CITY COUNCIL AGENDA ITEM

REQUESTED COUNCIL MEETING DATE 08/26/08

SUBJECT: Florida Health Care Contract Renewal Proposal

DEPARTMENT: Human Resources

RECOMMENDED MOTION:

Acceptance of the Florida Health Care's proposal to renew their contract for the period beginning October 1, 2008 through September 30, 2009.

SUMMARY:

For the past several weeks the City has been reviewing and negotiating various options relating to the renewal of the City's Health Insurance Program with Florida Health Care (FHC).

Several proposals were first offered by FHC. FHC's original proposal included a 9.9% increase in premium. The City was able to work with FHC to bring the proposed increases in premium down significantly. After further discussing and considering our loss experiences, FHC offered plans that included the following:

- 1.7% increase to the Select VP3 HMO Plan (base plan)
- 1.6% increase to the Premium Plus HMO Plan
- 1.6% increase to Premium Plus Triple Option

There would be no change in benefits to any of these plans.

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

[X] Other [X] Support Documents

DEPARTMENT HEAD	Robert Zicker, Human Resources Director	Date 8.14.8
FINANCE DEPARTMENT	Approved as to Budget Requirements	Date 8/14/08
CITY ATTORNEY	Approved as to Form and Legality	Date 8.14.08
CITY MANAGER	Approved Agenda Item For:	8-26-08

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

Florida Health Care Plans

City of Port Orange

Renewal Date: 10/1/2008

	Current:	Renewal:	Alternates:			Current:	Renewal:	Alternates:				
PLAN NAME	Premium Plus	Premium Plus	Premium	Select		Select VP-3	Select VP-3	Classic	Classic VP-3	Balance	Balance	Balance
Plan Type	HMO	HMO	HMO	HMO		HMO	HMO	HMO	HMO	HMO	HMO	HMO
Plan Code	033	033	030	024		H13	H13	H01	H04	H14	H15	H16
Annual Deductible												
Individual	$0	$0	$0	$0		$0	$0	$0	$0	$0	$500	$1,000
Family											$1,000	$2,000
Co-Insurance (Mbr Pays)	NA	NA	NA	NA		NA	NA	NA	NA	10%	20%	20%
Annual Out-of-Pocket Expense Limit												
Individual	$1,500	$1,500	$1,500	$1,500		$4,000	$4,000	$1,500	$4,000	$3,000	$3,000	$4,000
Family	$3,000	$3,000	$3,000	$3,000		$8,000	$8,000	$3,000	$8,000	$6,000	$6,000	$8,000
In-Patient	$200	$200	$200	$200		$500/Day (Days 1-5)	$500/Day (Days 1-5)	$200	$500/Day (Days 1-5)	Ded & Coins	Ded & Coins	Ded & Coins
PCP OV	$0	$0	$10	$15		$15	$15	$20	$20	$20	$20	$30
Specialist OV	$10	$10	$20	$25		$25	$25	$35	$35	$35	$35	$50
Out Patient Surgery	$0	$0	$0	$0		$200	$200	$0	$200	Ded & Coins	Ded & Coins	Ded & Coins
Emergency Visit												
Participating	$60	$60	$60	$60		$60	$60	$75	$75			
Non-Participating	$75	$75	$75	$75		$75	$75	$100	$100	Ded & Coins	Ded & Coins	Ded & Coins
Urgent Care Visit	$15	$15	$25	$30		$30	$30	$60	$60	Ded & Coins	Ded & Coins	Ded & Coins
PHARMACY												
Formulary Generic	$10	$10	$10	$10		$10	$10	$10	$10	$10	$10	$10
Formulary Preferred Brand	$30	$30	$30	$30		$30	$30	$30	$30	$30	$30	$30
Formulary Non Preferred Brand	$55	$55	$55	$55		$55	$55	$55	$55	$55	$55	$55
RATES												
Subgroup HMO												
Single	$440.61	$447.75	$442.37	$439.88		$414.40	$421.27	$434.48	$415.87	$417.56	$367.39	$336.29
EE & Child(ren)	$784.28	$797.00	$787.41	$782.98		$737.64	$749.85	$773.37	$740.25	$743.26	$653.95	$598.59
EE & Spouse	$784.28	$797.00	$787.41	$782.98		$737.64	$749.85	$773.37	$740.25	$743.26	$653.95	$598.59
Family < 7 Members	$960.53	$976.10	$964.36	$958.93		$903.40	$918.36	$947.17	$906.59	$910.28	$800.90	$733.11
Family 7 + Members	$960.53	$976.10	$964.36	$958.93		$903.40	$918.36	$947.17	$906.59	$910.28	$800.90	$733.11

