



Employee Benefits Consulting Group

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AUG 10 2010

HUMAN RESOURCES

August 10, 2010

Ms. Carmen Baker
Human Resource Manager
City of South Miami
6130 Sunset Drive
South Miami, Florida 33143

Re: Group Health Insurance

Dear Carmen:

As a follow-up to the Insurance Workshop we have designed a plan that will keep the City's annual contributions flat for the upcoming fiscal year. As you will note, there are 3 renewal options:

- **Option #1** – No change in benefits (Low HMO rates increased by 13.5%).
- **Option #2** – Change in benefits (Low HMO rates increased by 8.8%)
- **Option #3** – Change in benefits and keep the City's annual contribution flat for the upcoming fiscal year.

Carmen, please call me if you have any questions or concerns after reviewing this information. I look forward to discussing this in further detail.

Regards,

Gene Baynon
Principal

GB/jc

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City of South Miami

City's Annual Contribution Toward Health Insurance

	<u>Current Fiscal Year (10/1/2009-9/30/2010)</u>	<u>Renewal - Option #1</u>	<u>Renewal - Option #2</u>	<u>Renewal - Option #3</u>
a) Medical Insurance	\$568,208	\$645,033	\$617,936	\$575,066
b) Life/AD&D and Long Term Disability	\$29,621	\$23,468	\$23,468	\$23,468
c) Dental Insurance	<u>\$17,040</u>	<u>\$17,040</u>	<u>\$17,040</u>	<u>\$17,040</u>
d) TOTAL (a+b+c)	\$614,869	\$685,541	\$658,444	\$615,574
	<i>% Increase Over Current</i>	<i>11%</i>	<i>7%</i>	<i>0%</i>

Option #1 - No change in benefits (Low HMO rates increased by 13.5%).

Option #2 - Change in benefits (Low HMO rates increased by 8.8%).

Option #3 - Change in benefits and keep the City's contribution flat for the upcoming fiscal year.

The figures are based on 127 employees participating in the medical plan and 125 employees participating in the dental plan.

AvMed Renewal Alternative (Option #3)

Fully Insured Program: 10/1/2010 Effective Date

	<u>Current AvMed</u>	<u>Renewal AvMed (no benefit changes)</u>	<u>Renewal Alternative With AvMed</u>
Low HMO			
Employee only	\$372.84	\$423.25	\$377.34
Employee + child(ren)	\$659.92	\$749.16	\$667.92
Employee + spouse	\$734.48	\$833.82	\$743.38
Employee + child(ren) + spouse	\$1,099.86	\$1,248.60	\$1,113.19
% Increase Over Current		13.5%	1.2%
High HMO			
Employee only	\$432.51	\$490.92	\$440.78
Employee + child(ren)	\$765.55	\$868.93	\$780.19
Employee + spouse	\$852.04	\$967.11	\$868.35
Employee + child(ren) + spouse	\$1,275.91	\$1,448.21	\$1,300.32
% Increase Over Current		13.5%	1.9%



Low HMO Benefit Comparison (Option #3)

10/1/2010 Effective Date

	Current AvMed Network	Renewal Alternative Network
Deductible	\$250/person \$750/family	\$500/person \$1,500/family
Out-of-Pocket Maximum	\$1,500/person \$3,000/family	\$3,000/person \$6,000/family
Office Visit		
Primary Care Physician	\$15 copay/visit	\$25 copay/visit
Specialist	\$25 copay/visit	\$50 copay/visit
Inpatient Hospital	\$250 copay/day up to \$1,250/admission	80%*
Outpatient Surgery	\$250 copay/visit	80%*
Emergency Room	\$100 copay/visit	\$100 copay/visit
Rx Drugs (30 day supply)		
Generic	\$20 copay	\$20 copay
Brand - Formulary	\$40 copay	\$40 copay
Brand - Non Formulary	\$60 copay	\$60 copay
Self Injectables	\$75 copay	\$75 copay
Mail Order (90 day supply)	2x 30 day copay	2x 30 day copay



High HMO Benefit Comparison (Option #3)

