CITY COUNCIL AGENDA ITEM

REQUESTED COUNCIL MEETING DATE **7/17/07**

SUBJECT: **Florida Health Care Insurance Renewal**

DEPARTMENT: **Finance Department**

RECOMMENDED MOTION:

Acceptance of the proposal from Florida Health Care for the period beginning October 1, 2007 through September 30, 2008.

SUMMARY:

For the past several weeks the City has been reviewing various options as it relates to renewal of the City's health insurance program. We have reviewed several options that would accommodate the most cost savings for both the City and the employees, while at the same time providing needed health benefits to employees.

In summary, our cost utilization has been slightly higher than expected, this above average health claims has provided concern for our normal January 1st renewal premium options. In an effort to keep rates within reason we are proposing to change the anniversary date from January 1, 2008 to October 1, 2007. The annual out of pocket expenses are higher as well as co-pays for doctor visits and hospital stays. The medical drug program remains constant; however, the new standard overall places more cost on the employee. Please see the attached proposals from Florida Health Care for more specific information.

Should you have questions related to this topic, Staff and Representatives from Florida Health Care will be present.

ATTACHMENTS: [ ] Ordinance [ ] Resolution [ ] Budget Resolution

[X] Other [ ] Support Documents/Contracts Available for Review in Manager's Office

DEPARTMENT HEAD	John A. Shelley, Finance Director	Date 7/10/07
FINANCE DEPARTMENT	Approved as to Budget Requirements John A. Shelley	Date 7/10/07
CITY ATTORNEY	Approved as to Form and Legality Stella L. Lemere	Date
CITY MANAGER	Approved Agenda Item For:	7/17/07

COUNCIL ACTION: [ ] Approved as Recommended [ ] Disapproved [ ] Tabled Indefinitely
[ ] Continued to Date Certain [ ] Approved with Modification:

Florida Health Care Plans, Inc. 2007

	<----------Current 2006---------->		<----Weekly projected for 2007---->	
	Monthly Rates	Weekly Empl. Rate	Rates 2007/8	Weekly 2007/8
HMO - Current Premium +				
Single	$394.79	$ -	$440.61	$ 6.05
Single Parent	$690.88	$68.33	$784.28	$85.36
Couple	$690.88	$68.33	$784.28	$85.36
Family	$848.80	$104.77	$960.53	$126.03
Special Married Rate		$13.67		$30.40
Part Time Single		$45.55		$53.86
Part Time Single Parent		$113.88		$133.17
Part Time Couple		$113.88		$133.17
Part Time Family		$150.32		$173.85
HMO - Standard Alternate Select VP-3				
Single			$414.40	$ -
Single Parent			$737.64	$74.59
Couple			$737.64	$74.59
Family			$903.40	$112.85
Special Married Rate				$17.22
Part Time Single				$47.82
Part Time Single Parent				$122.41
Part Time Couple				$122.41
Part Time Family				$160.66
TRIPLE OPTION				
Single	$467.28	$16.73	$521.55	$24.73
Single Parent	$817.74	$97.60	$928.35	$118.60
Couple	$817.74	$97.60	$928.35	$118.60
Family	$1,004.65	$140.74	$1,136.97	$166.75
Special Married Rate		$49.63		$71.12
Part Time Single		$62.28		$72.54
Part Time Single Parent		$143.16		$166.42
Part Time Couple		$143.16		$166.42
Part Time Family		$186.29		$214.56

- Loss Ratio at 88%

- FHCP is the vehicle for processing claims, obtaining network, negotiating discounts from providers, purchasing stop-loss insurance, and utilization management.

- Proposed changes in medical benefits are in line with other local employers.

- Trend in group medical benefits is increased cost sharing.

- Premium costs are a direct function of medical costs.

- Loss Data shows increased in-hospitalization costs (more serious medical needs)

- Factors affecting medical costs are: new technology and new drugs (stimulated by marketing), the aging population, and increased utilization of medical services.

HMO	06-07	07-08
EE (City)	$394.79	$414.40
EE+Ch (Emp)	$296.09	$323.24
EE+Sp (Emp)	$296.09	$324.24
EE+Family (Emp)	$454.01	$489.00

City of Port Orange

Group #:	000075 & 00T075
Total EE's:	444
Estimated Members:	789
10/1/2007 Renewal With Composite Demo:	1.020060
Exper Adjmt Factor:	0.965571
Group 55% Credible SIC Factor:	1.05

HMO Renewal and Alternate Rates with Vision - Alternate Tier Structure

Current **Premium +** **$10/$30/$55 Rx & V HMO Rates:**		**Renewal Premium +** **$10/$30/$55 Rx & V** HMO Rates: **(33)**	**% Incr in Single Rate**
Single	$394.79	$440.61	11.6%
EE & Child(ren)	$690.88	$784.28	
EE & Spouse	$690.88	$784.28	
Family	$848.80	$960.53	

Alternate **Select** **$10/$30/$55 Rx & V & VP-3** HMO Rates: **(H13)**	**% Incr in Single Rate**
$414.40	5.0%
$737.64	
$737.64	
$903.40	

Triple Option Renewal Rates with Vision

Current **Triple Option** **$10/$30/$55 Exp Rx & V** Rates:		**Renewal Premium + Triple Option** **$10/$30/$55 Exp Rx & V** Rates: **(321)**	**% Incr in Single Rate**
Single	$467.28	$521.55	11.6%
EE & Child(ren)	$817.74	$928.35	
EE & Spouse	$817.74	$928.35	
Family	$1,004.65	$1,136.97	

NOTE: These rates are only effective if the Group elects to change their renewal date to 10/1/2007, and notifies us in writing of the renewal date change.
If the Group decides not to change their 01/01/2008 renewal date, then another renewal rating will be completed in or about September, 2007 for an effective date of 01/01/2008.