Renewal Census	**Subs:**	***Monthly Premium:***	***Monthly Premium:***	***Monthly Premium:***	***Monthly Premium:***	**Subs:**	***Monthly Premium:***	***Monthly Premium:***	***Monthly Premium:***	***Monthly Premium:***	***Monthly Premium:***	***Monthly Premium:***	***Monthly Premium:***
Single	232	$102,221.52	$103,878.00	$102,629.84	$102,052.16	21	$8,702.40	$8,846.67	$9,124.08	$8,733.27	$8,768.76	$7,715.19	$7,062.09
EE & Child(ren)	30	$23,528.40	$23,910.00	$23,622.30	$23,489.40	3	$2,212.92	$2,249.55	$2,320.11	$2,220.75	$2,229.78	$1,961.85	$1,795.77
EE & Spouse	42	$32,939.76	$33,474.00	$33,071.22	$32,885.16	5	$3,688.20	$3,749.25	$3,866.85	$3,701.25	$3,716.30	$3,269.75	$2,992.95
Family < 7 Members	65	$62,434.45	$63,446.50	$62,683.40	$62,330.45	2	$1,806.80	$1,836.72	$1,894.34	$1,813.18	$1,820.56	$1,601.80	$1,466.22
Family 7 + Members	0	$0.00	$0.00	$0.00	$0.00	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Totals:	369	$221,124.13	$224,708.50	$222,006.76	$220,757.17	31	$16,410.32	$16,682.19	$17,205.38	$16,468.45	$16,535.40	$14,548.59	$13,317.03

Total Annual Premium:	$2,653,489.56	$2,696,502.00	$2,664,081.12	$2,649,086.04		$196,923.84	$200,186.28	$206,464.56	$197,621.40	$198,424.80	$174,583.08	$159,804.36
Percent Change:		1.6%	0.4%	-0.2%			1.7%	4.8%	0.4%	0.8%	-11.3%	-18.8%
		Renewal					Renewal					

Florida Health Care Plans

City of Port Orange

Renewal Date: 10/1/2008

	Current:			Renewal:			Alternates:								
PLAN NAME	**Premium Plus Triple Option**			**Premium Plus Triple Option**			**Premium Triple Option**			**Classic Triple Option**			**Balance Triple Option**		
Plan Code	**321**			**321**			**322**			**323**			**324**		
BENEFITS	**In Network Option 1**	**Option 2**	**Option 3**	**In Network Option 1**	**Option 2**	**Option 3**	**In Network Option 1**	**Option 2**	**Option 3**	**In Network Option 1**	**Option 2**	**Option 3**	**In Network Option 1**	**Option 2**	**Option 3**
Annual Deductible Individual Family	$0	$250 $500	$500 $1000	$0	$250 $500	$500 $1000	$0	$250 $500	$500 $1000	$0	$250 $500	$500 $1000	$0	$500 $1000	$1000 $2000
Co-Insurance	NA	15%	30%	NA	15%	30%	NA	20%	40%	NA	30%	50%	10%	20%	40%
Annual Out-of-Pocket Expense Limit	$1500 $3000	$1500 $3000	$3000 $6000	$1500 $3000	$1500 $3000	$3000 $6000	$1500 $3000	$1500 $3000	$3000 $6000	$2000 $4000	$3000 $6000	$6000 $12,000	$3000 $6000	$3000 $6000	$6000 $12,000
In-Patient	$200	Ded & Coins	Ded & Coins	$200	Ded & Coins	Ded & Coins	$200	Ded & Coins	Ded & Coins	$250 day Days 1-5	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Primary Care Physician OV	$0	$10	Ded & Coins	$0	$10	Ded & Coins	$10	$15	Ded & Coins	$20	$30	Ded & Coins	$20	$30	Ded & Coins
Specialist OV	$10	Ded & Coins	Ded & Coins	$10	Ded & Coins	Ded & Coins	$20	Ded & Coins	Ded & Coins	$35	Ded & Coins	Ded & Coins	$35	Ded & Coins	Ded & Coins
Out Patient Surgery	$0	Ded & Coins	Ded & Coins	$0	Ded & Coins	Ded & Coins	$0	Ded & Coins	Ded & Coins	$100	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Emergency Visit Participating Non-Participating	$60 $75	Same as In-Network	Same as In-Network	$60 $75	Same as In-Network	Same as In-Network	$60 $75	Same as In-Network	Same as In-Network	$75 $100	Same as In-Network	Same as In-Network	Ded & Coins Ded & Ded Coins	Same as In-Network	Same as In-Network
Urgent Care Visit	$15	Same as In-Network	Same as In-Network	$15	Same as In-Network	Same as In-Network	$25	Same as In-Network	Same as In-Network	$60	Same as In-Network	Same as In-Network	Ded & Coins	Same as In-Network	Same as In-Network
NO PHARMACY BENEFIT															

