditional BCBSF providers + safety net
  - Market-based negotiated rates
  - Guaranteed Issuance = group product (with pre-existing exclusions)
    - Individual product = will exclude some individuals from coverage; however a *collaborative transitional initiative* will be available (to assist some individuals in qualifying for other non-underwritten product)
- Features
  - Insurance Company's Swipe Card (not a government program)
  - Electronic Record -- target = full electronic bill and patient file (Availity©)
  - Disease Management and ER alternatives (nurse line, web-based info and Urgent Care Centers)

For a complete description/package of this Low Cost Comprehensive Health Insurance Product, go to: http://www.miamidade.gov/govaction/legistarfiles/Matters/Y2008/081556.pdf

ATTACHMENT "B"

Miami-Dade Blue Health Plan -- Low Cost Comprehensive Health Insurance Product

Benefits Overview Matrix

Revised: 12-4-08

Proposed - These plans and rates are subject to review and approval by the Florida OIR and are based on a low cost provider network which must be developed with negotiations currently underway.

Benefits	Individual Plan ("medically underwritten" e.g., certain conditions prohibit coverage)	Group Plan ("guaranteed issuance" e.g., certain conditions subject to time limited exclusions)
Estimated Monthly Premiums		
Single Male Age 35 Individual Plan	$110	NA
Single Female Age 35 Individual Plan	$122	NA
Averaged Premium based on Single Males and Females Avg Age of 35 Group Plan (1)	NA	Total Premium $236 Employee Share $118
Calendar Year Deductible (CYD) - Only Applies As Indicated		
In-Network	$250 Deductible (yrly -- hospital & other)	Same as individual (per person)
Out-of-Network	$750 Deductible (yrly -- hospital & other)	Same as individual (per person)
Coinsurance		
In-Network	90% / 10% (BCBSF/member split of Discounted Hospital related)	Same as individual (per person)
Out-of-Network	60% / 40% (BCBSF/member split of Discounted Hospital related)	Same as individual (per person)
Out-of-Pocket Maximum - Most a Person Must Pay in Each Year (2)		
In-Network	$2,500 Per Person Per Year	Same as individual (per person)
Out-of-Network	$5,000 Per Person Per Year	Same as individual (per person)
Office Services		
In-Network Family Physician / PCP	$50 BCBSF Allowance (towards **Discounted** office visit --member pays balance)	Same as individual (per person)
In-Network Specialist	$50 BCBSF Allowance (towards **Discounted** office visit --member pays balance)	Same as individual (per person)
Lab performed at participating lab (Quest)	Fully Covered	Fully Covered
Out of Network Providers - Office Visits	$50 BCBSF Allowance (towards **NON**--Discounted office visit -- member pays balance)	Same as individual (per person)
Out of Network Providers - Surgical Services	$750 Deductible + 60% / 40% (BCBSF member split)	Same as individual (per person)
Urgent Care Center - In Network	$50 BCBSF Allowance (towards **Discounted** office visit --member pays balance)	Same as individual (per person)
Allergy Injection In-Network	$50 BCBSF Allowance (towards **Discounted** office visit --member pays balance)	Same as individual (per person)
Hospital Services		
Inpatient In-Network	$250 Deductible +90% / 10% (BCBSF/member split of **Discounted** Hospital Services)	Same as individual (per person)
Inpatient Out-of-Network	$500 Per Admission + $750 Deductible + 60% / 40% (BCBSF/member split of **Non-Discounted** out-of-network Hospital Services)	Same as individual (per person)
Outpatient In-Network - Surgical Services	$250 Deductible + 90% / 10% (BCBSF/member split of **Discounted** Hospital-based Outpatient Services)	Same as individual (per person)
Outpatient Out-of-Network - Surgical Services	$750 Deductible + 60% / 40% (BCBSF/member split of **Non-Discounted** out-of-network Hospital Services)	Same as individual (per person)
Emergency Room - In-Network - Surgical	$250 Deductible + 90% / 10% (BCBSF/member split of **Discounted** Hospital Services)	Same as individual (per person)
Emergency Room - In-Network - Non-Surgical	$500 Per Visit + $250 Deductible + 90% / 10% (BCBSF/member split of **Discounted** ER non-surgical services, after PAD and deductible)	Same as individual (per person)
Emergency Room - Out-of-Network - Surgical	$750 Deductible + 60% / 40% (BCBSF/member split of **Non-Discounted** Hospital Services)	Same as individual (per person)
Emergency Room - Out-of-Network - Non-Surgical	$1,000 Per Visit + $750 Deductible +60% / 40% (BCBSF/member split of **Non-Discounted** Hospital Services)	Same as individual (per person)
Benefit Maximums		
Lifetime Maximum	**$5,000,000**	**Same as individual (per person)**
Substance Dependency (Other Than Office Visit)	(Covered for Office Visits only)	Same as individual (per person)
Mental Health (Other Than Office Visit)	(Covered for Office Visits only)	Same as individual (per person)
Hospice	**$5,200 LTM (Life Time Maximum)**	**Same as individual (per person)**
Home Health Care	45 Visits Annual Maximum	Same as individual (per person)
Skilled Nursing Facility	45 Days Annual Maximum	Same as individual (per person)
Outpatient Therapy and Spinal Manipulations	**$1,500 Maximum Per Calendar Year**	**Same as individual (per person)**
Preventive Health		
Mammograms (Routine And Diagnostic)	Fully Covered	Same as individual (per person)
Well Child	$50 BCBSF Allowance (towards **Discounted** office visit --member pays balance)	Same as individual (per person)
Adult Wellness	$50 BCBSF Allowance (towards **Discounted** office visit --member pays balance)	Same as individual (per person)
Other		
Independent Clinical Labs	Fully Covered	Same as individual (per person)
Independent Diagnostic Testing Facility	$75 co-pay + BCBSF pays balance of **Discounted** fee	Same as individual (per person)
Contraceptive Injections	Not Covered	Same as individual (per person)
Prosthetics & Orthotics - Related to Surgical	$250 Deductible +90% / 10% (BCBSF/member split of **Discounted** Services)	Same as individual (per person)
Durable Medical Equipment - Related to Surgical, Inpatient Admission, ER Services	$250 Deductible + 90% / 10% (BCBSF/member split of **Discounted** Services)	Same as individual (per person)
Ambulance Services	$250 Deductible + 90% / 10% (BCBSF/member split) up to a Maximum $400 Per Day Ground & $4,000 Per Day Air/Water	Same as individual (per person)
Ambulatory Surgical Center - In Network	$250 Deductible +90% / 10% (BCBSF/ member split of **Discounted** Services)	Same as individual (per person)
Ambulatory Surgical Center - Out-of-Network	$750 Deductible + 60% / 40% (BCBSF/member split of **Non-Discounted** Services)	Same as individual (per person)
Outpatient Therapy and Spinal Manipulations	$250 Deductible + 90% / 10% (BCBSF/member split of **Discounted** Services)	Same as individual (per person)
Pharmacy	$10 Generic only Plus Discount Card For Non-Covered	Same as individual (per person)
Dental	$50 BCBSF Allowance (towards **Discounted** office visit --member pays balance)	Same as individual (per person)
Maternity	Maternity Rider available	**Maternity Covered**

