

Richard H. Hinds, Chief Financial Officer  
Financial Services

**SUBJECT: APPROVAL OF HEALTH INSURANCE RATES FOR NON-MEDICARE ELIGIBLE AND MEDICARE ELIGIBLE RETIREES FOR CALENDAR YEAR 2010**

**COMMITTEE: INNOVATION, EFFICIENCY, AND GOVERNMENTAL RELATIONS**

**LINK TO DISTRICT STRATEGIC PLAN: IMPROVE FINANCIAL SERVICES**

At the Board meeting of September 9, 2009, the Board authorized the Superintendent of Schools to award its contract for healthcare Administrative Services Only (ASO) to CIGNA HealthCare, pursuant to the provisions of Request For Proposal (RFP)# 071-JJ10, District Healthcare Benefit Program, for an initial 3-year contract effective January 1, 2010. CIGNA partnered with Humana to provide the Medicare Risk plans for Medicare eligible retirees since CIGNA does not offer Medicare Risk products. Monthly rates for retirees in 2010 are as follows:

**Retirees Under Age 65 and Not Medicare Eligible:**

<b>CIGNA</b>	<b><u>OAP20</u></b>	<b><u>OAP10</u></b>
Retiree only	\$ 453.00	\$ 492.00
Spouse/Domestic Partner	\$ 642.00	\$ 699.00
Child(ren)	\$ 453.00	\$ 493.00
26-30 year old dependent child*	\$ 385.00	\$ 419.00

\* Rate is per dependent in addition to other dependent rates as shown

The retiree only rate must be added to the dependent rate i.e., spouse/domestic partner, child(ren), to get the total monthly premium for retirees who cover eligible dependent(s) who are also under 65 and not Medicare eligible.

The plan designs for OAP20 and OAP10 are attached to this agenda item.

**Retiree/Spouse/Domestic Partner Over Age 65 and/or Medicare Eligible:**

<b>HUMANA - Miami-Dade County</b>	<b><u>Mo. Rate</u></b>
HMO 076/939	\$ 0.00
HMO 076/152	\$81.00

<b>HUMANA - Broward/Palm Beach Counties</b>	<b><u>Mo. Rate</u></b>
HMO 076/940	\$ 0.00
HMO 076/152	\$96.00

**HUMANA**  
PPO 079/540

\$303.00

The above monthly rate is per retiree and per eligible dependent over 65 and/or Medicare Eligible.

The Humana plan designs are attached to this agenda item.

**RECOMMENDED:** That The School Board of Miami-Dade County, Florida:

1. approve the following monthly healthcare rates for under age 65 and non Medicare eligible retirees administered by CIGNA effective January 1, 2010 through December 31, 2010:

Open Access Plus (OAP) 20

Retiree Only	\$ 453.00
Spouse/Domestic Partner	\$ 642.00
Child(ren)	\$ 453.00
26-30 year old dependent child*	\$ 385.00

Open Access Plus (OAP) 10

Retiree Only	\$ 492.00
Spouse/Domestic Partner	\$ 699.00
Child(ren)	\$ 493.00
26-30 year old dependent child*	\$ 419.00

\* Rate is per dependent in addition to other dependent rates as shown

2. approve the following monthly rates for over age 65 and Medicare eligible retirees for the Humana Medicare Risk plans effective January 1, 2010 through December 31, 2010.

	<u>Mo. Rate</u>
HUMANA - Miami-Dade County	
HMO 076/939	\$ 0.00
HMO 076/152	\$ 81.00
HUMANA - Broward/Palm Beach Counties	
HMO 076/940	\$ 0.00
HMO 076/152	\$ 96.00
HUMANA	
PPO 079/540	\$303.00

