The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

BUDGET SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS
Senator Negron, Chair

MEETING DATE: Tuesday, December 7, 2010
TIME: 12:30 —3:45 p.m.
PLACE: *Toni Jennings Committee Room,* 110 Senate Office Building

MEMBERS: Senator Negron, Chair

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Budget Overview		
2	Comparison of Medicaid/Private Health Insurance Benefits		

Budget Subcommittee on Health and Human Services Appropriations

Budget Overview
December 2010

Health and Human Services Appropriations
Committee Jurisdiction

- Agency for Health Care Administration
- Agency for Persons with Disabilities
- Department of Children and Families
- Department of Elder Affairs
- Department of Health
- Department of Veterans' Affairs

Health and Human Services Appropriations
Committee Staff and Assignments

Staff

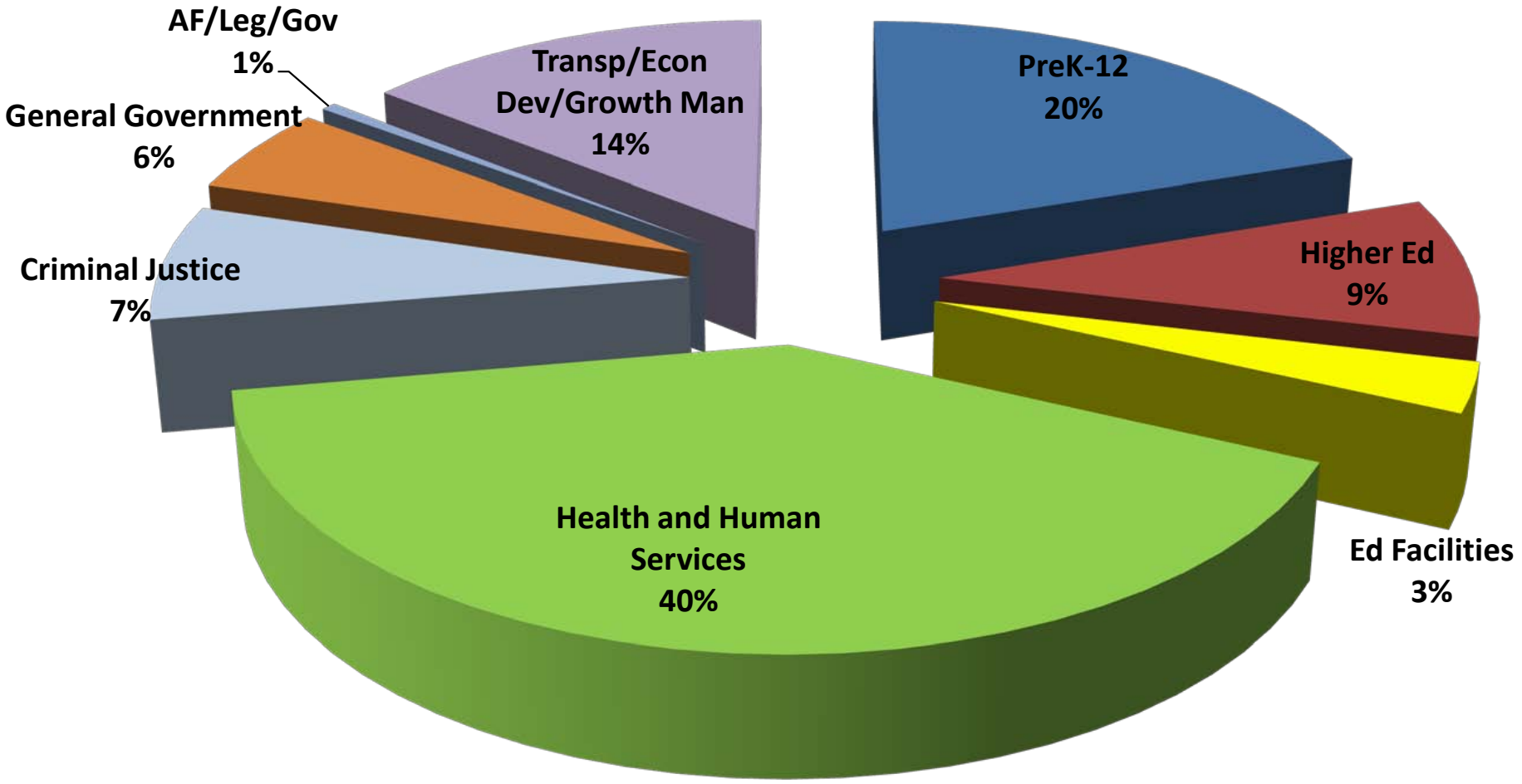
- Mike Hansen, Staff Director
- Robin Auber, Administrative Assistant
- Cindy Kynoch, Chief Legislative Analyst
- Sharon Bradford, Senior Legislative Analyst

Agency Assignment

• Agency for Health Care Administration	Cindy Kynoch
• Agency for Persons with Disabilities	Sharon Bradford
• Department of Children and Family Services	Vacant
• Department of Health	Sharon Bradford
• Department of Elder Affairs	Cindy Kynoch
• Department of Veterans' Affairs	Mike Hansen

Total State Budget

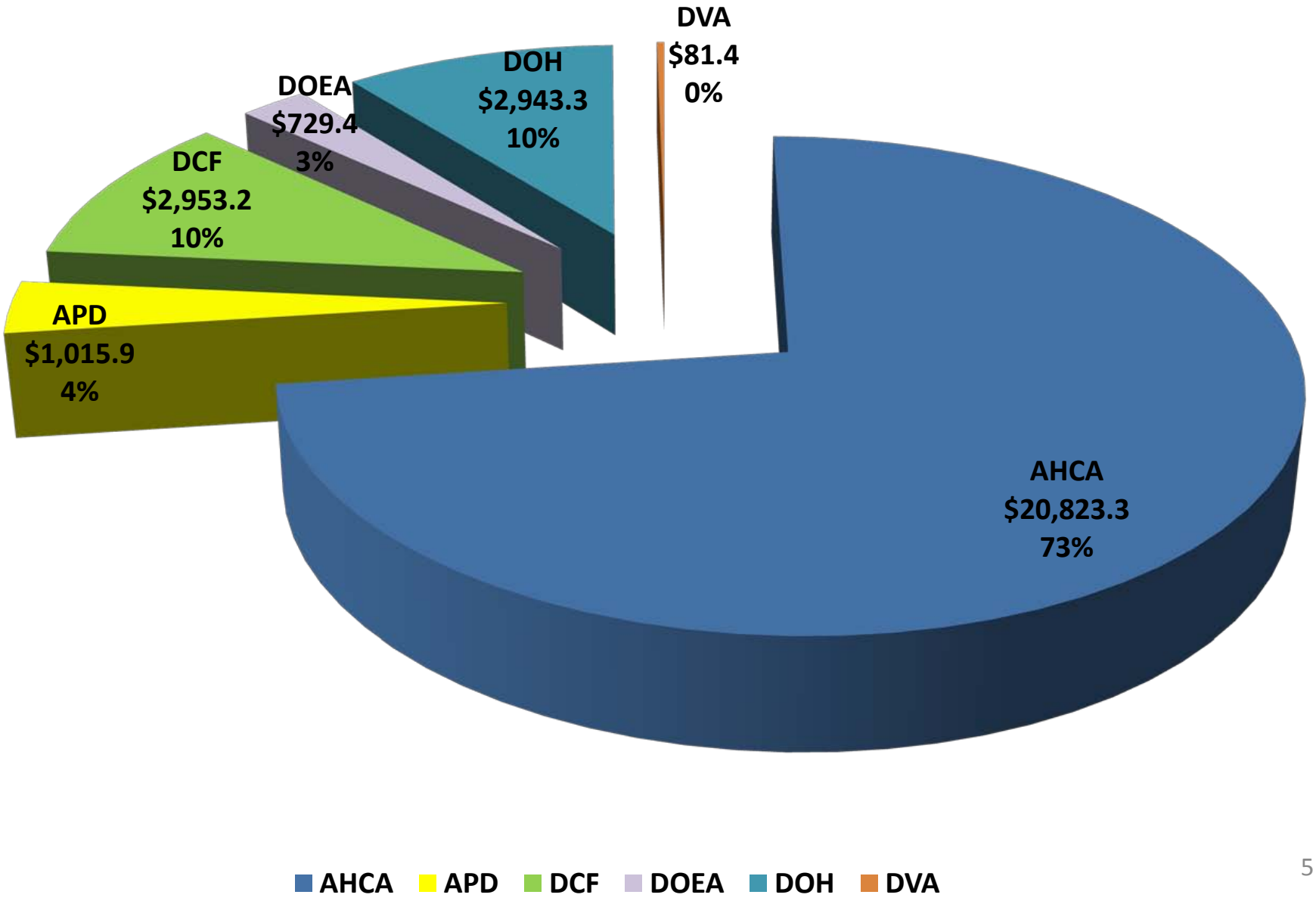
Fiscal Year 2010-2011 Budget: $70,476.8 Billion