Florida Health Care Plans

Now

PREMIUM PLUS HMO PLAN
LARGE GROUP
PLAN CODE 33

DEDUCTIBLE AND BENEFITS LIMITS	COVERED PERSON'S FINANCIAL RESPONSIBILITY
Annual Deductible - The amount you pay each calendar year before the plan begins covering your medical expenses. Individual Family	 $0 $0
Annual Out-of-Pocket Expense Limit Individual Family	 $1,500 $3,000
Coinsurance Plan Pays Covered Person Pays	 N/A
Lifetime Maximum for each Member as long as coverage is in effect.	$2,000,000
INPATIENT – Illness, Injury, Maternity, Newborn	
Inpatient	$200/Admission
In-Hospital Physician Services	Covered In Full
OUTPATIENT CARE	
Primary Care Office Visit	Covered In Full
Other Primary Care Services	Covered In Full
Specialist Office Visit	$10
Other Specialty Services	$10
Allergy Shots/Immunizations in Physician's Office (additional office copayment may apply)	Covered In Full
Outpatient Surgical Care or Invasive Procedure (Ambulatory Surgical Center, Outpatient Medical Facility or in Hospital)	Covered In Full
Therapy (Restorative Physical, Speech and Occupational) – Limited to 20 visits/cy	$15
Chiropractic (Restorative Non-Surgical Back Treatment) – Limited to 20 visits/cy	$10
MENTAL & NERVOUS DISORDER	
Inpatient – Limited to 30 days/cy	$200/Admission
Outpatient - Limited to 20 visits/cy	$10
ALCOHOL & DRUG ABUSE TREATMENT – Lifetime Maximum Benefit of $2,000	
Inpatient	$200/Admission
Outpatient - Limited to 44 visits/cy, Max Allowance of $35 per visit	$15
DIAGNOSTIC CARE	
Lab Test	Covered In Full
X-Ray and Ultrasound Procedures	Covered In Full
Advanced Imaging (includes nuclear studies such as MRI, MRA, PET, CT Scans)	Covered In Full
Other Diagnostic Procedures (includes EKG, Colonoscopy)	Covered In Full

PREVENTIVE CARE	
Well Baby Care & Child Health Supervision Visits	Covered In Full
Annual Adult Physical Health Screening	Covered In Full
Well Woman's Assessment	$0 PCP/$10 Specialist
Mammography Screening	Covered In Full
Bone Density Screening	Covered In Full
EMERGENCY CARE	
Inpatient	$200/Admission
Emergency Room Visit (Waived if Admitted)	$60 Participating $75 Non-Participating
Ambulance Services	$25
Urgent Care Center	$15 Participating
Non-scheduled MD Office Visit	$15
OTHER COVERED SERVICES	
Hearing Exam (Hearing Aids are not covered, but discounts may be available at select locations)	Covered In Full
Skilled Nursing (Limited to 20 days/cy)	Covered In Full
Home Health Care (Limited to 60 visits/cy)	Covered In Full
Hospice	Covered In Full
Durable Medical Equipment & Supplies	Covered In Full
Orthotics / Prosthetics	Covered In Full
DIABETES MONITORING - Deductible Does Not Apply	
Diabetes Outpatient Self-Management Education	Covered In Full
50 Test Strips/Sensors	$10
Lancets	$10
Glucometer	Covered In Full
Annual Retinal Screening (Optometrist/Ophthalmologist)	$10/$10

This plan requires use of FHCP network providers or pre-approved non-participating providers. Services rendered without prior authorization or pre-certification may not be covered - member will be responsible for 100% of charges.

Only allowable charges for covered services will be applied toward fulfilling applicable deductibles. Amounts in excess of allowable charges will not be applied to annual deductible or maximum out-of-pocket limit.

Member's failure to provide 24 hour notice of cancellation of scheduled appointment may result in a Provider No-Show Fee equal to the appropriate office visit cost sharing charges.

Please see your Certificate of Coverage for more detailed information regarding Claims, Exclusions & Limitation, Definitions, and Pre-certification/Authorization requirements.

"Proposed" 4

Florida Health Care Plans

SELECT VP3 HMO PLAN
LARGE GROUP
PLAN CODE H13

DEDUCTIBLE AND BENEFITS LIMITS	COVERED PERSON'S FINANCIAL RESPONSIBILITY
Annual Deductible - The amount you pay each calendar year before the plan begins covering your medical expenses.	
Individual	$0
Family	$0
Annual Out-of-Pocket Expense Limit	
Individual	$4,000
Family	$8,000
Coinsurance	
Plan Pays	N/A
Covered Person Pays	
Lifetime Maximum for each Member as long as coverage is in effect.	$2,000,000
INPATIENT – Illness, Injury, Maternity, Newborn	
Inpatient	$500/Day (Days 1-5)
In-Hospital Physician Services	Covered In Full
OUTPATIENT CARE	
Primary Care Office Visit	$15
Other Primary Care Services	$15
Specialist Office Visit	$25
Other Specialty Services	$25
Allergy Shots/Immunizations in Physician's Office (additional office copayment may apply)	Covered in Full
Outpatient Surgical Care or Invasive Procedure (Ambulatory Surgical Center, Outpatient Medical Facility or in Hospital)	$200
Therapy (Restorative Physical, Speech and Occupational) – Limited to 20 visits/cy	$15
Chiropractic (Restorative Non-Surgical Back Treatment) – Limited to 20 visits/cy	$10
MENTAL & NERVOUS DISORDER	
Inpatient – Limited to 30 days/cy	$500/Day (Days 1-5)
Outpatient - Limited to 20 visits/cy	$25
ALCOHOL & DRUG ABUSE TREATMENT – Lifetime Maximum Benefit of $2,000	
Inpatient	$500/Day (Days 1-5)
Outpatient - Limited to 44 visits/cy, Max Allowance of $35 per visit	$15
DIAGNOSTIC CARE	
Lab Test	Covered In Full
X-Ray and Ultrasound Procedures	Covered In Full
Advanced Imaging (includes nuclear studies such as MRI, MRA, PET, CT Scans)	Covered In Full
Other Diagnostic Procedures (includes EKG, Colonoscopy)	Covered In Full

PREVENTIVE CARE	
Well Baby Care & Child Health Supervision Visits	$15 PCP
Annual Adult Physical Health Screening	$15 PCP
Well Woman's Assessment	$15 PCP/$25 Specialist
Mammography Screening	Covered In Full
Bone Density Screening	Covered In Full
EMERGENCY CARE	
Inpatient	$500/Day (Days 1-5)
Emergency Room Visit (Waived if Admitted)	$60 Participating $75 Non-Participating
Ambulance Services	$25
Urgent Care Center	$30 Participating
Non-scheduled MD Office Visit	$30
OTHER COVERED SERVICES	
Hearing Exam (Hearing Aids are not covered, but discounts may be available at select locations)	Covered In Full
Skilled Nursing (Limited to 20 days/cy)	$15/Day
Home Health Care (Limited to 60 visits/cy)	Covered In Full
Hospice	Covered In Full
Durable Medical Equipment & Supplies	Covered In Full
Orthotics / Prosthetics	Covered In Full
DIABETES MONITORING - Deductible Does Not Apply	
Diabetes Outpatient Self-Management Education	Covered In Full
50 Test Strips/Sensors	$10
Lancets	$10
Glucometer	Covered In Full
Annual Retinal Screening (Optometrist/Ophthalmologist)	$10/$25

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Florida Health Care Plans
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PRESCRIPTION BENEFITS

$10/$30/$55 COPAYMENT - CERTIFICATE RIDER

HOW DOES PRESCRIPTION COVERAGE WORK?