RHH:abc

# Miami-Dade County Public Schools - 2010 Plan Design Options

## Open Access Plus (OAP) 20 and Open Access Plus (OAP) 10 - CIGNA National Network Platform

	OAP 20 Plan *		OAP 10 Plan *	
	In-Network	Non-Network	In-Network	Non-Network
<b>General Provisions</b>				
Annual deductible (I/E)	\$250/\$500	\$1,000/\$2,000	None	\$500 / \$1,000
Hospital Admission Copay (Employee Pays)	20% after deductible	40% after deductible	10% of allowable charges	30% after deductible
Annual Out-of-Pocket Max (excluding deductible) (I/E)	\$1,500 / \$3,000	\$5,000 / \$12,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Is a PCP election/referral required	No	No	No	No
Lifetime Maximum	Unlimited	\$2,000,000 per individual	Unlimited	\$2,000,000 per individual
Do deductibles cross accumulate (in/out of network)	No Cross Accumulation	No Cross Accumulation	Not Applicable	Not Applicable
Plan Coinsurance (Plan Pays)	80%	60%	90%	70%
<b>Outpatient Services</b>				
Physician Charges				
Primary Care Physician Office Visit	100% after \$20 copay	60% after deductible	100% after \$20 copay	70% after deductible
Specialist Office Visit	100% after \$40 copay	60% after deductible	100% after \$40 copay	70% after deductible
Preventive Care				
Immunizations	100% after \$20 copay	60% after deductible	100% after \$20 copay	70% after deductible
Hearing Examination (limit 1 per year through age 16)	100% after \$20 copay	60% after deductible	100% after \$20 copay	70% after deductible
Well Child Care- Performed by PCP/Pediatrician (immunizations included)	100% after \$20 copay	60% after deductible	100% after \$20 copay	70% after deductible
Annual Physical (limit 1 per year)	100% after applicable copay	Not Covered (except well woman exam)	100% after applicable copay	Not Covered (except well woman exam)
Vision Screening for children through age 18 (limit 1 per year at PCP office)	100% after applicable copay	60% after deductible	100% after applicable copay	70% after deductible
Gynecological visit (office visit, pap test)	100% after \$20 copay for annual wellness exam, \$40 copay for all other visits	60% after deductible	100% after \$20 copay for annual wellness exam, \$40 copay for all other visits	70% after deductible
Mammograms (routine)	100%	100%	100%	100%
Mammograms (Diagnostic)	100%	60% after deductible	100%	70% after deductible
Diagnosis and Treatment				
Laboratory	100%	60% after deductible	100%	70% after deductible
Non-Hospital Based Diagnostic Imaging (CT Scans, Pet Scans, MRI, nuclear medicine, X-Ray and Sonogram)	100% after \$100 copay	60% after deductible	100% after \$100 copay	70% after deductible
Hospital Based Diagnostic Imaging (CT Scans, Pet Scans, MAMRI, nuclear medicine, X-Ray and Sonogram)	80% after deductible	60% after deductible	90% of allowable charges	70% after deductible
Medication administered at provider location	80% after deductible	60% after deductible	90% of allowable charges	70% after deductible
Short-Term Therapies - Speech, Physical, Respiratory (prior notification required)	100% after \$40 copay	60% after deductible	100% after \$40 copay	70% after deductible
Therapeutic Treatments (Dialysis, intravenous, chemotherapy, radiation, or other intravenous infusion therapy)	40 visits each per calendar year combined in and out of network 80% after deductible	40 visits each per calendar year combined in and out of network 60% after deductible	40 visits each per calendar year combined in and out of network 90% of allowable charges	40 visits each per calendar year combined in and out of network 70% after deductible
Maternity Care	Pre/Post-Natal visits covered at 100% after initial \$40 copay. Obstetrical/midwifery services covered at 80% after deductible	60% after deductible	Pre/Post-Natal visits covered at 100% after initial \$40 copay. Obstetrical/midwifery services covered at 90% of allowable charges	70% after deductible
Childbirth Classes	Not covered	Not covered	Not covered	Not covered