Health and Human Services Appropriations

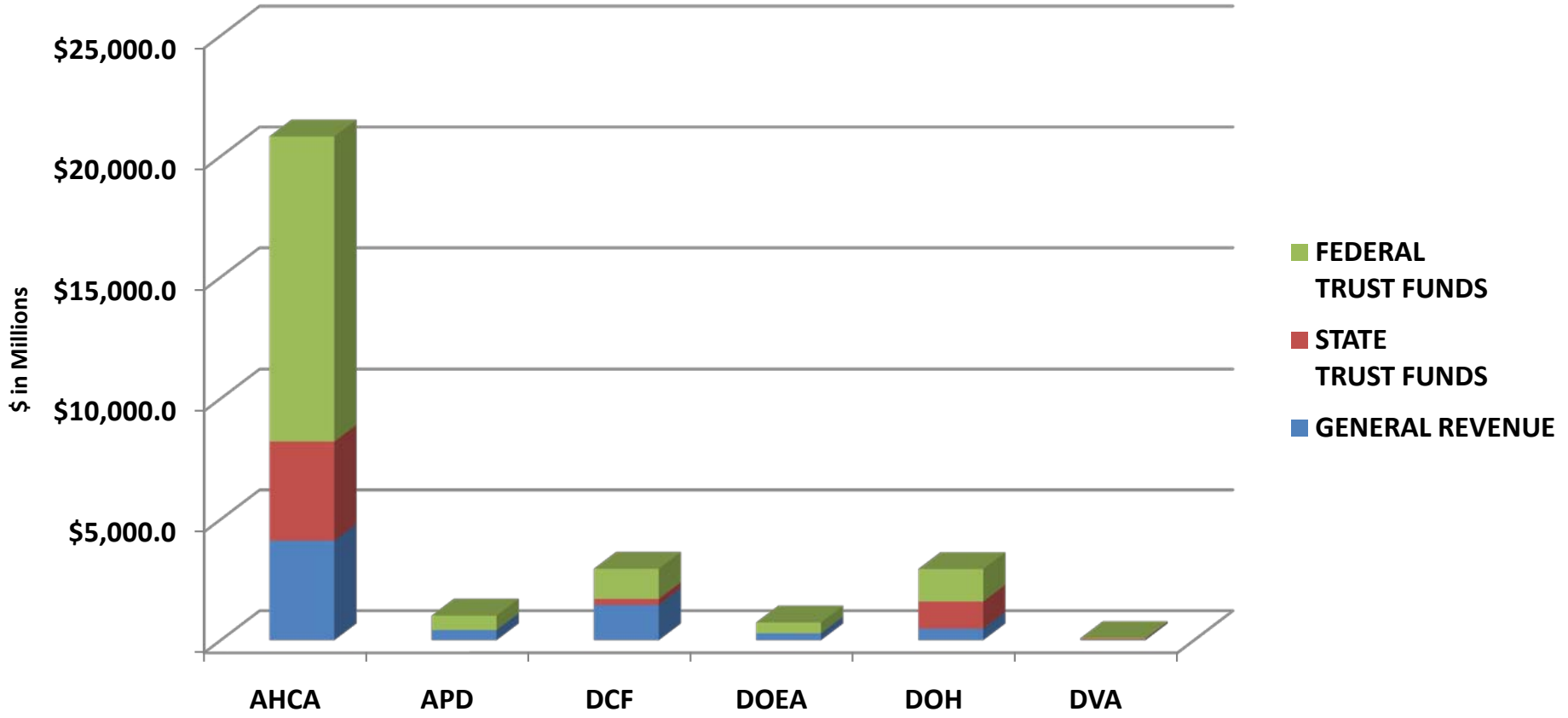
Fiscal Year 2010-2011 Budget: $28.5 Billion

(by Agency)



Health and Human Services Appropriations

Fiscal Year 2010-2011 – Funding by Agency and Fund Type

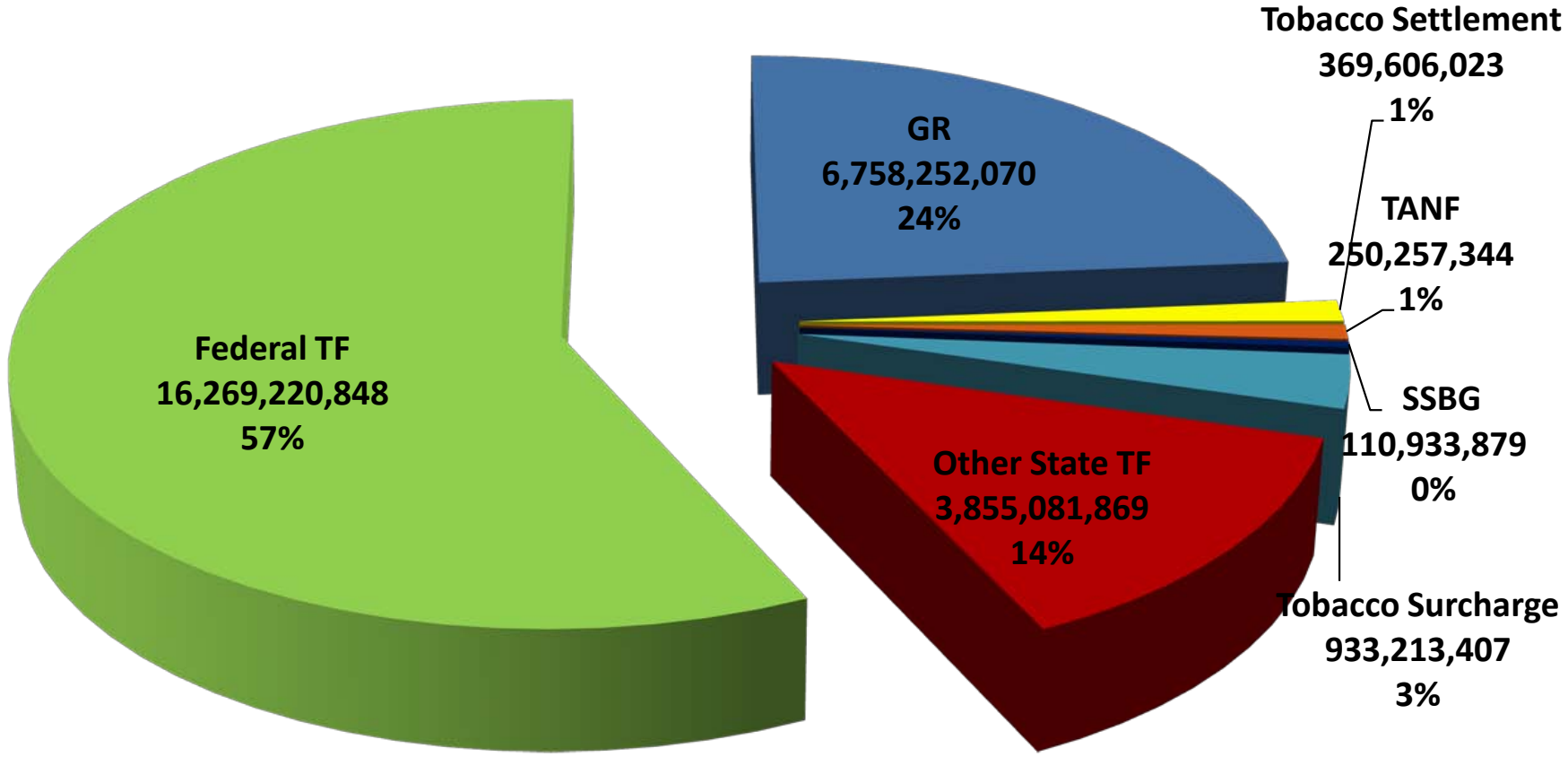


AGENCY	FTE	GENERAL REVENUE	STATE TRUST FUNDS	FEDERAL TRUST FUNDS	ALL FUNDS
Agency for Health Care Administration (AHCA)	1,662.50	$4,117.4	$4,099.8	$12,606.1	$20,823.3
Agency for Persons with Disabilities (APD)	3,078.00	$416.3	$2.8	$596.8	$1,015.9
Department of Children and Family Services (DCF)	13,186.75	$1,457.6	$246.8	$1,248.8	$2,953.2
Department of Elder Affairs (DOEA)	454.00	$279.1	$.7	$449.6	$729.4
Departement of Health (DOH)	17,367.50	$474.6	$1,122.6	$1,346.1	$2,943.3
Department of Veterans' Affairs (DVA)	1,123.00	$13.2	$46.3	$21.8	$81.4
Total: Health and Human Services Agencies	**36,871.75**	**$6,758.3**	**$5,519.1**	**$16,269.2**	**$28,546.6**