Option 1: HMO ***Participating*** Provider Network

Option 2: ***Non-Participating*** providers who accept discount fees such as VHN's EPO Network, DPSC Chiropractors and NHBC (Outside Volusia and Flagler Counties)

Option 3: ***Non-Participating*** **providers who do not accept a discount for their services. Please note that charges in excess of allowable may apply (Balance Billing).**

RATES					
Subgroup HMO					
Single	$521.55	$530.05	$502.85	$469.68	$464.24
EE & Child(ren)	$928.35	$943.49	$895.07	$836.02	$826.35
EE & Spouse	$928.35	$943.49	$895.07	$836.02	$826.35
Family < 7 Members	$1,136.97	$1,155.51	$1,096.21	$1,023.90	$1,012.05
Family 7 + Members	$1,136.97	$1,155.51	$1,096.21	$1,023.90	$1,012.05

Renewal Census	**Subs:**	***Monthly Premium***	***Monthly Premium***	***Monthly Premium***	***Monthly Premium***	***Monthly Premium***
Single	17	$8,866.35	$9,010.85	$8,548.45	$7,984.56	$7,892.08
EE & Child(ren)	0	$0.00	$0.00	$0.00	$0.00	$0.00
EE & Spouse	5	$4,641.75	$4,717.45	$4,475.35	$4,180.10	$4,131.75
Family < 7 Members	6	$6,821.82	$6,933.06	$6,577.26	$6,143.40	$6,072.30
Family 7 + Members	0	$0.00	$0.00	$0.00	$0.00	$0.00
Totals:	28	$20,329.92	$20,661.36	$19,601.06	$18,308.06	$18,096.13

Total Annual Premium:	$243,959.04	$247,936.32	$235,212.72	$219,696.72	$217,153.56
Percent Change:		1.6%	-3.6%	-9.9%	-11.0%
		Renewal			

Florida Health Care Plans

City of Port Orange

Renewal Date: 10/1/2008

Alternate Plans:

PLAN NAME		Select $500		Classic $500		Balance $500		Balance $1,000		HDHP-HRA		HDHP-HSA	
Plan Code		026		F01		F07		F06		B05		B15	
Network		In Net	Out of Net	In Net	Out of Net	In Net	Out of Net	In Net	Out of Net	In Net	Out of Net	In Net	Out of Net
Annual Deductible													
Individual			$500		$500		$500	$500	$1,000	$1,200	$2,400	$1,200	$2,400
Family		$0	$1,000	$0	$1,000	$0	$1,500	$1,000	$2,000	$2,400	$4,800	$2,400	$4,800
Co-Insurance (Mbr Pays)		NA	30%	NA	30%	10%	30%	20%	40%	20%	40%	20%	40%
Annual Out-of-Pocket Expense Limit													
Individual		$1,500	$3,000	$1,500	$3,000	$3,000	$3,000	$3,000	$6,000	$3,000	$6,000	$3,000	$6,000
Family		$3,000	$6,000	$3,000	$6,000	$6,000	$6,000	$6,000	$12,000	$6,000	$12,000	$6,000	$12,000
In-Patient		$200	Ded & Coins	$200	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
PCP OV		$15	Ded & Coins	$20	Ded & Coins	$20	Ded & Coins	$20	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Specialist OV		$25	Ded & Coins	$35	Ded & Coins	$35	Ded & Coins	$35	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Out Patient Surgery		$0	Ded & Coins	$0	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins	Ded & Coins
Emergency Visit													
Participating		$60		$75			Same as In-Network		Same as In-Network		Same as In-Network		Same as In-Network
Non-Participating		$75	Ded & Coins	$100	Ded & Coins	Ded & Coins		Ded & Coins		Ded & Coins		Ded & Coins	
Urgent Care Visit		$30	Ded & Coins	$60	Ded & Coins	Ded & Coins	Same as In-Network	Ded & Coins	Same as In-Network	Ded & Coins	Same as In-Network	Ded & Coins	Same as In-Network
PHARMACY													
Formulary Generic		$10	Walgreens $15	$10	Walgreens $15	$10	Walgreens $15	$10	Walgreens $15	$10	Walgreens $15	Ded	Walgreens Ded
Formulary Preferred Brand		$30	Walgreens $35	$30	Walgreens $35	$30	Walgreens $35	$30	Walgreens $35	$30	Walgreens $35	Ded	Walgreens Ded
Formulary Non Preferred Brand		$55	Walgreens $60	$55	Walgreens $60	$55	Walgreens $60	$55	Walgreens $60	$55	Walgreens $60	Ded	Walgreens Ded
RATES													
#NAME?													
Single		$488.01		$482.07		$455.12		$396.03		$338.47		$299.97	
EE & Child(ren)		$868.67		$858.08		$810.11		$704.93		$602.47		$533.95	
EE & Spouse		$868.67		$858.08		$810.11		$704.93		$602.47		$533.95	
Family < 7 Members		$1,063.87		$1,050.91		$992.15		$863.35		$737.86		$653.94	
Family 7 + Members		$1,063.87		$1,050.91		$992.15		$863.35		$737.86		$653.94	
Renewal Census	Subs:	*Monthly Premium*		*Monthly Premium*		*Monthly Premium*		*Monthly Premium*		*Monthly Premium*		*Monthly Premium*	
Single	17	$8,296.17		$8,195.19		$7,737.04		$6,732.51		$5,753.99		$5,099.49	
EE & Child(ren)	0	$0.00		$0.00		$0.00		$0.00		$0.00		$0.00	
EE & Spouse	5	$4,343.35		$4,290.40		$4,050.55		$3,524.65		$3,012.35		$2,669.75	
Family < 7 Members	6	$6,383.22		$6,305.46		$5,952.90		$5,180.10		$4,427.16		$3,923.64	
Family 7 + Members	0	$0.00		$0.00		$0.00		$0.00		$0.00		$0.00	
Totals:	28	$19,022.74		$18,791.05		$17,740.49		$15,437.26		$13,193.50		$11,692.88	
Total Annual Premium:		$228,272.88		$225,492.60		$212,885.88		$185,247.12		$158,322.00		$140,314.56	
Percent Change:		-6.4%		-7.6%		-12.7%		-24.1%		-35.1%		-42.5%	

City of Port Orange

Group #: 000075 & 00H075 & 00T075

SIC Factor: 1.05

10/01/2007 Renewal Info	
Total EE's:	444
Estimated Members:	789
10/1/2007 Renewal With	
Composite Demo:	1.020060
Blended Experience PMPM:	$309.46
Exper Adjmt Factor:	0.965571
Credibility:	55%
Members per Contract	1.777
Required P+ HMO Premium PMPM:	$338.32
Required S HMO Premium PMPM:	$318.20
Required P+TO Premium PMPM:	$400.47

10/01/2008 Renewal Info		**% Change**
Total EE's:	431	-2.9%
Estimated Members:	707	-10.4%
10/1/2007 Renewal With		
Composite Demo:	1.114992	9.3%
Blended Experience PMPM:	$347.47	12.3%
Exper Adjmt Factor:	0.881859	-8.7%
Credibility:	55%	0.0%
Members per Contract	1.640	-7.7%
Required P+ HMO Premium PMPM:	$369.50	9.2%
Required S HMO Premium PMPM:	$347.64	9.3%
Required P+TO Premium PMPM:	$437.42	9.2%

2007 - 2008

~~Current~~ Current Tier Structure

Renewal Premium +	
$10/$30/$55 Rx & V HMO Rates:	
Single	$440.61
EE & Child(ren)	$784.28
EE & Spouse	$784.28
Family	$960.53
Renewal Select	
$10/$30/$55 Rx & V & VP-3 HMO Rates:	
Single	$414.40
EE & Child(ren)	$737.64
EE & Spouse	$737.64
Family	$903.40
Renewal Premium + Triple Option	
$10/$30/$55 Exp Rx & V Rates:	
Single	$521.55
EE & Child(ren)	$928.35
EE & Spouse	$928.35
Family	$1,136.97