# Miami-Dade County Public Schools - 2010 Plan Design Options

## Open Access Plus (OAP) 20 and Open Access Plus (OAP) 10 - CIGNA National Network Platform

	OAP 20 Plan *	OAP 10 Plan *
<b>Other Services</b>		
Out of Area Hospitalization Emergency	100% after \$200 copay (waived if admitted) 80% after deductible	100% after \$200 copay (waived if admitted) 80% after deductible
Admission when referred by physician with approval from Care Coordination		100% after \$200 copay (waived if admitted) 90% of allowable charges
Skilled Nursing Facility	80% after deductible Prior notification required Limited to 90 days/calendar yr 100% after \$50 copay	60% after deductible 100% after \$50 copay
Emergency Ambulance Service		70% after deductible 100% after \$50 copay
Family Planning Counseling and evaluation in physician's office Counseling and evaluation in specialist's office Elective sterilization performed in physician's office Implantable or injectable contraceptives	Counseling covered at 100% after \$20 copay (PCP) or \$40 copay (Specialist) Elective sterilization covered at 100% after \$40 copay Implantable/injectable contraceptives covered at 100% after \$40 copay	Counseling covered at 100% after \$20 copay (PCP) or \$40 copay (Specialist) Elective sterilization covered at 100% after \$40 copay Implantable/injectable contraceptives covered at 100% after \$40 copay
Infertility Treatment (limited to diagnosis and correction of medical condition only) Medical office visit including test and counseling	Not covered	Not covered
In-Fertility Surgery (including In-Vitro Fertilization, Artificial Insemination, GIFT, ZIFT, etc.) Allergy Treatment/injections without an office visit PCP-evaluation/office visit Specialist-evaluation/office visit	Not covered Covered at 100% after \$20 copay (PCP) or \$40 copay (Specialist)	Not covered Covered at 100% after \$20 copay (PCP) or \$40 copay (Specialist)
Home Health Care (prior notification required)	100% after \$20 copay towards Home Health Therapy Days count	100% after \$20 copay
Prosthetics Devices	100% after \$100 copay	100% after \$100 copay
Durable Medical Equipment	100% after \$100 copay per item (initial purchase only)	100% after \$100 copay per item (initial purchase only)
Audiology Screening	Not covered	Not covered
Podiatry	100% after \$40 copay	100% after \$40 copay
Chiropractic	100% after \$40 copay	100% after \$40 copay
Dermatologist	80% after deductible	80% after deductible
Hospice Care		
Prescription Drugs Self Administered Injectables	Same as Retail/Mail benefit described below Some injectable medications require prior notification/auth and are not available through mail	Same as Retail/Mail benefit described below Some injectable medications require prior notification/auth and are not available through mail
Retail Generic / Formulary Brand / Non-Formulary (up to 31 day supply)	100% after \$10/\$30/\$50	100% after \$10/\$30/\$50
Mail Generic / Formulary Brand / Non-Formulary (up to 90 day supply)	100% after \$20/\$60/\$100	100% after \$20/\$60/\$100

\* OAP10 and OAP20 benefit designs include autism spectrum disorder coverage as specified by Florida Legislature.

## 2010 HUMANA MEDICARE RISK PROGRAM

2010 Comparison for Miami-Dade		2010 076/939 Miami-Dade \$0.00	2010 076/152 \$81.00	2010 Original Medicare
Service	Place of Treatment	Miami-Dade \$0.00	\$81.00	Original Medicare
Monthly Premium	MOOP	\$3,400	\$2,500	NA
Annual Maximum Out of Pocket (MOOP)	Exclusions	Benefits administered by a third party, prescription drugs, world wide coverage, extra services, and the plan premium do not apply to the maximum out of pocket.	Benefits administered by a third party, prescription drugs, all inpatient and outpatient mental health services, all inpatient and outpatient substance abuse services, extra services, and the plan premium do not apply to the maximum out of pocket.	NA
Physician and Professional Services	Primary Care Physician Specialist Office	\$0 copayment \$0 copayment	\$10 copayment \$20 copayment	20% of Medicare approved amounts \$135 annual Part B deductible 20% of Medicare approved amounts \$135 annual Part B deductible
Inpatient Care (Acute, Psychiatric, and Substance Abuse)	Inpatient Hospital	\$0 copayment	\$100/day (days 1-3)	\$267/day (days 61-90) \$534/day (days 91-150)
Outpatient Diagnostic Procedures and Tests	Inpatient Psychiatric Facility	\$0 copayment \$0 copayment (190 day lifetime limit in psychiatric facility)	\$100/day (days 1-3) (190 day lifetime limit in psychiatric facility)	\$1,068 deductible (days 1-60) \$267/day (days 61-90) \$534/day (days 91-150) (190 day lifetime limit in psychiatric facility) 20% coinsurance (excluding lab services which are covered at 0% coinsurance)
Outpatient Surgery Services	Freestanding Radiological Facility	\$0 copayment	\$0 copayment	20% coinsurance (excluding lab services which are covered at 0% coinsurance)
Observation	Outpatient Hospital	\$15 copayment	\$0 copayment	20% coinsurance
Skilled Nursing Care	Ambulatory Surgical Center Outpatient Hospital Outpatient Hospital	\$0 copayment \$25 copayment \$20 copayment	\$100 copayment \$100 copayment \$50 copayment	20% coinsurance 20% coinsurance 20% coinsurance
Emergency Services	Skilled Nursing Facility	\$50/day (days 7-100); no three day hospital stay required	\$0/day (days 1-100); no three day hospital stay required	\$133.50/day (days 21-100); three day hospital stay is required
Prescription Drugs	Emergency Room - Hospital	\$50 copayment; waived if admitted within 24 hours	\$50 copayment; waived if admitted within 24 hours	20% coinsurance; waived if admitted within 72 hours
Part D:	Medicare-Covered Part B	0% coinsurance Custom Rx	20% coinsurance Rx 1	You pay 100% for most prescription Drugs You pay 100% for most prescription Drugs
Initial Coverage Limit				
\$0 to \$2,830	Tier 1 Copay	\$0	\$10	NA
	Tier 2 Copay	\$0	\$20	NA
	Tier 3 Copay	\$35	\$40	NA
	Tier 4 Copay	33%	25%	NA
Coverage Gap				
\$2,830.01 to \$4,550	Tier 1 Copay	\$0	\$10	NA
	Tier 2 Copay	100%	\$20	NA
	Tier 3 Copay	100%	\$40	NA
	Tier 4 Copay	100%	25%	NA
Catastrophic				
\$4,550	Tier 1 & 2 after Catastrophic	\$2.50 or 5%	\$2.50 or 5%	NA
	Tier 3 & 4 after Catastrophic	\$6.30 or 5%	\$6.30 or 5%	NA
Mail Order Pharmacy **				
	Tier 1	\$0 copay 90 day supply	\$0 copay 90 day supply	NA
	Tier 2 & 3	2.5 X 90 day supply	2 X 90 day supply	NA
	Tier 4	33% 30 day supply	25% 30 day supply	NA
		** When coinsurance applies, there is no multiplying involved.	** When coinsurance applies, there is no multiplying involved.	