Health and Human Services Appropriations

Fiscal Year 2010-2011 Budget: $28.5 Billion

(by Fund Source)



Medicaid Program

Fiscal Year 2010-2011 State Funds

(based on August 2010 SSEC Data)

State Funds	Fiscal Year 2010-11	Fiscal Year 2011-12			Fiscal Year 2012-13			Fiscal Year 2013-14		
	Recur	Recur	Over/Under FY 10-11	% Diff	Recur	Over/Under FY 11-12	% Diff	Recur	Over/Under FY 12-13	% Diff
GENERAL REVENUE	3,453,747,554	5,464,419,032	2,010,671,478	36.8%	5,766,413,606	301,994,574	5.2%	5,983,251,990	216,838,384	3.6%
HEALTH CARE TRUST FUND *(Tobacco Surcharge)*	884,800,000	884,800,000	0	0.0%	871,200,000	(13,600,000)	-1.6%	862,300,000	(8,900,000)	-1.0%
PUBLIC MEDICAL ASSIST *(Hospital IP/OP Tax)*	546,120,000	546,120,000	0	0.0%	546,120,000	0	0.0%	546,120,000	0	0.0%
OTHER STATE FUNDS *(GR in Other HHS agencies)*	583,455,037	662,555,371	79,100,334	11.9%	649,816,838	(12,738,533)	-2.0%	645,115,711	(4,701,127)	-0.7%
TOBACCO SETTLEMENT	50,238,330	50,238,330	0	0.0%	50,238,330	0	0.0%	50,238,330	0	0.0%
TOTAL	5,518,360,921	7,608,132,733	**2,089,771,812**	27.5%	7,883,788,774	**275,656,041**	2%	8,087,026,031	**203,237,257**	2.5%

TOTAL PROGRAM	18,584,924,560	21,695,757,050	3,110,832,490	14.3%	22,623,131,737	927,374,687	10%	23,131,936,246	508,804,509	2.2%

Agency for Health Care Administration

- Health Care Services
  - Medicaid Program
  - KidCare Program
- Health Care Regulation
  - Facility Regulation
  - Certificate of Need
  - Organ Donor Program

Agency for Persons with Disabilities

- Home & Community Services
  - Home and Community Based Waiver
  - Family and Supported Living Waiver
  - Individual and Family Support
  - Room and Board Payments
- Developmental Disabilities Public Facilities

Department of Children and Family Services

- Family Safety Program
  - Child Care Regulation
  - Adult Protection
  - Child Protection & Permanency
  - Florida Abuse Hotline
- Mental Health Program
  - Violent Sexual Predator Program
  - Adult Community Mental Health
  - Children's Mental Health
- Adult Mental Health Treatment Facilities
- Substance Abuse Program
  - Child Substance Abuse Services
  - Adult Substance Abuse Services
- Economic Self-Sufficiency
  - Comprehensive Eligibility Services
  - Fraud Prevention & Benefit Recovery
  - Special Assistance Payments
  - Refugees

Department of Health

- Correctional Medical Authority
- Community Public Health
  - Family Health Services
  - Infectious Disease Control
  - Environmental Health Services
  - County Health Departments
  - Statewide Public Health
  - Support Services (EMS, biomedical research, bioterrorism)
- Disability Determination
- Children's Medical Services
  - CMS Networks
  - Poison Control Centers
  - Early Steps Program
  - Medical Services to Abused/Neglected Kids
  - Disease Specific Programs (kidney, heart, genetics)
- Health Care Practitioner/Access
  - Medical Quality Assurance
  - Community Health Resources (tobacco program, rural health networks, AHECs)

Department of Elder Affairs

- Comprehensive Eligibility Services
  - Comprehensive Assessment and Review for Long Term Care Services (CARES)
- Home & Community Services
  - Home and Community Based Waivers
  - Community Care for the Elderly (CCE)
  - Home Care for the Elderly (HCE)
  - Older Americans Act (OAA) Programs
  - Alzheimer Disease Programs
  - Local Services Programs
- Consumer Advocate Services
  - Long-Term Care Ombudsman
  - Guardianship Program

Department of Veterans' Affairs

- Veterans' Homes
- Executive Direction/Support Services
- Veterans' Benefits/Assistance

MEDICAID REFORM
Guiding Principals

1. Medicaid Reform has two goals: improved care and fiscal predictability, in that order.

2. Every Floridian receiving her or his health care through Medicaid will have a primary care physician. Delivery of and payment for health care in Medicaid will be focused on value and outcomes, not simply reimbursement for procedures.

3. In long-term care, home and community based options will be presented contemporaneously with nursing home alternative.

4. The AHCA Medicaid unit will be transformed from a check writing and fraud chasing agency into a contract compliance and monitoring operation.

5. To the extent that we deploy ACO's, PSN's, HMO's and other managed care organizations, we will insist on: guaranteed savings with performance bonds, strict prompt payment requirements, liquidated damages from posted cash reserves for contract breaches and patient abandonment, as well as periodic opportunities for Medicaid recipients to change plans. We will assume that our friends and neighbors enrolled in Medicaid can make informed judgments in their own best interests without a retinue of intermediaries substituting their collective preferences for individual choice.

6. The precise amount of money spent on Medicaid each fiscal year will represent a fixed appropriation in a total sum determined by the Legislature.

7. Medicaid health care benefits will be roughly comparable to the health insurance benefits received by Floridians who are paying the taxes that fund Medicaid.

8. Physicians that join us in taking care of our fellow citizens receiving Medicaid will benefit from increased compensation and enhanced legal protections.

COMPARISON OF MEDICAID BENEFITS AND SMALL GROUP STANDARD PLAN

MANDATORY MEDICAID SERVICES		*SMALL GROUP STANDARD PLAN (Coverage required to be offered to employers with 50 or fewer employees.)*
Hospital Inpatient Services	For persons age 21 and older, limited to 45 days or the number of days necessary to comply with the General Appropriations Act. No limit on the number of days for recipients 20 years of age or younger.	Covered subject to authorization.
Hospital Outpatient Services	Preventive, diagnostic, therapeutic, or palliative care, and other services provided by licensed physician or licensed dentist. Limited to $1,500 per state fiscal year per recipient, unless exception made by the AHCA, or with exception of a recipient under age 21, in which case the only limitation is medically necessity.	Coverage for treatment provided outside a hospital, such as an outpatient ambulatory surgical center, if such treatment would be covered on an inpatient basis and is provided by a provider whose services would be covered under the policy if the procedure was performed in a hospital. Subject to authorization. Rehabilitative outpatient therapies, which includes cardiac therapy, occupational therapy, speech therapy, and physical therapy are in addition to cardiac, occupational, physical, and speech benefits provided in the home health care, hospital, and skilled nursing faculty benefits. Limited to 20 visits per year.
Physician Services and Advanced Registered Practitioner Nurse Services	For a physician's services, includes covered services and procedures provided in the physician's office, a hospital, nursing home, or elsewhere. Does not include clinically unproven, experimental, or purely cosmetic procedures. Ten prenatal visits per recipient per pregnancy and 4 additional visits for high-risk pregnancies. Two postpartum visits per pregnancy. One new evaluation service per physician specialty, every 3 years if no services provided during the prior 3 years. For services provided by a ARNP who has a valid collaboration agreement with a licensed physician.	Covered.
Nursing Facility Services	24-hour-a-day nursing and rehabilitative services.	Lifetime benefit of 100 days in lieu of hospitalization.
Childhood Screening, Diagnosis, and Treatment	Early and periodic screening and diagnosis of children age 21 and under to determine mental and physical conditions and to provide treatment to correct or ameliorate these conditions. Includes personal care, private nursing duty, durable medical equipment, physical therapy, speech therapy, occupational therapy, respiratory therapy, and immunizations.	"Well Baby Care" (Childhood exams, immunizations, etc.,) services provided for children from birth to age 16 in accordance with recommendations of the American Academy of Pediatrics. Mandates specified coverage for cleft lip and cleft palate (medical, dental, speech therapy, audiology, and nutrition services)for a child under age 18.
Family Planning Services	Information, education, counseling, drugs, supplies, and freedom to choose any alternative family planning, as required by federal law.	Periodic health assessment exams and drugs covered subject to copayments and deductibles. Certain preventive services not subject to copayments and deductibles.
Home Health Care Services	Home health aide, supplies, appliances, and durable medical equipment. Does not include services, equipment, or supplies provided to a person in nursing home. Nursing and home health aide visit services limited to 4 visits by nurses and/or aides per day.	Limited to 60 visits per year. Services must be medically necessary and in lieu of hospitalization or continued hospitalization. Services include part-time or intermittent nursing care, physical therapy, occupational therapy, speech therapy, medical appliances, equipment, lab services, supplies, and drugs.