Your Prescription Benefit with Florida Health Care Plans is comprised of a list of prescription drugs called a formulary. When you get your prescription filled at one of FHCP's pharmacies or select Walgreens pharmacies, you pay the following copayment:

	FHCP In-House Pharmacy	Walgreens Pharmacy
Formulary Generic Drugs:	$10.00	$15.00
*Formulary Preferred Brand Drugs:	$30.00	$35.00
* Formulary Non Preferred Brand Drugs:	$55.00	$60.00
**Mail Order		
Formulary Generic Drugs:	$ 9.00	N/A
* Formulary Preferred Brand Drugs:	$29.00	N/A
* Formulary Non Preferred Brand Drugs:	$54.00	N/A
Pre-approved, pre-certified specialty drug formulary	$100.00	N/A

*If you purchase a preferred or non-preferred brand product when a generic is available, you will be responsible for paying the Average Wholesale Price (AWP) for that prescription.

**FHCP In-house Pharmacies also offer a mail order program. You may obtain up to a 90-day supply with a $1.00 discount on each 31-day supply of generic, preferred brand, or non-preferred brand medications.

Non-formulary drugs, while not covered by this plan, are available to members at a discount price of 85% of AWP at FHCP pharmacies only. Not covered items (Exclusions), as described below, are available at 100% of AWP at FHCP pharmacies only.

IN AN EMERGENCY...

Always present your FHCP membership card to allow the doctor or hospital to verify coverage with FHCP. Your coverage with FHCP includes prescriptions written during emergency situations.

WHAT IS COVERED?

Coverage for prescription drugs includes the following:

- The following Diabetic supplies are covered. The appropriate copay applies for each item.
  - Insulin, hypodermic needles, and syringes with insulin.
- Formulary self-injectables (excluding Insulin) (available at FHCP Pharmacies only);
- Must be prescribed by a Physician for the treatment of a Condition;
- Must be dispensed by a Pharmacist;
- Must be a generic medication when both a generic and a more expensive preferred or non-preferred brand drug is available;
- Up to a 31-day supply per prescription or unit of use, whichever is less (mail order provides up to a 93-day supply);
- Prescription refills, but will not be covered until at least 75% of the previous prescription has been used by the Member, (based on the dosage schedule prescribed by the Physician).

EXCLUSIONS AND LIMITATIONS

- Any drug, medicine, or medication that is consumed at the place where the prescription is given or that is dispensed by a Physician;
- Any portion of a prescription or refill that exceeds a 31-day supply;
- Prescription refills in excess of the number specified by the Physician;
- The administration of covered prescription medication;
- Prescriptions that may be paid without charge under local, state, or federal programs, including Worker's Compensation;
- Prescriptions that are to be taken by or administered to the Member in whole or in part, while he or she is a patient in a Hospital, Skilled Nursing Facility, convalescent Hospital, Inpatient hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis;
- Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision in this Group Plan;
- Any drug, medicine, or medication labeled "Caution-Limited by Federal Law to Investigational Use." Any experimental drug or drug used for non-FDA approved indication or prescribed for use by a route of administration that is not approved by the FDA even though a charge is made to the Member; A drug that is prescribed for the treatment of cancer is covered as long as that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature and included in FHCP's formulary;
- Immunizing agents, biological serums, or allergy serums;
- Any drug or medicine that is lawfully obtainable without a prescription, with the exception of insulin;
- Therapeutic devices or appliances, including hypodermic needles/syringes (exception: insulin needles/syringes with insulin), support garments, and other non-medical substances, regardless of intended use;
- Prescriptions filled at a Non-Participating Pharmacy, except for prescriptions required during Emergency Care;
- Nutritional supplements given as a medicine between meals to boost protein-caloric intake or the mainstay of a daily nutritional plan;
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss;
- Nicotine suppressants and smoking cessation products and services;
- Any drug for cosmetic use or alteration of one's appearance (i.e. Rogaine, Bleaching Agents, Acne Medications, Nail Fungus treatment);
- Infertility Agents;
- Transdermal Scopolamine patches; and
- Abortifacients.

QUESTIONS?

Call your Florida Health Care Plans Member Services Department at:
386-615-4022
1-877-615-4012
www.fhcp.com

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Triple Option Point of Service Rider

Florida Health Care Plans Group HMO Contract is hereby amended and supplemented by the terms and conditions of this Rider.

Nothing contained in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, exclusions or limitations of the Contract to which this Rider is attached, other than as specifically stated herein.

Additionally, this Rider in no way extends benefits beyond what has been stated in the HMO Contract and Plan Co-Payment, Benefits and Limitations Schedule in terms of specific service limits or benefit maximums. This Rider does not create any duplication of coverage or coordination of benefits contained in the FHCP Plan or any other Riders you may elect.

Please read this Rider carefully and keep it with your FHCP Plan Contract.

HOW THE TRIPLE OPTION Point of Service RIDER WORKS...

PLAN DESIGN
The "Triple Option" rider is designed to complement FHCP's existing HMO benefit plans. FHCP members are still members of our HMO, but have the added benefit of choosing to have their care rendered, at the point of service, by an HMO provider (Option 1), a non-participating provider who accepts discounted fees (Option 2), or a non-participating provider who has not agreed to accept a discount for their services (Option 3). With this rider, the plan is open access in that the member may self-refer to any provider.

OUT-OF-POCKET EXPENSE
A major feature of the Triple Option rider is that the amount of the member's out-of-pocket expense (cost sharing) is determined by the member's choice of provider at the point of service. Members choosing HMO providers will be responsible for the lowest cost sharing amounts. Members choosing Option 2 providers will be responsible for paying higher cost sharing. Members choosing Option 3 providers will pay the highest cost sharing in the form of higher deductibles and co-insurance and will also be at risk for non-participating providers fees that are in excess of allowable charges, commonly referred to as Balance Billing. Fees that are in excess of allowable charges are not a covered benefit and therefore do not apply to your deductible or annual out-of-pocket expense limit. These amounts can add up to considerable costs to members.