## 2010 HUMANA MEDICARE RISK PROGRAM

2010 Comparison for Miami-Dade		2010		2010
Service	Place of Treatment	076/640	076/152	Original Medicare
Monthly Premium		\$0.00	\$96.00	
	<b>MOOP</b>	\$5,000	\$2,500	NA
<b>Annual Maximum Out of Pocket (MOOP)</b>	<b>Exclusions</b>	Benefits administered by a third party, prescription drugs, world wide coverage, extra services, and the plan premium do not apply to the maximum out of pocket.	Benefits administered by a third party, prescription drugs, all inpatient and outpatient mental health services, all inpatient and outpatient substance abuse services, extra services, and the plan premium do not apply to the maximum out of pocket.	NA
<b>Physician and Professional Services</b>	<b>Primary Care Physician</b>	\$0 copayment	\$10 copayment	20% of Medicare approved amounts \$135 annual Part B deductible
	<b>Specialist Office</b>	\$10 copayment	\$20 copayment	20% of Medicare approved amounts \$135 annual Part B deductible
<b>Inpatient Care (Acute, Psychiatric, and Substance Abuse)</b>	<b>Inpatient Hospital</b>	\$90/day (days 1-10)	\$100/day (days 1-3)	\$1,068 deductible (days 1-60) \$534/day (days 61-150) \$267/day (days 91-150)
	<b>Inpatient Psychiatric Facility</b>	\$90/day (days 1-10) (190 day lifetime limit in psychiatric facility)	\$100/day (days 1-3) (190 day lifetime limit in psychiatric facility)	\$1,068 deductible (days 1-60) \$534/day (days 61-90) \$267/day (days 91-150) (190 day lifetime limit in psychiatric facility)
<b>Outpatient Diagnostic Procedures and Tests</b>	<b>Freestanding Radiological Facility</b>	\$0 copayment	\$0 copayment	20% coinsurance (excluding lab services which are covered at 0% coinsurance)
	<b>Outpatient Hospital</b>	\$25 copayment	\$0 copayment (copayment may apply if other services are received at the time of the visit)	20% coinsurance (excluding lab services which are covered at 0% coinsurance)
<b>Outpatient Surgery Services</b>	<b>Ambulatory Surgical Center</b>	\$25 copayment	\$100 copayment	20% coinsurance
	<b>Outpatient Hospital</b>	\$125 copayment	\$100 copayment	20% coinsurance
<b>Observation</b>	<b>Outpatient Hospital</b>	\$75 copayment	\$50 copayment	20% coinsurance
<b>Skilled Nursing Care</b>	<b>Skilled Nursing Facility</b>	\$75/day (days 11-100); no three day hospital stay required	\$0/day (days 1-100); no three day hospital stay required	\$133.50/day (days 21-100); three day hospital stay is required
<b>Emergency Services</b>	<b>Emergency Room - Hospital</b>	\$50 copayment; waived if admitted within 24 hours	\$50 copayment; waived if admitted within 24 hours	20% coinsurance; waived if admitted within 72 hours
<b>Prescription Drugs</b>	<b>Medicare-Covered Part B</b>	0% coinsurance Custom Rx	20% coinsurance Rx 1	You pay 100% for most prescription Drugs You pay 100% for most prescription Drugs
<b>Initial Coverage Limit</b>				
\$0 to \$2,830	Tier 1 Copay	\$0	\$10	NA
	Tier 2 Copay	\$15	\$20	NA
	Tier 3 Copay	\$60	\$40	NA
	Tier 4 Copay	33%	25%	NA
<b>Coverage Gap</b>				
\$2,830.01 to \$4,550	Tier 1 Copay	\$0	\$10	NA
	Tier 2 Copay	100%	\$20	NA
	Tier 3 Copay	100%	\$40	NA
	Tier 4 Copay	100%	25%	NA
<b>Catastrophic</b>				
\$4,550	Tier 1 & 2 after Catastrophic	\$2.50 or 5%	\$2.50 or 5%	NA
	Tier 3 & 4 after Catastrophic	\$6.30 or 5%	\$6.30 or 5%	NA
<b>Mail Order Pharmacy **</b>				
	Tier 1	\$0 copay 90 day supply	\$0 copay 90 day supply	NA
	Tier 2 & 3	2.5 X 90 day supply	2 X 90 day supply	NA
	Tier 4	33% 30 day supply	25% 30 day supply	NA

