CITY COUNCIL AGENDA ITEM

REQUESTED COUNCIL MEETING DATE 06/16/09

SUBJECT: Florida Health Care/Blue Cross/Blue Shield Contract Renewal Proposal

DEPARTMENT: Human Resources

RECOMMENDED MOTION:

Staff recommends accepting the proposal presented by Florida Health Care/Blue Cross/Blue Shield (FHC/BC/BS) to renew their contract for the period beginning July 1, 2009 through July 1, 2010.

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/Blue Cross/Blue Shield (FHC/BC/BS).

In order to take advantage of extremely favorable utilization over the past twelve months, the City requested FHC/BC/BS to provide a proposal for an early renewal beginning July 1, 2009. After some discussion, FHC/BC/BS was able to present a proposal with no increase in premium and no decrease in benefits for all three of our health plans.

- Select VP3 HMO Plan (base plan)
- Premium Plus HMO Plan
- Premium Plus Triple Option

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

[X] Other [X] Support Documents

DEPARTMENT HEAD	Robert Zicker, Human Resources Director	Date 6-2-9
FINANCE DEPARTMENT	Approved as to Budget Requirements	Date 6/2/09
CITY ATTORNEY	Approved as to Form and Legality	Date
CITY MANAGER	Approved Agenda Item For:	6/16/09

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

060209FHCCOUNCILAGENDA

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

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.

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.

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

Option 3
***Non-participating** providers who do not accept a*
discount for their services

$500 deductible, plus 30% coinsurance and charges that are in excess of allowable charge

Option 2
***Non-participating** providers who accept discounted fees:*
VHN's EPO Network, DPSC Chiropractors and NHBC (**OUTSIDE** Volusia and Flagler Counties)

PCP - $10 copay
Specialist - $250 deductible plus 15% coinsurance

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

PCP - $0 copay
Specialist - $10 copay

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.

PRESCRIPTION BENEFITS

$4/$10/$30/$55 - 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.

HMO Prescription benefits are available at all FHCP pharmacies & select Walgreens.

POS & Triple Option Prescription benefits are available at all FHCP pharmacies & all Walgreens nationwide.

FHCP pharmacies and select Walgreens pharmacy locations are available at www.fhcp.com. When you get your prescription filled at FHCP pharmacies or Walgreens pharmacies, you pay the following copayment:

	FHCP In-House Pharmacy	Walgreens Pharmacy
Formulary Preferred Generic:	$ 4.00	Only Available at FHCP
Formulary Non-Preferred Generic:	$10.00	$15.00
*Formulary Preferred Brand Drugs:	$30.00	$35.00
* Formulary Non Preferred Brand Drugs:	$55.00	$60.00
**Mail Order		
Formulary Preferred Generic:	$ 3.00	N/A
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 93-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; and
- Erectile Dysfunction drugs.

QUESTIONS?

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

Affiliate of Halifax Community Health Systems

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' 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 pri 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 1-8(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.

CLAIMS PROCEDURES...

Under 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 (386) 615-5010 to report the emergency as soon as medically possible. Before leaving the hospital or provider's office, obtain a copy of any documentation 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 and 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 t[illegible] other provisions, limitations and exclusions contained in the Contract and this Rider. Utilization of services rendere[illegible] 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.
2. Voluntary family planning services, sterilization, infertility evaluation and medical treatment, surgery for th[illegible] 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.

By:______________________

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

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?

Call your Florida Health Care Plans Member Services Department at:

386.615.4022

1.877.615.4022

www.fhcp.com

FHCP V - A1/03
Revised 9/07

FLORIDA HEALTH CARE PLAN, INC.
1340 RIDGEWOOD AVENUE
HOLLY HILL, FL 32117

Please call 386-615-4022 for assistance regarding coverage information.