This Rider gives you options as described below:

OPTION 1
You can self-refer to any provider listed in FHCP's HMO Participating Provider Network. When you go directly to one of these participating providers without a referral you will be responsible for cost sharing as noted in the attached Benefit Summary Chart.

OPTION 2
You can self-refer to any provider listed as an FHCP Option 2 provider. When accessing an Option 2 primary care physician (PCP), you will be responsible for higher cost sharing as noted in the attached Benefit Summary Chart. A deductible is not applied to Option 2 PCP visits. Visits to other Option 2 providers will require you to be responsible for payment of a deductible and co-insurance per the attached Benefit Summary Chart.

OPTION 3

You can self-refer to a non-participating provider not included in FHCP's HMO or Option 2 provider listings without a referral. When you choose a physician, provider or hospital not covered under Option 1 or Option 2, you pay a portion of your medical expenses through a separate deductible and coinsurance. Certain benefit limitations apply. You will also be responsible for the portion of non-participating provider/hospital fees that are in excess of FHCP's allowable charges (balance billing). These charges can be significant. We recommend whenever possible that you check with out-of-network providers to determine fees in advance.

HMO Benefit	Additional Choices	
Option 1	Option 2	Option 3
Visit your PCP or self-refer to a provider in the HMO Network	Go directly to any Option 2 Provider.	Go directly to a non-participating physician, facility or hospital outside the HMO network or Option 2 Providers.
Cost to you: Copay/Coinsurance, if any	**Cost to you:** Deductible and coinsurance or copayment	**Cost to you:** Higher Deductible, higher coinsurance and significant provider fees that are in excess of FHCP's allowable charges.

This Rider provides **separate** deductibles between Options 1, 2 and 3. Before FHCP will begin paying for Covered Services, a Member must satisfy the applicable Calendar Year Deductible which is set forth in the Benefit Summary Chart.

PRIOR AUTHORIZATION

On certain occasions your treating physician may recommend specialized services by a provider or facility that are not available within our immediate HMO network. In this circumstance your treating physician may request these out-of-network services be provided at an HMO benefit rate. This request is referred to as PRE-AUTHORIZATION. Pre-Authorization requests require medical necessity and must be made PRIOR to your receiving any services. You or your requesting physician may contact Florida Health Care Plans Pre-Authorization division by calling (386-238-3215 or 1-800-729-8349/ Pre-Authorization Department for instructions. Services rendered without prior authorization will be covered at the out-of-network benefit level and subject to higher cost sharing.

PRE-ADMISSION REVIEW AND CERTIFICATION...

Pre-Certification Of Services

While this is an open access plan, certain services must be pre-certified to avoid additional out-of-pocket expense for the member.

The following services must be pre-certified:
Hospital Confinements
Home Health Care
Skilled Nursing Care
Partial Hospitalization
Outpatient Surgical Procedure
Outpatient Rehabilitative Services

The member or his/her attending physician must contact FHCP at 386-238-3215 or 1-800-729-8349.

Pre-Admission Certification means the review to determine the number of days of Hospital Confinement which will be deemed to be Medically Necessary for the care or treatment of the Member's condition.

Certification Procedure...

a. The Member or his/her attending Physician must contact Florida Health Care Plans at 386-238-3215 or 1-800-729-8349 as follows:

1. at least ten days prior to the start of a Hospital Confinement, outpatient surgical procedures or invasive procedures to be performed in an Ambulatory Surgical Center or Hospital Outpatient Surgical Center or as soon as possible; or
2. in the case of an emergency Hospital Confinement, within 48 hours or, as soon as it is reasonably possible to do so after the start of such confinement, not counting any day of a weekend or a legal holiday. For this purpose; Friday, Saturday, or Sunday will be deemed a day of the weekend.
3. At least five days prior to the start of skilled nursing home admission; home health care and outpatient rehabilitative care.

b. Upon receipt of such request Florida Health Care Plans will:
   1. determine the number of days of Hospital Confinement deemed to be Medically Necessary for the care or treatment of the Member's condition. Elective surgery may be certified as medically necessary but only to be performed on an outpatient basis;
   2. communicate the above data to the attending physician and/or the Hospital.

c. The Member or his/her attending Physician may, at any time, ask Florida Health Care Plans, in writing, to re-evaluate or to extend the number of days of Hospital Confinement deemed by Florida Health Care Plans to be Medically Necessary for the treatment of the Member's condition.

Additionally, should you be unable to keep a scheduled appointment with a Non-Participating Provider, you must cancel the appointment within twenty-four (24) hours of the scheduled time. If you fail to notify the provider within this time frame, 100% of the cost of the service will be your responsibility.

DEFINITIONS...
Please refer to your handbook for specific definitions and a full description of covered benefits, exclusions, and limitations.

'LAIMS PROCEDURES...
Jnder this Rider, HMO and Option 2 providers will generally file claims for you.

If you go to a provider who does not participate, you may be asked to pay for health care services first, and file claims yourself for reimbursement from FHCP. In order to file a claim submit a copy of the bill and receipt to Florida Health Care Plans at P.O. Box 9910, Daytona Beach, FL 32120-9910.

Only those expenses related to covered benefits which are submitted as a claim to FHCP will be credited toward the Deductible or the Member's Annual Out-of-Pocket Expense Limit.

Reimbursement for Network Provider Services: Certain services require pre-authorization. FHCP will pay the Provider directly for all care received. The Member will not have to submit a claim for payment. Whenever HMO network services are utilized and FHCP's authorization procedure is followed, or Option 2 PCP services are utilized, HMO cost sharing will apply. Utilizing Option 2 providers without obtaining an FHCP authorization will result in benefits being paid at the Option 2 level.

In the event the Member requires Emergency Services and Care for an Emergency Medical Condition from a Non-Participating Provider while inside or outside the Service Area; or, if FHCP authorizes a referral of the Member to a Non-Participating Provider, and the Member is required to pay the Non-Participating Provider directly for such services, the Member will be reimbursed for the allowed cost of the services less any applicable HMO co-payments for each date of service.

In the event a Member requires Emergency Services and Care for an Emergency Medical Condition from a Non-Participating Provider, call the FHCP Medical Claims Department at 1-800-321-1227, Ext. 3208 to report the ıergency as soon as medically possible. Before leaving the hospital or provider's office, obtain a copy of any dictation or sign a medical release form to give legal permission to release the records to the FHCP Medical Claims Department upon their request. Bring or send all claims, bills and medical records to the FHCP Medical Claims Department at 1340 Ridgewood Avenue in Holly Hill, or mail the information to FHCP Medical Claims Department, P.O. Box 9910, Daytona Beach, Florida 32120-9910.