COMPARISON OF MEDICAID BENEFITS AND SMALL GROUP STANDARD PLAN

MANDATORY MEDICAID SERVICES		***SMALL GROUP STANDARD PLAN (Coverage required to be offered to employers with 50 or fewer employees.)***
Independent Lab Services	Medically necessary diagnostic procedures ordered by a licensed physician or other licensed practitioner.	Covered.
Portable X-Ray Services	Professional and technical portable radiological services provided in a setting other than a hospital, clinic, or office of a physician.	Covered.
Rural Health	Outpatient primary care services provided by a clinic located in a federally designated rural, medically underserved area.	N/A
Transportation Services	Transportation to a qualified Medicaid provider for medically necessary services provided that a client's ability to choose a transportation provider is limited to options implemented by AHCA to meet GAA limitations.	Not covered except for transportation (limited to $1,000) for newborns needing specialized care. The limit does not apply to HMO contracts.
OPTIONAL MEDICIAD SERVICES (States required to provide medically necessary care required by child eligibles.)		***SMALL GROUP STANDARD PLAN (Coverage required to be offered to employers with 50 or fewer employees.)***
Adult Dental	For recipients age 21 and older, covers medically necessary, emergency dental procedures to alleviate pain or infection. Emergency services limited to emergency oral exams, radiographs, extractions, and incision and drainage of abscess. Includes payment for partial and full dentures and the repair of full or partial dentures.	Dental services for the treatment of an accidental dental injury to teeth if the injury occurs and the services are rendered within 6 months of the accident. Provides coverage for necessary dental treatment that , if left untreated, is likel to result in a medical condition. Dental treatment in a hospital or ambulatory surgical center coverage is provided for general anesthesia and hospitalization services for a covered person who has one or more medical conditions that would create significant or undue medical risk if services were not delivered in a hospital or ambulatory surgical center. If coverage is provided for any diagnostic or surgical procedure involving bones or joints, must provide coverage for such procedures involving bones or joints of the mandible and facial area and such procedure is medically necessary to treat condition caused by congenital or developmental deformity, disorder, or injury.
Adult Health Screening	Annual exam for recipients age 21 or older.	Periodic health assessment including a physical exam, pap smear, and breast exam. Some preventive services not subject to copayments.
Ambulatory Surgical Centers	Covered.	Covered.
Anesthesiologist Assistant Services	Covered.	Covered.
Assistive Care Services	Services provided to recipients age 18 and older with functional or cognitive impairments residing in assisted living facilities, adult family-care homes, or residential treatment facilities. Services may include health support, assistance with activities and instrumental activities of daily living, and assistance with medication administration.	Services not generally covered.

COMPARISON OF MEDICAID BENEFITS AND SMALL GROUP STANDARD PLAN

OPTIONAL MEDICIAD SERVICES (States required to provide medically necessary care required by child eligibles.)		***SMALL GROUP STANDARD PLAN (Coverage required to be offered to employers with 50 or fewer employees.)***
Birth Center Services	Examinations and delivery, recovery, and newborn assessments, and related services for Medicaid recipients whose pregnancies are determined to be low risk.	A policy that provides maternity benefits must provide, as an option for the insured, coverage for the services rendered by nurse midwives, midwives, and the services of birth centers.
Case Management Services	Primary care case management services rendered pursuant to a waiver.	N/A
Chiropractic Services	Limited to 24 visits per year or one new patient visit and 23 established patient visits per year.	Limited to 10 visits per year.
Children's Dental Services	Diagnostic, preventive, or corrective procedures for children under age 21. Includes crowns, diagnostic evaluations, endodontic, dentures, oral surgery, orthodontic treatment, periodontal services, preventive services, radiographs, and restorations. Excludes fixed bridge work and sealants applied to baby teeth. Orthodontic services limited to treatment of severe malocclusions or correction of a dental condition deterring physical development.	Dental services for the treatment of an accidental dental injury to teeth if the injury occurs and the services are rendered within 6 months of the accident. Provides coverage for necessary dental treatment that , if left untreated, is likel to result in a medical condition. Dental treatment in a hospital or ambulatory surgical center coverage is provided for general anesthesia and hospitalization services for a a dependent child under age 8 has a complex dental condition or a developmental disability or a covered person who has one or more medical conditions that would create significant or undue medical risk if services were not delivered in a hospital or ambulatory surgical center.If coverage is provided for any diagnostic or surgical procedure involving bones or joints, must provide coverage for such procedures involving bones or joints of the mandible and facial area and such procedure is medically necessary to treat condition caused by congenital or developmental deformity, disorder, or injury.
Community Mental Health Services	Mental health and substance abuse services.	N/A
County Health Department Clinic Serv	Adult screening, child check-ups, dental services, family planning, immunizations, medical primary care services, and nursing protocol services.	N/A
Dialysis Facility Services	Subject to an appropriation, may pay for dialysis facility, routine lab tests, dialysis-related supplies and ancillary, and parenteral items. Hemodialysis in a freestanding center is limited one treatment per day, up to 3 times per week. Home peritoneal dialysis limited to one treatment per day. Reimbursement for approved medications is limited to up to 3 times per week.	Includes equipment, training, and medical supplies required for home dialysis.
Durable Medical Equipment	Medical necessity for equipment and supplies must be documented by a prescription, a statement of medically necessity, and a plan of care or hospital discharge plan.	Covered.

COMPARISON OF MEDICAID BENEFITS AND SMALL GROUP STANDARD PLAN

OPTIONAL MEDICIAD SERVICES (States required to provide medically necessary care required by child eligibles.)		*SMALL GROUP STANDARD PLAN (Coverage required to be offered to employers with 50 or fewer employees.)*
Early Intervention Services	Services for children from birth to age 3 who are receiving services via Early Steps program who with a developmental disability or a condition that has a high probability of resulting in a developmental delay. Services include screenings, evaluations, and early intervention sessions. Limited to 3 screenings per year; one initial psychosocial and developmental exam per lifetime, per recipient, and up to 3 follow-up psychosocial and developmental evaluations per year.	See childhood screening services, home health care services, and hospital outpatient services.
Healthy Start Services	Includes a continuum of risk-appropriate medical and psychosocial services for the federal Healthy Start program.	N/A
Hearing Services	Hearing evaluations, hearing aid devices, and related repairs. Newborn screening limited two screenings. Testing for children through age 20. r.Hearing aid evaluation limited to one every 3 years. Hearing aids limited to one per ear, per recipient, every 3 years.	Coverage for newborn's (12 months and under) initial hearing screening and any medically necessary follow-up reevaluation leading to a diagnosis unless child has permanent hearing impairment.
Home and Community-Based Services	Services provided pursuant to federal waiver.	N/A
Home and Community-Based Services/ Autism Disorders and other Developmental Disorders	Authorizes AHCA to seek federal waiver for the provision of occupational therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services for persons under age 5 who have been diagnosed with autism spectrum disorder, a developmental disability, or Down's Syndrome. Coverage would be limited to $36,000 annually and $108,000 in total lifetime benefits.	See mental and nervous disorder benefits under Community Mental Health Services
Hospice Services	For recipients who have a life expectancy of 6 months or less who elect a hospice. Includes hospice care, direct care services by a physician, and nursing facility room and board. Once election made, Medicaid will not reimburse for other Medicaid services that treat the terminal condition for adults 21 and older. Medicaid can reimburse for services for conditions that are totally unrelated to the terminal condition.	Benefits provided in cases where a person is not expected to live longer than 1 year and such coverage would be most appropriate and the most cost-effective method. Hospice coverage authorized in lieu of hospitalization. Care includes physician services, nursing care, home health aides, respiratory therapy, medical social services, medical supplies and drugs, medical counseling, and physical, occupational and speech therapy if approved by carrier. does not include custodial care. Inpatient hospice car if approved by carrier, includes pain control or acute chronic symptom management.
Intermediate Care Facilities/Developmentally Disabled	Health related-care and services on a 24-hour-a-day basis. No limitation on the length of stay in a ICF/DD. Reimbursement for a reserved bed is limited to 15 days per hospital stay and 45 days per fiscal year for therapeutic leave.	See Community Mental Health Services.