Group Insurance Contract

(herein called the Contract)

Florida Health Care Plan, Inc., (hereinafter called FHCP), agrees to provide the health care services described under the provisions of this Group Plan to all Covered Employees of the Employer and their Covered Dependents. The provision of services is subject to all of the terms on this page and those that follow, including any limitations, restrictions or exclusions, as well as any amendments made a part of this Group Plan.

The Employer may act on behalf of all eligible employees and dependents. Every act by, agreement made with, or notice given to the Employer will be binding on all Covered Employees and Covered Dependents.

This Group Plan is issued in consideration of the application of the Employer and payment of Premium in advance by the Employer at FHCP's corporate office in Holly Hill, FL 32117

This Group Plan is effective on the Group Effective Date shown on the Group Plan Information Page. The first Premium covers the period starting on the Group Effective Date.

EMPLOYER PROVISIONS

Responsibilities of the Employer

The Employer is eligible for the health care coverage provided under this Group Plan by virtue of being an Employer, as defined in the Florida Statutes, at the time this Group Plan is issued. The Employer shall offer to all eligible employees the opportunity to become a Covered Employee under this Group Plan. Such offer shall be made in such a fashion that employees are made aware, and understand, that this Group Plan contains a benefit structure that may require the use of a Primary Care Physician and/or Participating Providers.

The Employer may require an employee to pay some portion of the Premium. However, the Employer must contribute the same percentage toward the cost of all health benefit plans established and maintained by the Employer.

Responsibilities of FHCP

In consideration of the payment of Premium by the Employer, FHCP shall provide coverage for Covered Employees and their Covered Dependents. In doing so, FHCP may enter into agreements with providers of health care, one or more other Group Policies or insurers and such other individuals and entities as may be necessary to enable FHCP to fulfill its obligations under this Group Plan.

FHCP agrees to provide coverage without discrimination because of race, color, sex, religion, national origin or any other basis prohibited by law.

Employee Eligibility

Subject to any Eligibility Exceptions noted on the Group Plan Information Page, an individual becomes eligible for coverage on the date he or she completes any waiting period established by the Employer, as shown on the Group Plan Information Page. The waiting period is the length of time an employee must wait before becoming eligible for coverage. The waiting period designated by the Employer is shown on the Group Plan Information Page.

If an eligible person is covered under any other Plan issued by FHCP, or any other health benefit plan established and maintained by the Employer, they will not be considered eligible for coverage under this Group Plan.

Commencement of Coverage

On the Group Plan Effective Date as shown on the Group Plan Information Page, FHCP agrees to provide the coverage stipulated in this Group Plan to all Covered Employees and their Covered Dependents, if any. Such coverage begins on the Covered Person's effective date, which will be the first of the month after the receipt and approval of the application by FHCP, unless this Group Plan specifies a date other than the first of the month (See Special Enrollees, Late Enrollees and Dependent Effective Date provisions). FHCP accepts no liability for benefits related to expenses incurred prior to the Covered Person's effective date or after the Covered Person's termination date, which will be on the last day of the coverage month, except as described in the Extension of Benefits provision or as specified in the Terms of Renewal and Termination provisions.

Minimum Participation Requirements
If the Employer pays the entire Premium:

A. For employee coverage, requiring no contribution for such coverage by employees, all eligible employees must be covered under this Group Plan or another group plan established and maintained by the Employer.
B. For dependent coverage, requiring no contribution for such coverage by employees, all eligible dependents must be covered under this Group Plan or another group plan established and maintained by the Employer.

If the Employer requires employees to contribute a portion of the Premium:

A. For employee coverage, at least 75% of eligible employees must be covered under this Group Plan or another group plan established and maintained by the Employer.
B. For dependent coverage, at least 50% of eligible dependents must be covered under this Group Plan or another group plan established and maintained by the Employer.

When applying minimum participation requirements, FHCP does not have to consider as an eligible employee, employees or dependents who have qualifying existing coverage in an employer-based insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met.

If these participation requirements are not satisfied, FHCP reserves the right to terminate this Group Plan after giving the Employer forty-five (45) days written notice prior to the Group's anniversary date.

