

ATTACHMENT "B"

Miami-Dade County/BlueCross BlueShield of Florida -- Low Cost Comprehensive Health Insurance Product

Benefits Overview Matrix

draft revision : 5-27-09

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	\$101	NA
Single Female Age 35 Individual Plan	\$111	NA
Averaged Premium based on Single Males and Females Avg Age of 35 Group Plan (1)	NA	Total Premium \$196 Employee Share \$98
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 <u>Discounted</u> Hospital related)	Same as individual (per person)
Out-of-Network	60% / 40% (BCBSF/member split of <u>Discounted</u> 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 <u>Discounted</u> office visit --member pays balance)	Same as individual (per person)
In-Network Specialist	\$50 BCBSF Allowance (towards <u>Discounted</u> office visit --member pays balance)	Same as individual (per person)
Lab performed at participating lab (Quest)	Fully Covered	Fully Covered
Out of Network Providers - Family Physician / PCP	\$50 BCBSF Allowance (towards NON--Discounted office visit -- member pays balance)	Same as individual (per person)
Out of Network Providers - Specialist	\$50 BCBSF Allowance (towards NON--Discounted office visit -- member pays balance)	Same as individual (per person)
Urgent Care Center - In Network	\$50 BCBSF Allowance (towards <u>Discounted</u> office visit --member pays balance)	Same as individual (per person)
Allergy Injection In-Network	\$50 BCBSF Allowance (towards <u>Discounted</u> office visit --member pays balance)	Same as individual (per person)
Hospital Services		
Inpatient In-Network	\$250 Deductible +90% / 10% (BCBSF/member split of <u>Discounted</u> 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 <u>Discounted</u> 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 <u>Discounted</u> Hospital Services)	Same as individual (per person)
Emergency Room - In-Network - Non-Surgical	\$500 Per Visit + \$250 Deductible + 90% / 10% (BCBSF/member split of <u>Discounted</u> 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 <u>Discounted</u> office visit --member pays balance)	Same as individual (per person)
Adult Wellness	\$50 BCBSF Allowance (towards <u>Discounted</u> 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 <u>Discounted</u> 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 <u>Discounted</u> Services)	Same as individual (per person)
Durable Medical Equipment - Related to Surgical, Inpatient Admission, ER Services	\$250 Deductible + 90% / 10% (BCBSF/member split of <u>Discounted</u> 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 <u>Discounted</u> 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 <u>Discounted</u> 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 <u>Discounted</u> 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