10/1/2010 Effective Date

	Current AvMed Network	Renewal Alternative Network
Deductible	None	\$250/person* \$750/family*
Out-of-Pocket Maximum	\$1,500/person \$3,000/family	\$1,500/person \$3,000/family
Office Visit Primary Care Physician Specialist	\$15 copay/visit \$25 copay/visit	\$15 copay/visit \$25 copay/visit
Inpatient Hospital	\$250 copay/admission	\$250 copay/admission
Outpatient Surgery	\$250 copay/visit	\$250 copay/visit
Emergency Room	\$75 copay/visit	\$100 copay/visit
Rx Drugs (30 day supply)		
Generic	\$20 copay	\$20 copay
Brand - Formulary	\$40 copay	\$40 copay
Brand - Non Formulary	\$60 copay	\$60 copay
Self Injectables	\$75 copay	\$75 copay
Mail Order (90 day supply)	2x 30 day copay	2x 30 day copay

(* Deductible and 10% coinsurance would apply toward the following care: outpatient diagnostic tests, skilled nursing facilities, home health care, durable medical equipment, and prosthetic devices.



**LOW HMO RENEWAL
ALTERNATIVE (OPTION #3)**

Benefit Summary



LARGE GROUP \$25/\$500/20%	SCHEDULE OF BENEFITS	COST TO MEMBER
CALENDAR YEAR DEDUCTIBLE	INDIVIDUAL/ FAMILY <i>The Deductible does not apply toward the Out-of-Pocket Maximum</i>	\$500 / \$1,500 annually
CO-INSURANCE OUT-OF-POCKET MAXIMUM	INDIVIDUAL/ FAMILY per calendar year	\$3,000 / \$6,000 annually
AVMED PRIMARY CARE PHYSICIAN	Services at Participating Physicians' offices include, but are not limited to: <ul style="list-style-type: none"> ▪ Routine office visits/annual well-woman examination when performed by Primary Care Physician ▪ Pediatric care and well-child care ▪ Periodic health evaluation and immunizations ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures ▪ Vision and hearing screenings for children under 18 	\$25 per visit
MATERNITY CARE	<ul style="list-style-type: none"> ▪ Initial visit ▪ Subsequent visits 	\$25 Co-payment NO CHARGE
AVMED SPECIALITY HEALTH CARE PHYSICIAN SERVICES	<ul style="list-style-type: none"> ▪ Office visits ▪ Annual well-woman examination when performed by a participating Specialty Health Care Physician <p>Additional charges will apply if Outpatient Diagnostic Tests are performed in the Specialist's Office.</p>	\$50 per visit
HOSPITAL	Inpatient care at Hospitals includes: <ul style="list-style-type: none"> ▪ Room and board -- unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care unit and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies 	20% of the contracted rate, after Deductible
OUTPATIENT SERVICES	<ul style="list-style-type: none"> ▪ Outpatient surgeries, including cardiac catheterizations and angioplasty ▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> ▪ Drug infusion therapy ▪ Injectable Drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy) ▪ Preventive and diagnostic colonoscopies <ul style="list-style-type: none"> ▪ One preventive colonoscopy per lifetime (Not subject to Calendar Year Deductible) 	20% of the contracted rate, after Deductible 20% of the contracted rate, after Deductible \$75 Co-payment 20% of the contracted rate, after Deductible NO CHARGE
OUTPATIENT DIAGNOSTIC TESTS	<ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ Other diagnostic imaging tests <p>Charges for office visits will also apply if services are performed in a Specialist's office.</p>	20% of the contracted rate, after Deductible
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-payment waived if admitted) <ul style="list-style-type: none"> ▪ Emergency services at Participating Hospitals ▪ Emergency services at non-participating Hospitals, facilities and/or physicians <p>AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible.</p>	\$100 Co-payment