2008 - 2009

Current Tier Structure

		% Increase
Renewal Premium +		
$10/$30/$55 Rx & V HMO Rates:		
Single	$447.75	1.6%
EE & Child(ren)	$797.00	
EE & Spouse	$797.00	
Family	$976.10	
Renewal Select		**% Increase**
$10/$30/$55 Rx & V & VP-3 HMO Rates:		
Single	$421.27	1.7%
EE & Child(ren)	$749.85	
EE & Spouse	$749.85	
Family	$918.36	
Renewal Premium + Triple Option		**% Increase**
$10/$30/$55 Exp Rx & V Rates:		
Single	$530.05	1.6%
EE & Child(ren)	$943.49	
EE & Spouse	$943.49	
Family	$1,155.51	

SELECT HMO VP3 PLAN – 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 Family	 $0 $0
Annual Out-of-Pocket Expense Limit Individual Family	 $4,000 $8,000
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	$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

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.

Select VP3 - 11/06
Large Group Plan Code H13

Florida Health Care Plans
An Affiliate of Healthy Health

PREMIUM PLUS HMO PLAN - 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

Florida Health Care Plans
An Affiliate of Halifax Community Health System

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

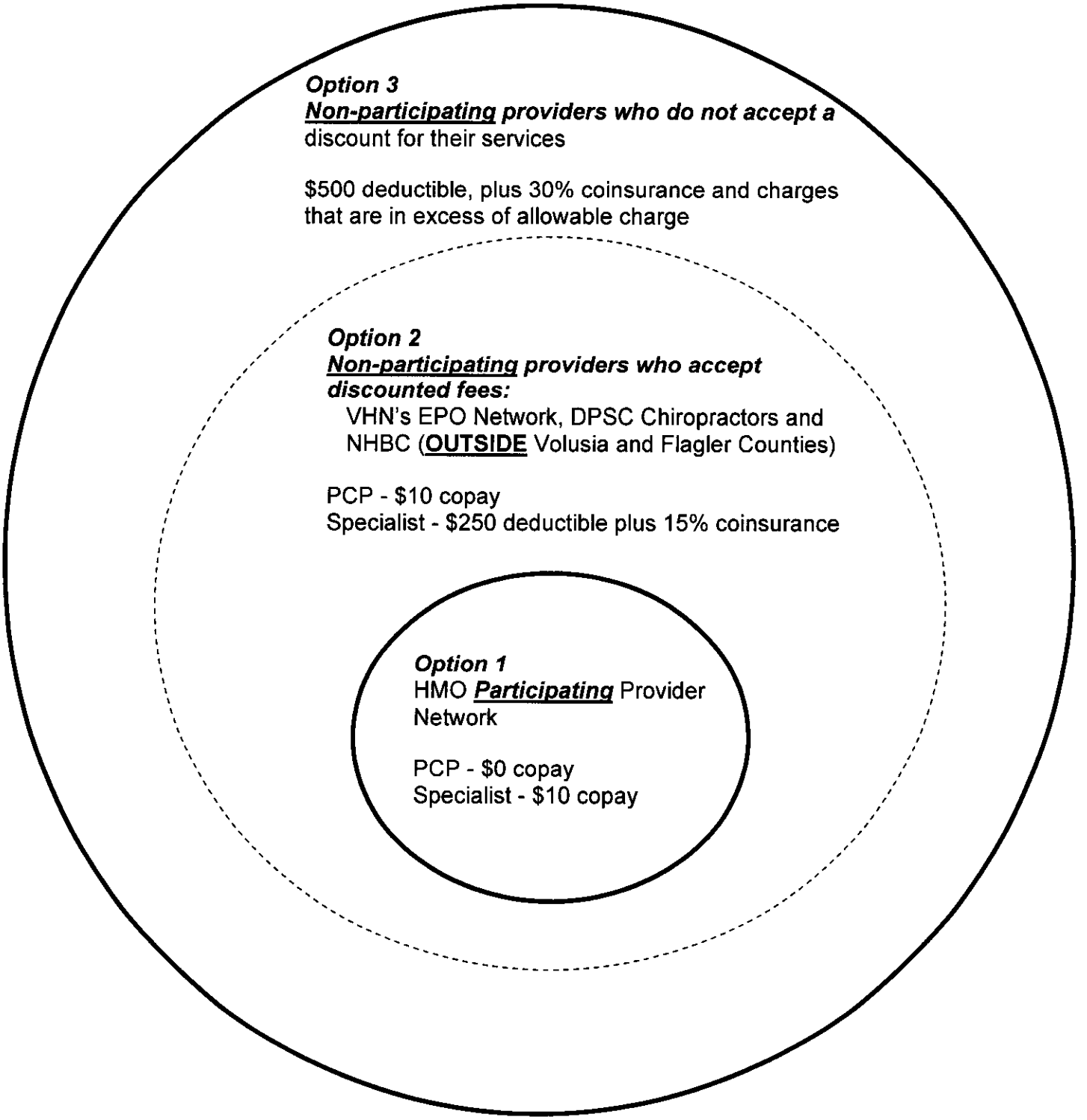
This plan requires use of FHCP network providers or pre-approved non-participating providers. Services rendered without prior authorization or pre-certification may not be covered - member will be responsible for 100% of charges.