Medical Payment Guidelines For Non-Participating Provider Care: Whenever utilizing Non-Participating Providers and/or facilities for other than an Emergency Medical Condition, Out-of-Network benefits, deductibles and coinsurance fees that exceed allowable charges will apply. FHCP's payment for services covered by this Rider will be determined according to the FHCP allowance guidelines (usual and customary rate – UCR) in effect at the time the service was rendered. These guidelines apply to Covered Services only and are not in addition to all of the other provisions, limitations and exclusions contained in the Contract and this Rider. Utilization of services rendered by non-participating providers and/or facilities may result in the member being responsible for significant balance billing in addition to their Option 3 deductible and coinsurance.

INFORMATION LINES
Please contact FHCP at 386-238-3215 or at 1-800-729-8349 for information and follow the instructions for obtaining pre-certifications, benefit information, verification of coverage, etc.

EXCLUSIONS AND LIMITATIONS...
All services covered under this Rider must be Medically Necessary as defined in your HMO Contract. The benefit exclusions and limitations specified in the Contract and Co-Payment, Benefits, and Limitations Schedule are also applicable to the benefits specified in this Triple Option Rider. Additionally, the following services are not covered or are limited under this Rider:

1. Emergency Services. Emergency Services and Care administered by any provider for an Emergency Medical Condition will be covered under the HMO Contract benefits. In order for care to be covered under the Contract, FHCP must be notified as described in the Emergency Care provision in the Contract's Covered Services section. If notification is not provided as specified in the Contract, services for an Emergency Medical Condition may be payable under the Rider if the service or supply is a covered service as specified in the Rider Benefit Summary and not specifically excluded herein.
   Voluntary family planning services, sterilization, infertility evaluation and medical treatment, surgery for the enhancement of fertility and genetic counseling.
3. Hearing examinations for hearing aids are available only under the HMO Contract and are not an out-of-network benefit.
4. Vision examinations are available only under the HMO Contract by rider and are not an out-of-network benefit, if elected.
5. Dental services are available only under the HMO contract by rider and are not an out-of-network benefit, if elected.
6. The day or visit maximum indicated for Skilled Nursing Facility care, Mental Health services and Substance Abuse services, is the total number of days or visits you may receive under your HMO Contract (in-network) **and** this Rider (out-of-network), combined.

Florida Health Care Plan, Inc. (hereinafter called FHCP) agrees to provide the health care services described under the provisions of this Triple Option Rider for the Member and his or her Covered Dependents.

Signed for Florida Health Care Plan, Inc. at its facility in Holly Hill, Florida to take effect on the Subscriber's Effective Date, for delivery in the State of Florida.

David C. Schandel
Chief Financial Officer/Associate CEO
Florida Health Care Plan, Inc.

Florida Health Care Plans

PREMIUM PLUS LG TRIPLE OPTION
OPEN ACCESS POINT OF SERVICE
PLAN CODE 321

DEDUCTIBLE AND BENEFITS LIMITS	COVERED PERSON'S FINANCIAL RESPONSIBILITY		
	Option 1 Premium+ LG HMO In Network	Option 2	Option 3
Annual Deductible - The amount you pay each calendar year before the plan begins covering your medical expenses. Individual Family	 $0 $0	 $250 $500	 $500 $1,000
Annual Out-of-Pocket Expense Limit Individual Family	 $1,500 $3,000	 $1,500 $3,000	 $3,000 $6,000
Coinsurance Plan Pays Covered Person Pays Precertification Penalty	 N/A	 85% 15% Yes – 20%	 70% 30% Yes – 20%
Lifetime Maximum for each Member as long as coverage is in effect.	$2,000,000	$2,000,000	$2,000,000
INPATIENT – Illness, Injury, Maternity, Newborn			
Inpatient	$200/Admission	Ded & Coins	Ded & Coins
In-Hospital Physician Services	Covered In Full	Ded & Coins	Ded & Coins
OUTPATIENT CARE			
Primary Care Office Visit	$0	$10	Ded & Coins
Other Primary Care Services	$0	$10	Ded & Coins
Sp ist Office Visit	$10	Ded & Coins	Ded & Coins
Other Specialty Services	$10	Ded & Coins	Ded & Coins
Allergy Shots/Immunizations in Physician's Office (additional office copayment may apply)	Covered in Full	Ded & Coins	Ded & Coins
Outpatient Surgical Care or Invasive Procedure (Ambulatory Surgical Center, Outpatient Medical Facility or in Hospital)	Covered in Full	Ded & Coins	Ded & Coins
Therapy (Restorative Physical, Speech and Occupational) – Limited to 20 visits/cy	$15	Ded & Coins	Ded & Coins
Chiropractic (Restorative Non-Surgical Back Treatment) – Limited to 20 visits/cy	$10	Ded & Coins	Ded & Coins
MENTAL & NERVOUS DISORDER			
Inpatient – Limited to 30 days/cy	$200/Admission	Ded & Coins	Ded & Coins
Outpatient - Limited to 20 visits/cy	$10	Ded & Coins	Ded & Coins
ALCOHOL & DRUG ABUSE TREATMENT – Lifetime Maximum Benefit of $2,000			
Inpatient	$200/Admission	Ded & Coins	Ded & Coins
Outpatient - Limited to 44 visits/cy, Max Allowance of $35 per visit	$15	Ded & Coins	Ded & Coins
DIAGNOSTIC CARE			
Lab Test	Covered In Full	Ded & Coins	Ded & Coins
X-Ray and Ultrasound Procedures	Covered In Full	Ded & Coins	Ded & Coins
Ad ed Imaging (includes nuclear studies such as MRI, MRA, PET, CT Scans)	Covered In Full	Ded & Coins	Ded & Coins
Other Diagnostic Procedures (includes EKG, Colonoscopy)	Covered In Full	Ded & Coins	Ded & Coins