Notes: (1) Based on a 40 person census all age 35, 20 males and 20 females

(2) All deductibles, coinsurance, and co-payments (except for pharmacy co-payments) count towards the Annual Out-Of-Pocket Maximum

ATTACHMENT "C"

Miami-Dade Blue Health Plan
Low Cost Comprehensive Health Insurance Product

Proposed Rates

Note: These monthly premium rates are subject to review and approval by the Florida OIR and are based on a low cost provider network which must be developed with negotiations currently underway.

Rates for Individual Product		
Age	**Sex**	**Rate**
10	F	$ 65.02
20	F	$ 77.76
30	F	$ 101.96
35	**F**	**$ 122.00**
40	F	$ 142.34
50	F	$ 202.90
64	F	$ 272.70
10	M	$ 65.02
20	M	$ 72.32
30	M	$ 91.08
35	**M**	**$ 110.00**
40	M	$ 128.74
50	M	$ 187.94
64	M	$ 324.38

Rates for Group Product					
Age	**Male**	**Female**	**EE + Sp**	**Male EE + Ch**	**Female EE + Ch**
00-24	$ 100.62	$ 250.26	$ 350.88	$ 401.62	$ 551.26
25-29	$ 129.86	$ 285.52	$ 416.24	$ 425.70	$ 581.36
30-34	$ 165.98	$ 290.68	$ 456.66	$ 470.42	$ 594.26
35-39	$ 172.86	$ 297.56	$ 470.42	$ 471.28	$ 595.12
40-44	$ 244.24	$ 331.96	$ 576.20	$ 514.28	$ 602.00
45-49	$ 309.60	$ 354.32	$ 663.92	$ 566.74	$ 611.46
50-54	$ 411.94	$ 437.74	$ 849.68	$ 649.30	$ 674.24
55-59	$ 528.90	$ 509.12	$ 1,038.02	$ 774.86	$ 755.08
60-64	$ 725.84	$ 624.36	$ 1,350.20	$ 894.40	$ 792.06

Note: EE = Employee; Sp = Spouse; Ch = Child

Note: Rates for Groups are based on the census of the group using the age and sex of each member of the group. For example, a group of 40 persons all age 35, half male and half female would have a group rate of $236.00 per person, at least half of which would be paid by the employer resulting in each person paying $118.00 (if the employer paid only half).