Benefit Summary, continued

URGENT/IMMEDIATE CARE	<ul style="list-style-type: none"> ▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office \$40 Co-payment ▪ Medical Services at a participating retail clinic \$25 per visit ▪ Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic \$60 Co-payment 	
FAMILY PLANNING	<ul style="list-style-type: none"> ▪ Voluntary family planning services \$25 per visit ▪ Sterilization (In addition to any Outpatient Facility charge) \$250 Co-payment 	
ALLERGY TREATMENTS	<ul style="list-style-type: none"> ▪ Injections \$25 per visit ▪ Skin testing \$50 per course of testing 	
AMBULANCE	<ul style="list-style-type: none"> ▪ Ambulance transport for emergency services \$100 Co-payment ▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means 	
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES	<ul style="list-style-type: none"> ▪ Short-term physical, speech or occupational therapy for acute conditions \$25 per visit <p>Coverage is limited to 30 visits per calendar year for all services combined</p>	
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER	<ul style="list-style-type: none"> ▪ Applied Behavior Analysis services \$50 per visit ▪ Physical, speech or occupational therapy for the treatment of Autism Spectrum Disorder \$25 per visit <p>Coverage for all services related to Autism Spectrum Disorder is limited to \$36,000 annually and may not exceed \$200,000 in total benefits.</p>	
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	<ul style="list-style-type: none"> ▪ Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed 20% of the contracted rate, after Deductible 	
CARDIAC REHABILITATION	<p>Cardiac rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ Acute myocardial infarction \$25 per visit ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant <p>Benefits limited to \$1,500 per calendar year</p> <p>Coverage is limited to 18 visits per calendar year</p>	
HOME HEALTH CARE	<ul style="list-style-type: none"> ▪ Limited to 60 skilled visits per calendar year 20% of the contracted rate, after Deductible 	
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	<p>Equipment includes:</p> <ul style="list-style-type: none"> ▪ Hospital beds 20% of the contracted rate, after Deductible ▪ Walkers ▪ Crutches ▪ Wheelchairs <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ Leg, arm, back and neck custom-made braces <p>Benefits limited to \$2,000 per calendar year</p>	
PROSTHETIC DEVICES	<p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> ▪ Artificial limbs 20% of the contracted rate, after Deductible ▪ Artificial joints ▪ Ocular prostheses 	

FOR ADDITIONAL INFORMATION, PLEASE CALL: 1-800-88-AVMED (1-800-882-8633)

This Schedule of Benefits is not a contract. For specific information on Benefits, Exclusions and Limitations, please consult your AvMed Group Medical and Hospital Service Contract.

**HIGH HMO RENEWAL
ALTERNATIVE (OPTION #3)**

Benefit Summary



LARGE GROUP \$15/\$250/\$1,500/10%	SCHEDULE OF BENEFITS	COST TO MEMBER
CALENDAR YEAR DEDUCTIBLE	INDIVIDUAL/ FAMILY <i>The Deductible does not apply toward the Out-of-Pocket Maximum</i>	\$250 / \$750 annually
OUT-OF-POCKET MAXIMUM	INDIVIDUAL/ FAMILY per calendar year <i>The Out-of-Pocket Maximum includes Co-payments and Co-insurance amounts unless otherwise excluded</i>	\$1,500 / \$3,000 annually
AVMED PRIMARY CARE PHYSICIAN	Services at Participating Physicians' offices include, but are not limited to: <ul style="list-style-type: none"> ▪ Routine office visits/annual well-woman examination when performed by Primary Care Physician ▪ Pediatric care and well-child care ▪ Periodic health evaluation and immunizations ▪ Diagnostic imaging, laboratory or other diagnostic services ▪ Minor surgical procedures ▪ Vision and hearing screenings for children under 18 	\$15 per visit
MATERNITY CARE	<ul style="list-style-type: none"> ▪ Initial visit ▪ Subsequent visits 	\$15 Co-payment NO CHARGE
AVMED SPECIALITY HEALTH CARE PHYSICIAN SERVICES	<ul style="list-style-type: none"> ▪ Office visits ▪ Annual well-woman examination when performed by a participating Specialty Health Care Physician <p>Additional charges will apply if Outpatient Diagnostic Tests are performed in the Specialist's Office.</p>	\$25 per visit
HOSPITAL	Inpatient care at Hospitals includes: <ul style="list-style-type: none"> ▪ Room and board – unlimited days (semi-private) ▪ Physicians', specialists' and surgeons' services ▪ Anesthesia, use of operating and recovery rooms, oxygen, drugs and medication ▪ Intensive care unit and other special units, general and special duty nursing ▪ Laboratory and diagnostic imaging ▪ Required special diets ▪ Radiation and inhalation therapies 	\$250 per admission; 100% coverage thereafter
OUTPATIENT SERVICES	<ul style="list-style-type: none"> ▪ Outpatient surgeries, including cardiac catheterizations and angioplasty ▪ Outpatient therapeutic services, including: <ul style="list-style-type: none"> ▪ Drug infusion therapy ▪ Injectable Drugs (Co-payment for Injectable Drug waived if incidental to same-day drug infusion therapy) ▪ Preventive and diagnostic colonoscopies <ul style="list-style-type: none"> ▪ One preventive colonoscopy per lifetime (Not subject to Calendar Year Deductible) 	\$250 Co-payment \$100 Co-payment \$75 Co-payment \$250 Co-payment NO CHARGE
OUTPATIENT DIAGNOSTIC TESTS	<ul style="list-style-type: none"> ▪ CAT Scan, PET Scan, MRI ▪ Other diagnostic imaging tests <p>Charges for office visits will also apply if services are performed in a Specialist's office.</p>	10% of the contracted rate, after Deductible
EMERGENCY SERVICES	An emergency is the sudden and unexpected onset of a condition requiring immediate medical or surgical care. (Co-payment waived if admitted) <ul style="list-style-type: none"> ▪ Emergency services at Participating Hospitals ▪ Emergency services at non-participating Hospitals, facilities and/or physicians <p>AvMed must be notified within 24 hours of inpatient admission following emergency services or as soon as reasonably possible.</p>	\$100 Co-payment