PREVENTIVE CARE			
Well Baby Care & Child Health Supervision Visits	$0 PCP	$10	Ded & Coins
Annual Adult Physical Health Screening	$0 PCP	$10	Ded & Coins
Well Woman's Assessment (PCP/Specialist)	$0 PCP $10 Spec	$10 PCP Coins Spec (Ded does not apply)	Ded & Coins
Mammography Screening	Covered In Full	Ded & Coins	Ded & Coins
Bone Density Screening	Covered In Full	Ded & Coins	Ded & Coins
EMERGENCY CARE			
Inpatient	$200/Admission	Same as In-Network	Same as In-Network
Emergency Room Visit (Waived if Admitted)	$60 Participating $75 Non-Particip.	Same as In-Network	Same as In-Network
Ambulance Services	$25	Same as In-Network	Same as In-Network
Urgent Care Center	$15 Participating	Same as In-Network	Same as In-Network
Non-scheduled MD Office Visit	$15	Same as In-Network	Same as In-Network
OTHER COVERED SERVICES			
Hearing Exam (Hearing Aids are not covered, but discounts may be available at select locations)	Covered In Full	Ded & Coins	Ded & Coins
Skilled Nursing (Limited to 20 days/cy)	Covered In Full	Ded & Coins	Ded & Coins
Home Health Care (Limited to 60 visits/cy)	Covered In Full	Ded & Coins	Ded & Coins
Hospice	Covered In Full	Ded & Coins	Ded & Coins
Durable Medical Equipment & Supplies (Maximum $5,000/cy)	Covered In Full	Ded & Coins	Ded & Coins
Orthotics / Prosthetics (Maximum $5,000/cy)	Covered In Full	Ded & Coins	Ded & Coins
DIABETES MONITORING - Deductible Does Not Apply			
Diabetes Outpatient Self-Management Education	Covered In Full	Not Applicable	Covered In-Network Only
50 Test Strips/Sensors	$10	Not Applicable	Ded & Coins
Lancets	$10	Not Applicable	Ded & Coins
Glucometer	Covered In full	Not Applicable	Ded & Coins
Annual Retinal Screening (Optometrist/Ophthalmologist)	$10/$20	Not Applicable	Ded & Coins

This plan is an Open Access Point of Service plan. Services rendered without prior authorization or pre-certification will be covered at the out-of-network benefit level and subject to higher coinsurance.

Only allowable charges for covered services will be applied toward fulfilling applicable deductibles. Amounts in excess of allowable charges will not be applied to annual deductible or maximum out-of-pocket limit. Members choosing out-of-network providers will pay higher deductibles and coinsurance and will also be at risk for non-participating providers fees that are in excess of allowable charges (balance billing).

Member's failure to provide 24 hour notice of cancellation of scheduled appointment may result in a Provider No-Show Fee equal to the appropriate office visit cost sharing charges or out-of-network equal to full office visit charges.

Please see your Certificate of Coverage for more detailed information regarding Claims, Exclusions & Limitation, Definitions, and Pre-certification/Authorization requirements.

Florida Health Care Plans
An Affiliate of Halifax Community Health System

PRESCRIPTION BENEFITS

POS AND TRIPLE OPTION
$10/$30/$55 COPAYMENT - CERTIFICATE RIDER

HOW DOES PRESCRIPTION COVERAGE WORK?

Your prescription Benefit with Florida Health Care Plans is comprised of a list of prescription drugs called a formulary. When you get your prescription filled at one of FHCP's pharmacies or any Walgreens pharmacy, you pay the following copayment:

	FHCP In-House Pharmacy	Walgreen Pharmacy
Formulary Generic Drugs:	$10.00	$15.00
* Formulary Preferred Brand Drugs:	$30.00	$35.00
* Formulary Non-Preferred Brand Drugs:	$55.00	$60.00
Mail Order		
Formulary Generic Drugs:	$ 9.00	N/A
* Formulary Preferred Brand Drugs:	$29.00	N/A
* Formulary Non-Preferred Brand Drugs:	$54.00	N/A
Pre-approved, pre-certified specialty drug formulary	$100.00	N/A

*If you purchase a preferred or non-preferred brand product when a generic is available, you will be responsible for paying the Average Wholesale Price (AWP) for that prescription.

** FHCP In-house Pharmacies also offer a mail order program. You may obtain up to a 90-day supply with a $1.00 discount on each 31-day supply of generic, preferred brand, or non-preferred brand medications.

Non-formulary drugs, while not covered by this plan, are available to members at a discount price of 85% of AWP at FHCP pharmacies only. Not covered items (Exclusions), as described below, are available at 100% of AWP at FHCP pharmacies only.

IN AN EMERGENCY...

Always present your FHCP membership card to allow the doctor or hospital to verify coverage with FHCP. Your coverage with FHCP includes prescriptions written during emergency situations.

WHAT IS COVERED?

Coverage includes the following:

- The following Diabetic supplies are covered. The appropriate copay applies for each item.
  - Insulin, hypodermic needles, and syringes with insulin.
- Self-injectables (excluding Insulin) (available at FHCP Pharmacies only);
- Must be prescribed by a Physician for the treatment of a Condition;
- Must be dispensed by a Pharmacist;
- Must be a generic medication when both a generic and a more expensive preferred or non-preferred brand drug is available;
- Up to a 31-day supply per prescription or per unit of use, whichever is less (mail order provides up to a 93-day supply);
- Prescription refills, but will not be covered until at least 75% of the previous prescription has been used by the Member, (based on the dosage schedule prescribed by the Physician).

EXCLUSIONS AND LIMITATIONS

- Any drug, medicine, or medication that is consumed at the place where the prescription is given or that is dispensed by a Physician;
- Any portion of a prescription or refill that exceeds a 31-day supply;
- Prescription refills in excess of the number specified by the Physician;
- The administration of covered prescription medication;
- Prescriptions that may be paid without charge under local, state, or federal programs, including Worker's Compensation;
- Prescriptions that are to be taken by or administered to the Member in whole or in part, while he or she is a patient in a Hospital, Skilled Nursing Facility, convalescent Hospital, Inpatient hospice facility, or other facility where drugs are ordinarily provided by the facility on an inpatient basis;
- Prescriptions ordered or received in excess of any maximums covered under this benefit, and not covered under any other provision in this Group Plan;
- Any drug, medicine, or medication labeled "Caution-Limited by Federal Law to Investigational Use." Any experimental drug or drug used for non-FDA approved indication or prescribed for use by a route of administration that is not approved by the FDA even though a charge is made to the Member; A drug that is prescribed for the treatment of cancer is covered as long as that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature;
- Immunizing agents, biological serums, or allergy serums;
- Any drug or medicine that is lawfully obtainable without a prescription, with the exception of insulin;
- Therapeutic devices or appliances, including hypodermic needles/syringes (exception: insulin needles/syringes with insulin), support garments, and other non-medical substances, regardless of intended use;
- Prescriptions filled at a Non-Participating Pharmacy, except for prescriptions required during Emergency Care;
- Nutritional supplements given as a medicine between meals to boost protein-caloric intake or the mainstay of a daily nutritional plan;
- Prescription and non-prescription appetite suppressants and products for the purpose of weight loss;
- Nicotine suppressants and smoking cessation products and services;
- Any drug for cosmetic use or alteration of one's appearance (i.e. Rogaine, Bleaching Agents, Acne Medications, Nail Fungus treatment);
- Infertility Agents;
- Transdermal Scopolamine patches; and
- Abortifacients.