FHCP reserves the right to requests evidence of employee and dependent coverage under other plans to verify compliance with this provision.

Termination of this Plan by the Employer
The Employer may terminate this Group Plan as of any Premium due date and should give FHCP at least forty-five (45) days prior written notice. In such event, no benefits will be provided on or after such termination date, except as specifically set forth in this Group Plan.

Termination of this Plan by FHCP
FHCP may terminate this Group Plan as of any Premium due date if the Employer has not paid the required Premium by the end of the grace period, as defined in the Grace Period provision. However, if the Employer has given FHCP prior written notice in advance of an earlier date of termination, this Group Plan will terminate as of that earlier date. The Employer is liable to FHCP for any unpaid Premium for the time the Group Plan was in force, or for any amounts otherwise due FHCP.

If the Group's coverage is terminated for any reason set forth in this Group Plan, FHCP will mail the Employer a written notification that this Group Plan has terminated. This notification will disclose the date of termination and the reason(s) for termination. It is the Employer's obligation to immediately notify each Covered Person of any such termination.

Terms of Renewal
This Group Plan is a guaranteed renewable Plan. This means the Plan renews each year on the Group Plan Anniversary Date shown on the Group Plan Information Page. FHCP guarantees the Employer the right to renew the Group Plan each year, at the Employer's option, with the exception of non-payment of Premium or loss of eligibility. FHCP will give the Group at least forty-five (45) days advance written notice of our intent to non-renew this Group Plan, if one of the following circumstances has occurred:

A. The Employer fails to timely pay Premium or contributions in accordance with the terms of this Group Plan;
B. The Employer fails to comply with material provisions of this Group Plan which relates to rules for contribution or participation;
C. FHCP ceases offering this Plan to all policyholders;
D. The Employer and enrollees no longer work or reside in the service area of FHCP or in the area in which FHCP is authorized to do business;
E. The Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Group Plan;

Discontinuance of this Plan
FHCP may discontinue offering this particular Group Plan if:

A. We provide at least ninety (90) days notice to each policyholder and to participants and beneficiaries covered under the Plan prior to renewal; and
B. We offer each policyholder the option to purchase other coverage currently being offered by FHCP.

Discontinuance of all Coverage in the Group Market
FHCP may discontinue offering all coverage in Florida if:

A. We provide notice to the Office of Insurance Regulation (hereinafter called Office) and each Employer and enrollee 180 days prior to renewal; and
B. All health coverage issued or delivered for issuance in Florida is discontinued and coverage under such health coverage is not renewed;

PREMIUM PROVISIONS

Premium: any payments required by a health contract for coverage, by whatever name called, are deemed part of the premium. This includes but is not limited to any monthly subscription fee.

Premium Due Date
After the Group Effective Date shown on the Group Plan Information Page, the Premium due date will be the first day of each month.

Payment of Premium
The first Premium payment is due on the Effective Date shown on the Plan Information Page. Each following Premium payment is due monthly unless the Employer and FHCP agree on some other method and/or frequency of payment. Premium payments should be sent to FHCP's home office or the billing address provided by FHCP.

The Grace Period

This Plan has a 10-day grace period. A grace period means that if any required Premium is not paid on or before the date it is due, it may be paid during the grace period immediately following that Premium due date. During the grace period, the Plan will stay in force. The grace period does not apply to the Premium due on the Effective Date, or if the Employer has given FHCP written notice that the Plan is to be terminated prior to the Premium due date. If the Premium is not paid by the end of the grace period, the Plan may terminate as of the date the payment was due. Any late payment penalties are subject to Department of Insurance approval.