\*\* When coinsurance applies, there is no multiplying involved.

\*\* When coinsurance applies, there is no multiplying involved.

## 2010 HUMANA MEDICARE RISK PROGRAM

2010 Comparison for Miami-Dade		2010 Original Medicare	
Service	Place of Treatment	2010 079/B40	2010 Original Medicare
Monthly Premium	MOOP	IN \$303.00 \$2,500	OON \$2,500 NA
Annual Maximum Out of Pocket (MOOP)	Exclusions	Benefits administered by a third party, prescription drugs, routine dental, extra services, and the plan premium do not apply to the maximum out of pocket.	Benefits administered by a third party, prescription drugs, routine dental, worldwide coverage, and the plan premium do not apply to the maximum out of pocket.
Physician and Professional Services	Primary Care Physician	\$5 copayment	\$5 copayment
	Specialist Office	\$15 copayment	\$15 copayment
	Inpatient Hospital	\$175/admission	\$175/admission
	Inpatient Psychiatric Facility	\$175/admission (190 day lifetime limit in psychiatric facility)	\$175/admission (190 day lifetime limit in psychiatric facility)
	Freestanding Radiological Facility	\$15 copayment	\$15 copayment
	Outpatient Hospital	\$50 copayment	\$50 copayment
	Ambulatory Surgical Center	\$15 copayment	\$15 copayment
	Outpatient Hospital	\$50 copayment	\$50 copayment
	Outpatient Hospital	\$50 copayment	\$50 copayment
	Skilled Nursing Facility	\$50/day (days 21-100); no three day hospital stay required	\$50/day (days 21-100); no three day hospital stay required
	Emergency Room - Hospital	\$50 copayment; waived if admitted within 24 hours	\$50 copayment; waived if admitted within 72 hours
	Medicare-Covered Part B	20% coinsurance	20% coinsurance
	Part D:	FX 3	You pay 100% for most prescription Drugs You pay 100% for most prescription Drugs
Initial Coverage Limit			
\$0 to \$2,830	Tier 1 Copay	\$5	NA
	Tier 2 Copay	\$30	NA
	Tier 3 Copay	\$60	NA
	Tier 4 Copay	25%	NA
Coverage Gap			
\$2,830.01 to \$4,550	Tier 1 Copay	\$5	NA
	Tier 2 Copay	100%	NA
	Tier 3 Copay	100%	NA
	Tier 4 Copay	100%	NA
Catastrophic			
\$4,550	Tier 1 & 2 after Catastrophic	\$2.50 or 5%	NA
	Tier 3 & 4 after Catastrophic	\$6.30 or 5%	NA
Mail Order Pharmacy **			
	Tier 1	\$0 copay 90 day supply	NA
	Tier 2 & 3	2 X 90 day supply	NA
	Tier 4	25% 30 day supply	NA

\*\* When coinsurance applies, there is no multiplying involved.