COMPARISON OF MEDICAID BENEFITS AND SMALL GROUP STANDARD PLAN

OPTIONAL MEDICIAD SERVICES (States required to provide medically necessary care required by child eligibles.)		*SMALL GROUP STANDARD PLAN (Coverage required to be offered to employers with 50 or fewer employees.)*
Intermediate Care Nursing and Rehabilitation Facility Services	24-hour-a-day nursing and rehabilitative services limited to 8 days per hospital stay and 16 days per fiscal year. Hospital-based skilled nursing unit services limited to 30 days, unless one 15-day extension is authorized. Swing bed services limited to 60 days unless prior authorization obtained.	See Nursing Facility Services.
Physician Assistant Services	Covered.	Covered.
Podiatric Services	Includes diagnosis and medical, surgical, palliative, and mechanical treatment. Reimburses for routine foot care if the recipient is under a physician's care for a metabolic disease, has a circulatory impairment, or has conditions of desensitization of the legs or feet. Visits in custodial care and nursing facilities are limited to one visit per month, per provider. One new patient evaluation every 3 years.	Coverage for services within the scope of a podiatric physician.
Prescribed Drugs	Covered.	Subject to applicable copayments and/or coinsurance.
Private Duty Nursing, Personal Care, and Therapy services for Children age 20 and Younger	For children who are medically complex. Private duty nursing and personal care services limited to 2 to 24 hours of private duty nursing per day, per recipient and 2 to 24 hours of personal care per day, per recipient. Each therapy (occupational, physical, respiratory, and speech) is limited to 14 units (1 unit= 15 minutes) per week.	Nursing limited to part-time and intermittent care. See rehabilitative therapies under outpatient services --generally 20 visits per year.
Registered Nurse First Assistant Servi	Covered.	Covered.
School-Based Services	Covered.	N/A
State Mental Hospital Services	Psychiatric inpatient services age 65 and older.	See Community Mental Health.
Subacute Inpatient Psychiatric Program for Children	Long-term inpatient services to children age 17 and younger.	Services not generally covered.
Vision Services	Examination, diagnosis, treatment, eyeglasses prescribed by a licensed physician or by a licensed optometrist. For adults (age 21 and older) limited to one pair of eyeglasses every 2 years and one pair of lenses every 365 days. Second pair of eyeglass frames and pair of lenses may be provided to an adult subject to prior authorization. For adults, eyeglasses limited to two pairs (two frames and four lenses) once every 365 days unless authorized.	Limited to physician services needed to treat injury, disease, or covered condition of the eyes plus initial glasses or contact lenses after cataract surgery.

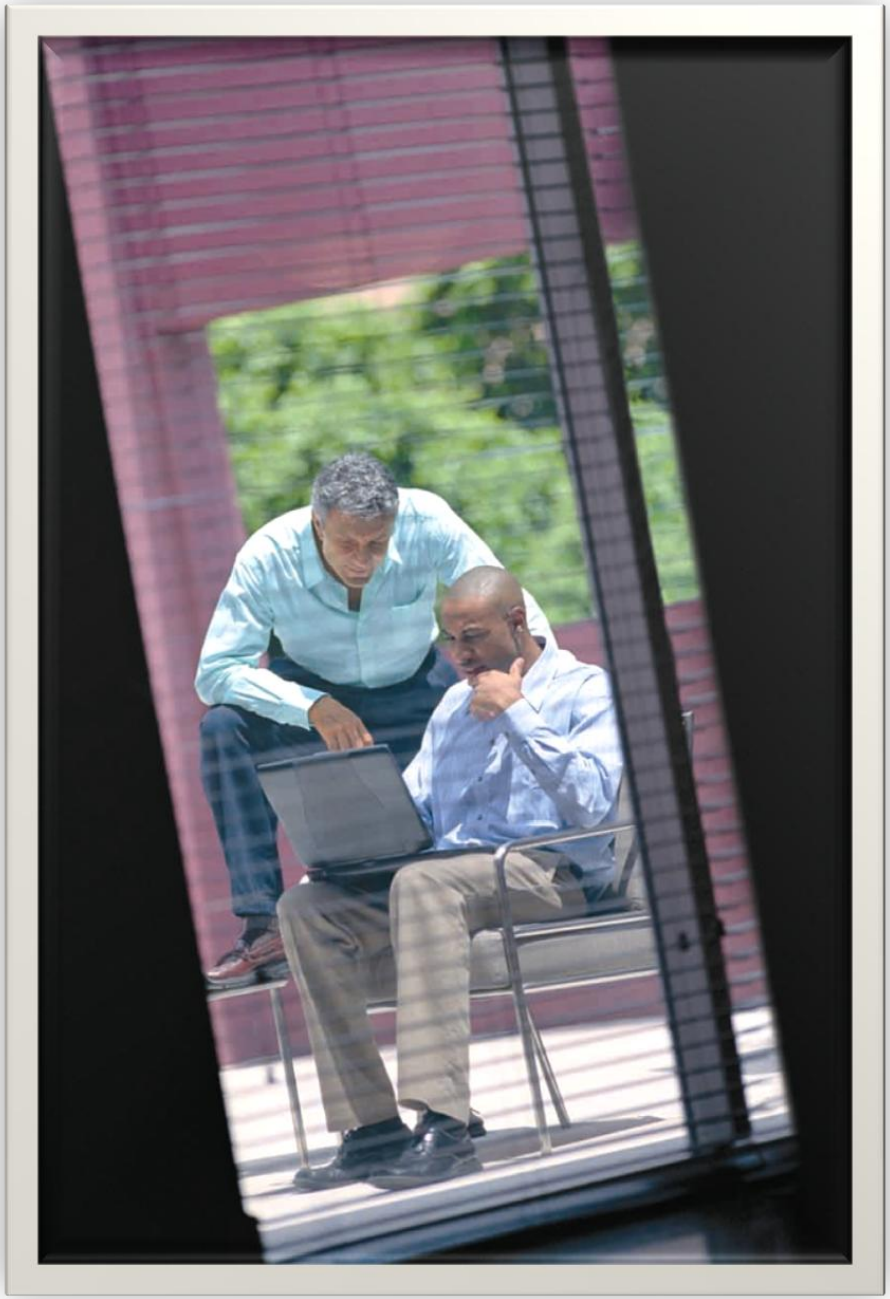
Metal Essence, Inc.
Health Insurance Plan