QUESTIONS?

Call your Florida Health Care Plans Member Services Department at:
386-615-4022
1-800-352-9824, Ext. 4022
www.fhcp.com

Florida Health Care Plans
An Affiliate of Halifax Community Health System

VISION BENEFIT CERTIFICATE RIDER

HOW DOES YOUR VISION COVERAGE WORK?

Coverage for diseases of the eye or visits to an Ophthalmologist are covered through your medical coverage with Florida Health Care Plans. Your Employer has elected to include additional vision benefits offered by this rider.

How the coverage works:

1. Present your FHCP Membership card each time you visit your FHCP Participating Optometrist.
2. Pay the following copayment:
    - $10 copay/exam for Eyeglasses
    - $50 copay/exam for Contact Lenses
    - $10 copay/exam for Eye disease, visual disturbances, etc.

WHAT IS COVERED?

Eye Care is limited to routine eye care provided by a participating optometrist.

You do not need a referral to an optometrist. Simply call and schedule your appointment.

EXCLUSIONS AND LIMITATIONS

Eye Care, including but not limited to the purchase or fitting of eyeglasses or contact lenses.

QUESTIONS?

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1-800-352-9824, Ext. 4022

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FHCP V - A1/03
Revised 9/05

Florida Health Plans
Caring for Our Community

Confidential Information Statement

ALL075: CITY OF PORT ORANGE: All Plans

Month/ Year	Contracts Single	Emp/Sps	Emp/Dep	Sml Fam	Lrg Fam	Total Subs	Members	Premiums	Capitation & Clinic	Paid Claims Inpatient	Outpatient	Total Facility	Professional	Other	Total Claims	Pharmacy & Supplies	Total Medical	PMPM
Apr-06	269	56	36	86	0	447	814	217,626.18	41,272.72	40,248.82	39,921.47	80,170.29	35,463.68	1,879.28	117,513.25	10,918.01	169,703.98	
May-06	270	59	36	83	0	448	816	217,621.10	41,272.53	82,632.81	36,430.93	119,063.74	24,591.18	8,838.64	152,493.56	12,602.72	206,368.81	
Jun-06	270	59	38	83	0	450	815	218,956.85	39,844.26	17,505.84	47,701.52	65,207.36	42,146.81	4,497.44	111,851.61	13,013.49	164,709.36	
Jul-06	273	57	39	80	0	449	803	217,725.99	43,985.28	45,402.79	56,053.52	101,456.31	42,723.97	3,406.26	147,586.54	14,126.93	205,698.75	
Aug-06	277	55	40	80	0	452	803	217,787.28	44,006.08	16,667.29	36,986.76	53,654.05	33,542.48	4,721.13	91,917.66	15,143.54	151,067.28	
Sep-06	277	55	40	79	0	451	800	216,987.80	46,779.63	52,292.85	35,059.95	87,352.80	38,634.72	3,832.20	129,819.72	12,744.00	189,343.35	
Oct-06	280	54	41	79	0	454	803	218,035.58	41,187.67	84,867.00	44,341.89	129,208.89	47,853.12	4,718.66	181,780.67	13,384.70	236,353.04	
Nov-06	279	54	41	78	0	452	800	217,284.67	38,780.19	33,052.00	45,528.89	78,580.89	29,475.36	3,228.60	111,284.85	7,239.47	157,304.51	
Dec-06	279	52	41	78	0	450	799	215,777.75	49,989.82	42,498.00	53,188.92	95,686.92	33,394.50	2,929.94	132,011.36	6,637.16	188,838.34	
Jan-07	274	52	41	82	0	449	808	245,296.94	47,347.67	65,758.76	52,840.89	118,599.65	38,978.92	2,870.48	160,449.03	15,972.36	223,769.06	
Feb-07	277	54	44	75	0	450	801	244,564.94	40,004.32	42,827.01	72,748.71	115,575.72	46,540.07	11,099.15	173,214.94	15,556.14	228,775.40	
Mar-07	282	52	43	77	0	454	801	245,387.54	38,596.12	50,754.11	85,825.77	136,579.88	59,413.49	10,358.19	206,351.56	19,895.24	264,842.92	
TOTALS	3,307	659	480	960	0	5,406	9,663	2,693,052.62	513,066.29	574,507.28	606,629.22	1,181,136.50	472,758.30	62,379.95	1,716,274.75	157,433.76	2,386,774.80	247.00

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Florida Health Plans
Caring for Our Community

Confidential Information Statement

000075: City of Port Orange: HMO

Month/ Year	Contracts Single	Emp/Sps	Emp/Dep	Sml Fam	Lrg Fam	Total Subs	Members	Premiums	Capitation & Clinic	Paid Claims Inpatient	Outpatient	Total Facility	Professional	Other	Total Claims	Pharmacy & Supplies	Total Medical	PMPM
Apr-06	246	50	36	81	0	413	758	199,305.73	40,211.70	40,104.34	24,954.24	65,058.58	33,874.91	1,598.06	100,531.55	9,186.89	149,930.14	
May-06	246	53	36	78	0	413	759	198,886.63	39,870.24	82,485.75	35,707.16	118,192.91	22,376.60	8,005.30	148,574.81	10,147.44	198,592.49	
Jun-06	246	52	38	78	0	414	756	199,497.84	37,523.87	17,353.62	34,058.77	51,412.39	39,713.43	4,341.32	95,467.14	10,699.06	143,690.07	
Jul-06	249	50	39	76	0	414	748	198,432.59	42,130.99	45,335.14	46,793.61	92,128.75	42,051.27	2,993.89	137,173.91	12,080.96	191,385.86	
Aug-06	253	48	40	76	0	417	748	199,218.42	42,505.23	16,599.64	30,083.88	46,683.52	28,615.90	3,947.78	79,247.20	13,226.10	134,978.53	
Sep-06	252	49	40	75	0	416	746	198,729.46	45,454.77	52,226.43	29,504.22	81,730.65	35,230.08	3,676.08	120,636.81	10,348.10	176,439.68	
Oct-06	255	48	41	75	0	419	749	199,777.24	38,276.93	75,147.00	35,366.26	110,513.26	44,880.85	4,371.29	159,765.40	11,323.02	209,365.35	
Nov-06	254	48	41	74	0	417	746	199,026.33	37,284.00	33,052.00	45,073.42	78,125.42	25,678.36	2,620.84	106,424.62	5,964.23	149,672.85	
Dec-06	253	46	41	74	0	414	744	197,105.39	47,580.61	42,498.00	34,490.77	76,988.77	30,251.29	2,786.88	110,026.94	5,950.50	163,558.05	
Jan-07	249	47	40	75	0	411	740	222,069.27	44,541.60	65,733.25	45,858.56	111,591.81	36,862.98	2,511.99	150,966.78	13,307.09	208,815.47	
Feb-07	253	49	42	69	0	413	737	222,167.95	38,551.99	38,043.00	72,421.70	110,464.70	43,661.89	10,026.29	164,152.88	12,929.01	215,633.88	
Mar-07	257	47	41	71	0	416	736	222,523.27	35,990.40	49,129.73	47,270.67	96,400.40	52,183.97	9,588.50	158,172.87	17,224.13	211,387.40	
TOTALS	3,013	587	475	902	0	4,977	8,967	2,456,740.12	489,922.33	557,707.90	481,583.26	1,039,291.16	435,381.53	56,468.22	1,531,140.91	132,386.53	2,153,449.77	240.15