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.

FLORIDA HEALTH CARE PLAN
PREMIUM PLUS TRIPLE OPTION PLAN
(OPEN ACCESS)



PREMIUM PLUS TRIPLE OPTION OPEN ACCESS POINT OF SERVICE - 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
Specialist 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
Advanced 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.

PREMPLUS TOPOS – 11/06
Large Group Plan Code 321

Florida Health Care Plans
An Affiliate of Healthy Health

Florida Health Care Plans
An Affiliate of Halifax Health

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
- Abortifacients;
- Erectile Dysfunction drugs.

QUESTIONS?

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

Health & Dental Insurance Premiums
2008-2009

FLORIDA HEALTH CARE PLANS

Select VP-3 HMO

PREMIUM INCREASE OF 1.7%
NO BENEFIT CHANGES

	Monthly Premiums	Annual Premiums	Employer Annual Premiums	Employee Annual Premiums	Employee Weekly P/R Deduction	Previous Weekly P/R Deduction
Single	421.27	5,055.24	5,055.24	0.00	0.00	0.00
Employee/Child (ren)	749.85	8,998.20	5,055.24	3,942.96	75.83	74.59
Employee/Spouse	749.85	8,998.20	5,055.24	3,942.96	75.83	74.59
Family	918.36	11,020.32	5,055.24	5,965.08	114.71	112.85
PART TIME						
Single	421.27	5,055.24	2,527.62	2,527.62	48.61	47.82
Employee/Child (ren)	749.85	8,998.20	2,527.62	6,470.58	124.43	122.41
Employee/Spouse	749.85	8,998.20	2,527.62	6,470.58	124.43	122.41
Family	918.36	11,020.32	2,527.62	8,492.70	163.32	160.66

Premium Plus HMO

PREMIUM INCREASE OF 1.6%
NO BENEFIT CHANGES

	Monthly Premiums	Annual Premium	Employer Annual Premiums	Employee Annual Premiums	Employee Weekly P/R Deduction	Previous Weekly P/R Deduction
Single	447.75	5,373.00	5,055.24	317.76	6.11	6.05
Employee/Child (ren)	797.00	9,564.00	5,055.24	4,508.76	86.71	85.36
Employee/Spouse	797.00	9,564.00	5,055.24	4,508.76	86.71	85.36
Family	976.10	11,713.20	5,055.24	6,657.96	128.04	126.03
PART TIME						
Single	447.75	5,373.00	2,527.62	2,845.38	54.72	53.86
Employee/Child (ren)	797.00	9,564.00	2,527.62	7,036.38	135.32	133.17
Employee/Spouse	797.00	9,564.00	2,527.62	7,036.38	135.32	133.17
Family	976.10	11,713.20	2,527.62	9,185.58	176.65	173.85

Premium Plus Triple Option

PREMIUM INCREASE OF 1.6%
NO BENEFIT CHANGES

	Monthly Premiums	Annual Premiums	Employer Annual Premiums	Employee Annual Premiums	Employee Weekly P/R Deduction	Previous Weekly P/R Deduction
Single	530.05	6,360.60	5,055.24	1,305.36	25.10	24.73
Employee/Child (ren)	943.49	11,321.88	5,055.24	6,266.64	120.51	118.6
Employee/Spouse	943.49	11,321.88	5,055.24	6,266.64	120.51	118.6
Family	1,155.51	13,866.12	5,055.24	8,810.88	169.44	166.75
PART TIME						
Single	530.08	6,360.96	2,527.62	3,833.34	73.72	72.54
Employee/Child (ren)	943.49	11,321.88	2,527.62	8,794.26	169.12	166.42
Employee/Spouse	943.49	11,321.88	2,527.62	8,794.26	169.12	166.42
Family	1,155.51	13,866.12	2,527.62	11,338.50	218.05	214.56