Expense Category	2009-2010 Plan	Proposed Renewel 2010-2011 Plan	Final 2010-2011 Plan	Over/Under
Lifetime Maximum Benefit	$5,000,000 Per Person	$5,000,000 Per Person	$5,000,000 Per Person	
Calendar Year Deductible	Yes	Yes	Yes	
Single Employee	$500.00	$500.00	$2,000.00	$1,500.00
Family Maximum	$1,500.00	$1,500.00	$4,000.00	$2,500.00
PCP OV Copay	$15.00	$15.00	$30.00	$15.00
Spec OV Copay	$35.00	$35.00	$60.00	$25.00
Chiropractic	$35.00 copay	$35.00 copay	$60.00	$25.00
Maximum Visits Per Calendar Year	20	20	20	
Advanced Imaging (CT Scans, MRI, Etc)				
PCP	$15.00	$15.00	$250.00	$235.00
Specialist	$35.00	$35.00	$250.00	$215.00
Maternity				
Specialist	$35.00	$35.00	$60.00	$25.00
Medical Pharmacy				
In Network ($200/ OOP Maximum)	N/A	20%	20%	20%
Out of Network	N/A	Ded, 50%	Ded, 50%	Ded, 50%
Preventive Care				
Adult Wellness				
In Network PCP/Specialist	$15.00/$35.00	$15.00/$35.00	$30.00/$60.00	$15.00/$25.00
Out of Network	50%	50%	50%	
Routine Adult Physical Exam & Immunization				
In Network PCP/Specialist	$15.00/$35.00	$15.00/$35.00	$30.00/$60.00	$15.00/$25.00
Out of Network	50%	50%	50%	
Mammograms	$0.00	$0.00	$0.00	
Well child				
In Network				
PCP	$15.00	$15.00	$30.00	$15.00
Specialist	$35.00	$35.00	$60.00	$25.00
Out of Network	50%	50%	50%	
Urgent Care				
In Network	$40.00	$40.00	$75.00	$35.00
Out of Network	Ded, 50%	Ded, 50%	Ded, 50%	
Emergency Room (Facility Charge)				
In Network	$100.00	$100.00	$250.00	$150.00
Out of Network	$200.00	$200.00	Ded, 50%	
Provider Services at Emergency Room				
In Network	$0.00	$50.00	Ded, 80%	
Out of Network	$0.00	$50.00	Ded, 50%	
Out Patient Diagnostic Testing Services				
In Network	$50.00	$50.00	$50.00	
In Network - Advanced Imaging Services			$250.00	$250.00
Out of Network	Ded, 50%	Ded, 50%	Ded, 50%	
Independent Clinical Labs				
In Network	$0.00	$0.00	$0.00	$0.00
Out of Network	Ded, 50%	Ded, 50%	Ded, 50%	
Mental Health				
Out-Patient	$35.00 copay	$35.00 copay	$30.00	
In-Patient	$600 copay	$600 copay	$60.00	
DME Copay				
Hospital In-patient Cost	$600 copay	$600 copay	Ded, 80%	
Out-Patient Surgery Cost (In network)	$100 copay	$100 copay	$300.00	
Maximum Out of Pocket (In Network)				
Single	$2,500.00	$2,500.00	$3,500.00	$1,000.00
Family Maximum	$5,000.00	$5,000.00	$7,000.00	$2,000.00
RX Plan				
Generic	$15.00		$10.00	($5.00)
Preferred Brand	$30.00		$30.00	
Brand	$50.00		$50.00	
38 y/o female employee plus family	**$915.94**	**$1,118.66**	**$973.19**	**$57.25**
42 y/o female employee plus family	**$1,009.50**	**$1,232.93**	**$1,072.61**	**$63.11**
30 y/o female employee only	**$342.02**	**$424.26**	**$369.09**	**$27.07**
28 y/o female + children	**$707.09**	**$844.90**	**$735.05**	**$27.96**
Total Monthly	**$2,974.55**	**$3,620.75**	**$3,149.94**	**$175.39**
Increase	**N/A**	**$646.20**	**$175.39**	
Percentage Increase		**21.72%**	**5.90%**	**5.90%**

Budget Subcommittee on Health and Human Services Appropriations

Scott Bryant
Director, Product Management
Blue Cross Blue Shield of Florida

12/7/2010



The Florida Blue Plan

- In business since 1944 with a focus on health care in Florida
- Serves more than 8.6 million people
- Over 35,000 group employers enrolled
- Average Small Group size is 8
- 1 in 3 Floridians who enroll in a commercial product have Blue Cross and Blue Shield of Florida (BCBSF)
- 32% market share – more than double that of nearest competitor
- Committed to the community

Flexible Employee Health Benefit Platform

Value-based, Wellness-focused, Incentive-driven, Financially-integrated

BlueOptions®			BlueChoice®	BlueCare®*	Specialty**
Medical Plans	Multi-Plan Packages	Consumer-Directed Plans	PPO Plans	HMO Plans	Solutions for Individuals and Consumers
Broad range of benefits, pricing 1st dollar coverage Annual caps Smart cost sharing design features MyBasic	Multiple plans in choice packages Choose plan that best meets needs Contribution optimization Low cost products 50/50 coinsurance Hospital / Surgical plans	Account-based, integrated health and financial solutions Tax-advantaged FSA, HRA, HSA Debit Cards Banking, Investments Higher Deductible 100/90/80 coinsurance	Flexible Plans No PCP Required No Referral Required	Predictable cost NCQA Accreditation Individual practice models statewide major metro Staff models in selected markets	Dental Life, AD&D Vision EAP Workers Comp FamilyBlue Discount GoBlue Limited Benefit BlueSelect Blue@Work
Blueprint for Health®					
NetworkBlue℠ Network			PPC Network	Health Options, Inc. (HOI) Network)	
Traditional Program Network (balanced-billing protection)					
BlueCard® Program when traveling out of state				Away from Home Care®	

* Health Options, Inc. ** Available through Florida Combined Life Insurance Company, Inc.

Group Plan Ranking

	Top Plans 2010	Calendar Year Deductible In Network (Ind/Fam)	Coinsurance (In/Out Network)	Physician Office Srvcs (PCP/Spec)	OOP Max In Network (Ind/Fam)
Group 1-50					
1	Lower Cost Plan 5800	$1,500/NA	50%/50%	$35/50	$10,000/10,000
2	Predictable Cost Plan 5462	$500 /1,500	80%/50%	$15/35	$2,500/5,000
3	Predictable Cost Plan 5464	$2,000/6,000	100%/50%	$30/60	$2,000/6,000
4	HSA Comp. Health Plan 5068/5069	$2,500/5,000	100%/80%	Ded + Ded	$2,500/5,000
5	HSA Comp. Health Plan 5040/5041	$1,500/3,000	100%/60%	Ded+Coins	$3,000/6,000

Additional handouts with complete benefit structures provided

Thank You!

BlueOptions

For Small Groups
Health Benefit Summary Plans 5040 and 5041

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Benefits for Covered Services

Amount Member Pays

	HSA-Compatible Plan 5040 Single Coverage	HSA-Compatible Plan 5041 Family Coverage
Office Services		
Physician Office Services		
In-Network Family Physician	DED[1] + 10% Coinsurance	DED + 10% Coinsurance
In-Network Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network Office Visit	DED + 40% Coinsurance	DED + 40% Coinsurance
In-Network e-Office Visit	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network e-Office Visit	DED + 40% Coinsurance	DED + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Maternity Initial Visit		
In-Network Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Allergy Injections		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Medical Pharmacy		
In-Network Monthly Out-of-Pocket (OOP) Maximum[2]	$200	$200
In-Network Provider	DED + 20% Coinsurance	DED + 20% Coinsurance
Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance
Preventive Care		
Adult Wellness Benefit Maximum (PBP[3] Max, includes Routine Adult Physical Exam and Immunizations & Well Woman)		
In-Network	No Maximum	No Maximum
Out-of-Network	$150	$150
Routine Adult Physical Exam and Immunizations		
In-Network Family Physician	10% Coinsurance	10% Coinsurance
In-Network Specialist	10% Coinsurance	10% Coinsurance
Out-of-Network	40% Coinsurance	40% Coinsurance
Well Woman Exam (e.g. Annual GYN)		
In-Network Family Physician	10% Coinsurance	10% Coinsurance
In-Network Specialist	10% Coinsurance	10% Coinsurance
Out-of-Network	40% Coinsurance	40% Coinsurance
Mammograms (Covered at 100% of Allowed Amount)		
In- and Out-of-Network	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies) (Covered at 100% of Allowed Amount)		
In and Out-of-Network	$0	$0
Well Child (No PBP Max)		
In-Network Family Physician	10% Coinsurance	10% Coinsurance
In-Network Specialist	10% Coinsurance	10% Coinsurance
Out-of-Network	40% Coinsurance	40% Coinsurance

1 DED = Deductible
2 Monthly OOP max does not apply until the In-Network DED is met. In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once the OOP max is met.
3 PBP = Per Benefit Period

Note: Out-of-Network services may be subject to balance billing.