Benefit Summary, continued

URGENT/IMMEDIATE CARE	<ul style="list-style-type: none"> ▪ Medical Services at a participating Urgent/Immediate Care facility or services rendered after hours in your Primary Care Physician's office ▪ Medical Services at a participating retail clinic ▪ Medical Services at a non-participating Urgent/Immediate Care facility or non-participating retail clinic 	<p>\$40 Co-payment</p> <p>\$15 per visit</p> <p>\$60 Co-payment</p>
FAMILY PLANNING	<ul style="list-style-type: none"> ▪ Voluntary family planning services ▪ Sterilization (In addition to any Outpatient Facility charge) 	<p>\$15 per visit</p> <p>\$250 Co-payment</p>
ALLERGY TREATMENTS	<ul style="list-style-type: none"> ▪ Injections ▪ Skin testing 	<p>\$15 per visit</p> <p>\$50 per course of testing</p>
AMBULANCE	<ul style="list-style-type: none"> ▪ Ambulance transport for emergency services ▪ Non-emergent ambulance services are covered when the skill of medically trained personnel is required and the Member cannot be safely transported by other means 	<p>\$100 Co-payment</p>
PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES	<ul style="list-style-type: none"> ▪ Short-term physical, speech or occupational therapy for acute conditions <p>Coverage is limited to 30 visits per calendar year for all services combined</p>	<p>\$15 per visit</p>
DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER	<ul style="list-style-type: none"> ▪ Applied Behavior Analysis services ▪ Physical, speech or occupational therapy for the treatment of Autism Spectrum Disorder <p>Coverage for all services related to Autism Spectrum Disorder is limited to \$36,000 annually and may not exceed \$200,000 in total benefits.</p>	<p>\$25 per visit</p> <p>\$15 per visit</p>
SKILLED NURSING FACILITIES AND REHABILITATION CENTERS	<ul style="list-style-type: none"> ▪ Up to 20 days post-hospitalization care per calendar year when prescribed by physician and authorized by AvMed 	<p>10% of the contracted rate, after Deductible</p>
CARDIAC REHABILITATION	<p>Cardiac rehabilitation is covered for the following conditions:</p> <ul style="list-style-type: none"> ▪ Acute myocardial infarction ▪ Percutaneous transluminal coronary angioplasty (PTCA) ▪ Repair or replacement of heart valves ▪ Coronary artery bypass graft (CABG), or ▪ Heart transplant <p>Coverage is limited to 18 visits per calendar year</p>	<p>\$15 per visit</p> <p>Benefits limited to \$1,500 per calendar year</p>
HOME HEALTH CARE	<ul style="list-style-type: none"> ▪ Limited to 60 skilled visits per calendar year 	<p>10% of the contracted rate, after Deductible</p>
DURABLE MEDICAL EQUIPMENT AND ORTHOTIC APPLIANCES	<p>Equipment includes:</p> <ul style="list-style-type: none"> ▪ Hospital beds ▪ Walkers ▪ Crutches ▪ Wheelchairs <p>Orthotic appliances are limited to:</p> <ul style="list-style-type: none"> ▪ Leg, arm, back and neck custom-made braces 	<p>10% of the contracted rate, after Deductible</p> <p>Benefits limited to \$2,000 per calendar year</p>
PROSTHETIC DEVICES	<p>Prosthetic devices are limited to:</p> <ul style="list-style-type: none"> ▪ Artificial limbs ▪ Artificial joints ▪ Ocular prostheses 	<p>10% of the contracted rate, after Deductible</p>

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