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Florida Health Plans
Caring for Our Community

Confidential Information Statement

00T075: City of Port Orange: Triple Option

Month/ Year	Contracts Single	Emp/Sps	Emp/Dep	Sml Fam	Lrg Fam	Total Subs	Members	Premiums	Capitation & Clinic	Paid Claims Inpatient	Outpatient	Total Facility	Professional	Other	Total Claims	Pharmacy & Supplies	Total Medical	PMPM
Apr-06	23	6	0	5	0	34	56	18,320.45	1,061.02	144.48	14,967.23	15,111.71	1,588.77	281.22	16,981.70	1,731.12	19,773.84	
May-06	24	6	0	5	0	35	57	18,734.47	1,402.29	147.06	723.77	870.83	2,214.58	833.34	3,918.75	2,455.28	7,776.32	
Jun-06	24	7	0	5	0	36	59	19,459.01	2,320.39	152.22	13,642.75	13,794.97	2,433.38	156.12	16,384.47	2,314.43	21,019.29	
Jul-06	24	7	0	4	0	35	55	19,293.40	1,854.29	67.65	9,259.91	9,327.56	672.70	412.37	10,412.63	2,045.97	14,312.89	
Aug-06	24	7	0	4	0	35	55	18,568.86	1,500.85	67.65	6,902.88	6,970.53	4,926.58	773.35	12,670.46	1,917.44	16,088.75	
Sep-06	25	6	0	4	0	35	54	18,258.34	1,324.86	66.42	5,555.73	5,622.15	3,404.64	156.12	9,182.91	2,395.90	12,903.67	
Oct-06	25	6	0	4	0	35	54	18,258.34	2,910.74	9,720.00	8,975.63	18,695.63	2,972.27	347.37	22,015.27	2,061.68	26,987.69	
Nov-06	25	6	0	4	0	35	54	18,258.34	1,496.19	0	455.47	455.47	3,797.00	607.76	4,860.23	1,275.24	7,631.66	
Dec-06	26	6	0	4	0	36	55	18,672.36	2,409.21	0	18,698.15	18,698.15	3,143.21	143.06	21,984.42	866.66	25,260.29	
Jan-07	25	5	0	6	0	36	61	21,798.60	2,537.99	22.88	6,979.70	7,002.58	2,115.94	358.47	9,476.99	2,667.54	14,682.52	
Feb-07	24	5	0	5	0	34	55	20,326.67	1,217.69	4,780.63	323.63	5,104.26	2,838.87	1,072.86	9,015.99	2,627.13	12,860.81	
Mar-07	25	5	0	5	0	35	56	20,793.95	2,470.44	1,621.00	38,551.72	40,172.72	7,229.52	769.69	48,171.93	2,660.61	53,302.98	
TOTALS	294	72	0	55	0	421	671	230,742.79	22,505.96	16,789.99	125,036.57	141,826.56	37,337.46	5,911.73	185,075.75	25,039.00	232,620.71	346.68

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Florida Healt e Plans
Caring for Our Community

Confidential Information Statement

00H075: City of Port Orange: HDHP

Month/ Year	Contracts Single	Emp/Sps	Emp/Dep	Sml Fam	Lrg Fam	Total Subs	Members	Premiums	Capitation & Clinic	Paid Claims Inpatient	Outpatient	Total Facility	Professional	Other	Total Claims	Pharmacy & Supplies	Total Medical	PMPM
Apr-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
May-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Jun-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Jul-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Aug-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Sep-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Oct-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Nov-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Dec-06	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Jan-07	0	0	1	1	0	2	7	1,429.07	268.08	2.63	2.63	5.26	0	0	5.26	-2.27	271.07	
Feb-07	0	0	2	1	0	3	9	2,070.32	234.64	3.38	3.38	6.76	39.31	0	46.07	0	280.71	
Mar-07	0	0	2	1	0	3	9	2,070.32	135.28	3.38	3.38	6.76	0	0	6.76	10.50	152.54	
TOTALS	0	0	5	3	0	8	25	5,569.71	638.00	9.39	9.39	18.78	39.31	0	58.09	8.23	704.32	28.17

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City of Port Orange Grp# 000075 & 00T075 10/1/2007 Census for Renewal

Contract Type	Age Band of Employee 0-29	30-39	40-49	50-54	55-59	60-64	65+	Total
single male	30	43	54	22	24	18	5	196
single female	12	18	17	13	10	8	2	80
dep male	1	13	12	1	0	0	0	27
dep female	3	4	4	2	0	0	0	13
couple	4	7	11	10	14	4	1	51
family	4	22	36	9	4	0	2	77
large family	0	0	0	0	0	0	0	0
Total	54	107	134	57	52	30	10	444
						Group Total		444

City of Port Orange Grp# 000075 & 00T075 1/1/2007 Census for Renewal

	Age Band of Employee							
Contract Type	0-29	30-39	40-49	50-54	55-59	60-64	65+	Total
single male	31	47	52	21	22	13	4	190
single female	8	23	17	16	9	8	3	84
dep male	3	11	10	2	2	0	0	28
dep female	4	3	3	2	0	0	0	12
couple	4	6	13	10	16	5	1	55
family	6	27	36	4	3	1	2	79
large family	0	0	0	0	0	0	0	0
Total	56	117	131	55	52	27	10	448
						Group Total		448