BlueOptions

For Small Groups
Health Benefit Summary Plans 5040 and 5041

Benefits for Covered Services

	Amount Member Pays	
	HSA-Compatible Plan 5040 Single Coverage	**HSA-Compatible Plan 5041 Family Coverage**
Emergency Medical Care		
Urgent Care Centers In-Network Out-of-Network	 DED + 10% Coinsurance DED + 40% Coinsurance	 DED + 10% Coinsurance DED + 40% Coinsurance
Emergency Room Facility Services (per visit) In-Network Out-of-Network	 DED + 10% Coinsurance DED + 40% Coinsurance	 DED + 10% Coinsurance DED + 40% Coinsurance
Ambulance Services (Ground, air and water travel, combined per day maximum) In-Network and Out-of-Network	$5,000 In-Network DED + 10% Coinsurance	$5,000 In-Network DED + 10% Coinsurance
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Out-of-Network	 DED + 10% Coinsurance DED + 10% Coinsurance DED + 40% Coinsurance	 DED + 10% Coinsurance DED + 10% Coinsurance DED + 40% Coinsurance
Independent Clinical Lab (e.g. Blood Work) In-Network Out-of-Network	 DED DED + 40% Coinsurance	 DED DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	 DED + 10% Coinsurance DED + 40% Coinsurance	 DED + 10% Coinsurance DED + 40% Coinsurance
Mental Health/Substance Dependency		
Mental Health (PBP Max) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network	30 Inpatient days, 20 Outpatient visits DED + 10% Coinsurance DED + 40% Coinsurance DED + 10% Coinsurance DED + 40% Coinsurance	30 Inpatient days, 20 Outpatient visits DED + 10% Coinsurance DED + 40% Coinsurance DED + 10% Coinsurance DED + 40% Coinsurance
Substance Dependency (Lifetime Max) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network	$2,500 DED + 10% Coinsurance DED + 40% Coinsurance DED + 10% Coinsurance DED + 40% Coinsurance	$2,500 DED + 10% Coinsurance DED + 40% Coinsurance DED + 10% Coinsurance DED + 40% Coinsurance
Other Provider Services		
Provider Services at Hospital and ER In-Network and Out-of-Network	 In-Network DED + 10% Coinsurance	 In-Network DED + 10% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network and Out-of-Network	 In-Network DED + 10% Coinsurance	 In-Network DED + 10% Coinsurance

BlueOptions

For Small Groups
Health Benefit Summary Plans 5040 and 5041

Benefits for Covered Services

	Amount Member Pays	
	HSA-Compatible Plan 5040 Single Coverage	**HSA-Compatible Plan 5041 Family Coverage**
Other Provider Services (Continued)		
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician	DED + 10% Coinsurance	DED + 10% Coinsurance
In-Network Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP Max)	$2,500	$2,500
In-Network Locations other than Hospital and Physician's Office	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network Locations other than Hospital	DED + 40% Coinsurance	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit)		
In-Network (Option 1 / Option 2)	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics (PBP Max)	No Maximum	No Maximum
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Home Health Care (PBP Max)	$2,500	$2,500
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Skilled Nursing Facility (PBP Max)	60 days	60 days
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Hospice (Lifetime Max)	No Maximum	No Maximum
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC)		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max)	Rehabilitative Services limit - 21 days	Rehabilitative Services limit - 21 days
In-Network (Option 1 / Option 2)	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit)		
In-Network – Therapy Services (Option 1 / Option 2)	DED + 10% Coinsurance	DED + 10% Coinsurance
In-Network – All other Services (Option 1 / Option 2)	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance
Emergency Room Facility Services (per visit)		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 40% Coinsurance	DED + 40% Coinsurance

BlueOptions

For Small Groups
Health Benefit Summary Plans 5040 and 5041

Benefits for Covered Services

Amount Member Pays

	HSA-Compatible Plan 5040 Single Coverage	HSA-Compatible Plan 5041 Family Coverage
Financial Features		
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before BCBSF pays)	 $1,500 / Not Applicable $3,000 / Not Applicable	 $3,000 / $3,000 $6,000 / $6,000
Coinsurance In-Network / Out-of-Network (Coinsurance is the percentage the member pays for services)	10% / 40%	10% / 40%
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED and Coinsurance; Excludes Prescription Drugs)	 $3,000 / Not Applicable $6,000 / Not Applicable	 $6,000 / $6,000 $12,000 / $12,000
Total Lifetime Maximum Benefit	$5,000,000	$5,000,000

Additional Benefits and Features

BlueScript Prescription Drug Program
In the event your Group has purchased pharmacy coverage from Blue Cross and Blue Shield of Florida, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

Access to Our Strong Networks

NetworkBlue℠ is the Preferred Provider Network designated as "In-Network" for BlueOptions. However, you will have **protection from balance billing** when you receive covered services from a provider in our Traditional Program Network. You may also receive **out-of-state coverage through the BlueCard®** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

An Array of Value-Added Programs and Services*

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***www.bcbsfl.com*** and other interactive web-based support tools.
- **MyBlueService** is your online gateway to everything about your health benefit plan as well as all of our self-service tools, now including an enhanced **WebMD** website especially for our members only.
- **Expert advice on call.** For more personal assistance, you can call our care consultants for cost-effective, quality care options. Plus, health coaches are available 24/7 on your schedule.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.**
- BlueOptions members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, BCBSF does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at **www.bcbsfl.com.**

* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has entered into arrangements with various vendors to provide value-added features that include care decision support tools and services to its members. These programs are not part of insurance coverage. All decisions that members make pertaining to medical/clinical judgment should be made in conjunction with their Physician since neither BCBSF nor its vendors provide medical care or advice. ** As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

67923-0509

BlueOptions
For Small Groups
Health Benefit Summary Plan 5462

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Benefits for Covered Services	*Amount Member Pays*
Office Services	
Physician Office Services	
In-Network Family Physician	$15 Copayment
In-Network Specialist	$35 Copayment
Out-of-Network Office Visit	DED[1] + 50% Coinsurance
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	DED + 50% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$150 Copayment
Out-of-Network	DED + 50% Coinsurance
Maternity Initial Visit	
In-Network Specialist	$35 Copayment
Out-of-Network	DED + 50% Coinsurance
Allergy Injections (per visit)	
In-Network Family Physician	$10 Copayment
In-Network Specialist	$10 Copayment
Out-of-Network	DED + 50% Coinsurance
Medical Pharmacy (applies to Office Setting and Specialty Pharmacy Vendors)	
In-Network Monthly Out-of-Pocket (OOP) Maximum[2]	$200
In-Network Provider	20% Coinsurance
Out-of-Network	DED + 50% Coinsurance
Preventive Care	
Adult Wellness Benefit Maximum (PBP[3], includes Routine Adult Physical Exam and Immunizations & Well Woman)	
In-Network	No Maximum
Out-of-Network	$150
Routine Adult Physical Exam and Immunizations	
In-Network Family Physician	$15 Copayment
In-Network Specialist	$35 Copayment
Out-of-Network	50% Coinsurance
Well Woman Exam (e.g. Annual GYN)	
In-Network Family Physician	$15 Copayment
In-Network Specialist	$35 Copayment
Out-of-Network	50% Coinsurance
Mammograms (Covered at 100% of Allowed Amount)	
In- and Out-of-Network	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies) (Covered at 100% of Allowed Amount)	
In- and Out-of-Network	$0
Well Child (No PBP Max)	
In-Network Family Physician	$15 Copayment
In-Network Specialist	$35 Copayment
Out-of-Network	50% Coinsurance

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] PBP = Per Benefit Period

BlueOptions
For Small Groups
Health Benefit Summary Plan 5462

Benefits for Covered Services	*Amount Member Pays*
Emergency Medical Care	
Urgent Care Centers In-Network Out-of-Network	 $40 Copayment DED + 50% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network Out-of-Network	 $100 Copayment $200 Copayment
Ambulance Services (Ground, air and water travel, combined per day maximum) In-Network and Out-of-Network	$5,000 In-Network DED + 20% Coinsurance
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Out-of-Network	 $50 Copayment $150 Copayment DED + 50% Coinsurance
Independent Clinical Lab (e.g. Blood Work) In-Network Out-of-Network	 $0 DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network (Option 1 / Option 2) Out-of-Network	 $250 Copayment / $350 Copayment DED + 50% Coinsurance
Mental Health/Substance Dependency	
Mental Health (PBP Max) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network	30 Inpatient days, 20 Outpatient visits $600 Copayment / $1,000 Copayment DED + 50% Coinsurance $35 Copayment DED + 50% Coinsurance
Substance Dependency (Lifetime Max) Inpatient Hospital Facility Services (per admit) In-Network (Option 1 / Option 2) Out-of-Network Outpatient Office Visit In-Network Specialist Out-of-Network	$2,500 $600 Copayment / $1,000 Copayment DED + 50% Coinsurance $35 Copayment DED + 50% Coinsurance
Other Provider Services	
Provider Services at Hospital and ER In-Network and Out-of-Network	 $50 Copayment
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network and Out-of-Network	 $35 Copayment
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 $15 Copayment $35 Copayment DED + 50% Coinsurance

BlueOptions
For Small Groups
Health Benefit Summary Plan 5462

Benefits for Covered Services	*Amount Member Pays*
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP Max) In-Network Locations other than Hospital and Physician's Office Out-of-Network Locations other than Hospital Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network	 $2,500 DED + 20% Coinsurance DED + 50% Coinsurance $40 Copayment / $50 Copayment DED+ 50% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics (PBP Max) In-Network Out-of-Network	No Maximum DED + 20% Coinsurance DED + 50% Coinsurance
Home Health Care (PBP Max) In-Network Out-of-Network	$2,500 DED + 20% Coinsurance DED + 50% Coinsurance
Skilled Nursing Facility (PBP Max) In-Network Out-of-Network	60 days DED + 20% Coinsurance DED + 50% Coinsurance
Hospice (Lifetime Max) In-Network Out-of-Network	No Maximum DED + 20% Coinsurance DED + 50% Coinsurance
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $100 Copayment DED + 50% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network (Option 1 / Option 2) Out-of-Network	Rehabilitative Services limit - 21 days $600 Copayment / $1,000 Copayment DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All other Services (Option 1 / Option 2) Out-of-Network	 $40 Copayment / $50 Copayment $250 Copayment / $350 Copayment DED + 50% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network Out-of-Network	 $100 Copayment $200 Copayment
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before BCBSF pays)	 $500 / $1,500 $1,000 / $3,000
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 20% 50%
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	 $2,500 / $5,000 $5,000 / $10,000
Total Lifetime Maximum Benefit	$5,000,000

Additional Benefits and Features

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An Array of Value-Added Programs and Services*

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- **MyBlueService** is your online gateway to everything about your health benefit plan as well as all of our self-service tools, now including an enhanced **WebMD** website especially for our members only.
- **Expert advice on call.** For more personal assistance, you can call our care consultants for cost-effective, quality care options. Plus, health coaches are available 24/7 on your schedule.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.**
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** As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

BlueOptions
For Small Groups
Health Benefit Summary Plan 5800

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

Benefits for Covered Services	*Amount Member Pays*
Office Services	
Physician Office Services	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network Office Visit	DED[1] + 50% Coinsurance
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	DED + 50% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$250 Copayment
Out-of-Network	DED + 50% Coinsurance
Maternity Initial Visit	
In-Network Specialist	$50 Copayment
Out-of-Network	DED + 50% Coinsurance
Allergy Injections (per visit)	
In-Network Family Physician	$10 Copayment
In-Network Specialist	$10 Copayment
Out-of-Network	DED + 50% Coinsurance
Medical Pharmacy (applies to Office Setting and Specialty Pharmacy Vendors)	
In-Network Monthly Out-of-Pocket (OOP) Maximum[2]	$200
In-Network Provider	20% Coinsurance
Out-of-Network	DED + 50% Coinsurance
Preventive Care	
Adult Wellness Benefit Maximum (PBP[3], includes Routine Adult Physical Exam and Immunizations & Well Woman)	
In-Network	No Maximum
Out-of-Network	$150
Routine Adult Physical Exam and Immunizations	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	50% Coinsurance
Well Woman Exam (e.g. Annual GYN)	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	50% Coinsurance
Mammograms (Covered at 100% of Allowed Amount)	
In- and Out-of-Network	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies) (Covered at 100% of Allowed Amount)	
In- and Out-of-Network	$0
Well Child (No PBP Max)	
In-Network Family Physician	$35 Copayment
In-Network Specialist	$50 Copayment
Out-of-Network	50% Coinsurance

[1] DED = Deductible

[2] In-Network medical pharmacies are paid at 100% for the remainder of the calendar month once OOP max is met.

[3] PBP = Per Benefit Period

BlueOptions
For Small Groups
Health Benefit Summary Plan 5800

Benefits for Covered Services	*Amount Member Pays*
Emergency Medical Care	
Urgent Care Centers	
In-Network	50% Coinsurance
Out-of-Network	DED + 50% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network	DED + 50% Coinsurance
Out-of-Network	DED + 50% Coinsurance
Ambulance Services (Ground, air and water travel, combined per day maximum)	$5,000
In-Network and Out-of-Network	In-Network DED + 50% Coinsurance
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS)	DED + 50% Coinsurance
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$250 Copayment
Out-of-Network	DED + 50% Coinsurance
Independent Clinical Lab (e.g. Blood Work)	
In-Network	$0
Out-of-Network	DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays)	
In-Network (Option 1 / Option 2)	$300 Copayment / $400 Copayment
Out-of-Network	DED + 50% Coinsurance
Mental Health/Substance Dependency	
Mental Health (PBP Max)	30 Inpatient days, 20 Outpatient visits
Inpatient Hospital Facility Services (per admit)	
In-Network (Option 1 / Option 2)	DED + 50% Coinsurance
Out-of-Network	DED + 50% Coinsurance
Outpatient Office Visit	
In-Network Specialist	$50 Copayment
Out-of-Network	DED + 50% Coinsurance
Substance Dependency (Lifetime Max)	$2,500
Inpatient Hospital Facility Services (per admit)	
In-Network (Option 1 / Option 2)	DED + 50% Coinsurance
Out-of-Network	DED + 50% Coinsurance
Outpatient Office Visit	
In-Network Specialist	$50 Copayment
Out-of-Network	DED + 50% Coinsurance
Other Provider Services	
Provider Services at Hospital and ER	
In-Network and Out-of-Network	In-Network DED + 50% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network and Out-of-Network	In-Network DED + 50% Coinsurance
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	DED + 50% Coinsurance
In-Network Specialist	DED + 50% Coinsurance
Out-of-Network	DED + 50% Coinsurance

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Benefits for Covered Services	*Amount Member Pays*
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP Max) In-Network Locations other than Hospital and Physician's Office Out-of-Network Locations other than Hospital Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network	 $1,500 DED + 50% Coinsurance DED + 50% Coinsurance $55 Copayment / $65 Copayment DED+ 50% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics (PBP Max) In-Network Out-of-Network	No Maximum DED + 50% Coinsurance DED + 50% Coinsurance
Home Health Care (PBP Max) In-Network Out-of-Network	$1,000 DED + 50% Coinsurance DED + 50% Coinsurance
Skilled Nursing Facility (PBP Max) In-Network Out-of-Network	60 days DED + 50% Coinsurance DED + 50% Coinsurance
Hospice (Lifetime Max) In-Network Out-of-Network	No Maximum DED + 50% Coinsurance DED + 50% Coinsurance
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 DED + 50% Coinsurance DED + 50% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network (Option 1 / Option 2) Out-of-Network	Rehabilitative Services limit - 21 days DED + 50% Coinsurance DED + 50% Coinsurance
Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All other Services (Option 1 / Option 2) Out-of-Network	 $55 Copayment / $65 Copayment $300 Copayment / $400 Copayment DED + 50% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network Out-of-Network	 DED + 50% Coinsurance DED + 50% Coinsurance
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before BCBSF pays)	 $1,500 / Not Applicable $4,500 / Not Applicable
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 50% 50%
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance and Copayments; Excludes Prescription Drugs)	 $10,000 / $10,000 $20,000 / $20,000
Total Lifetime Maximum Benefit	$1,000,000

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Additional Benefits and Features

BlueScript Prescription Drug Program
In the event your Group has purchased pharmacy coverage from Blue Cross and Blue Shield of Florida, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

Access to Our Strong Networks

NetworkBlue℠ is the Preferred Provider Network designated as "In-Network" for BlueOptions. However, you will have **protection from balance billing** when you receive covered services from a provider in our Traditional Program Network. You may also receive **out-of-state coverage through the BlueCard®** Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

An Array of Value-Added Programs and Services*

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***www.bcbsfl.com*** and other interactive web-based support tools.
- **MyBlueService** is your online gateway to everything about your health benefit plan as well as all of our self-service tools, now including an enhanced **WebMD** website especially for our members only.
- **Expert advice on call.** For more personal assistance, you can call our care consultants for cost-effective, quality care options. Plus, health coaches are available 24/7 on your schedule.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.**
- BlueOptions members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, BCBSF does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at **www.bcbsfl.com.**

* As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has entered into arrangements with various vendors to provide value-added features that include care decision support tools and services to its members. These programs are not part of insurance coverage. All decisions that members make pertaining to medical/clinical judgment should be made in conjunction with their Physician since neither BCBSF nor its vendors provide medical care or advice.
** As a courtesy, Blue Cross and Blue Shield of Florida, Inc. has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.