Monthly Premium Statement

FHCP will prepare a monthly statement of the Premium due on or before the Premium due date. This monthly statement will also reflect any pro rata Premium charges and credits resulting from changes in the number of Covered Persons and changes in the amounts of coverage that took place in the previous month. If a Covered Person becomes ineligible for coverage under this Group Plan for any reason, the Employer shall, if possible, provide FHCP with prior written notice of such ineligibility. However, in any event, written notice of such ineligibility shall be provided by the Employer to FHCP no later than thirty (30) days after such ineligibility. In the event that notice of termination of a Covered Person, or a decrease in coverage, is received by FHCP more than one month after the termination or decrease, retroactive credit will be limited to premium paid after date of termination or decrease in coverage.

FHCP's billing cycle is as follows:

1. If members are added on or before the 15th of the month, they are billed for the whole month. If members are added on or after the 16th of the month, they are not billed for that month.
2. If members are canceled on or before the 15th of the month, they will not be billed for that month. If members are canceled on or after the 16th of the month, they are billed for the whole month.

This is called the "wash cycle". If you have any questions, please call the FHCP Enrollment Department at 386-676-7176 or 1-800-352-9824 ext. 7176 during business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m.

Simplified Accounting

To simplify the accounting process, Premium adjustments will be made on the monthly Premium statement date that is the same as or next follows the date:

A. A person becomes covered;
B. The amount of coverage on a Covered Person changes, but not due to a revision of the coverage plan; or
C. A person ceases to be covered.

Changes in Premium

No change in Premium rates will be made for the first twelve (12) months that this Group Plan is in effect. A change in Premium rates will not be made more often than once in a twelve (12) month period. FHCP will give the Employer written notice of any changes in Premium rates at least thirty (30) days prior to the Group's renewal date.

Incorrect Premium Payment

Any Premium adjustment made due to the correction of an error in the Premium payment will be made without interest on the next Premium due date after the facts are made known to FHCP.

GENERAL PLAN PROVISIONS

Entire Plan

The entire agreement is made up of this document, the Employer's application for coverage and any amendments or riders attached hereto along with the applications for all Covered Employees and their covered dependents. All statements made by the Employer or by a Covered Employee are considered to be representations, not warranties. This means that the statements are considered to have been made in good faith. No such statement will void this Plan, reduce the benefits it provides, or be used in defense to a claim for coverage unless it is contained in a written application and a copy is furnished to the person making such statement.

Time Limits for Certain Defenses

After two years from the effective date of this Plan, no misstatement made by the Employer, except a fraudulent misstatement made in the Employer's application for this Plan, may be used to void this Plan. After two years from a Covered Person's effective date, no misstatement made by the Covered Person, except a fraudulent misstatement on his or her application, may be used to deny a claim for any benefit which begins after the end of the two-year period from the Covered Person's effective date.

Employer as FHCP's Agent for Limited Purposes

The Employer is considered to be an agent of FHCP only for the following purposes:

A. Collecting employee enrollment information;
B. Collecting any required employee contribution; and
C. Giving out Certificates of Coverage or other coverage information to the Covered Employees.

Administration

The Employer must provide FHCP with the information it needs to administer this Group Plan and to compute the Premium due. Failure of the Employer to provide this information will not void or continue a Covered Person's coverage. FHCP has the right to examine the Employer's records on any issues necessary for the proper administration of this Group Plan at any reasonable time while this Group Plan is in force.

Financial Responsibilities of the Employer

FHCP reserves the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Recovery efforts will relate to benefit payments made for services or supplies rendered subsequent to the Covered Person's termination date and prior to the date notice of coverage termination by the Employer. The Employer shall cooperate with and support such recovery efforts.

In the event that the Employer does not comply with the notice requirements set forth in the Premium Statement section, the Employer shall be solely liable to FHCP to the extent of any payment made on behalf of such individual for services or supplies rendered subsequent to the date notice of a Covered Person's termination was due.

Certificates of Coverage

FHCP will issue Certificates of Coverage for each Covered Employee. The certificate will describe the benefits provided and the limitations of this Group Plan. Nothing in the certificate will change or void the terms of this Group Plan.

The Employer agrees that, if requested by FHCP, the Employer will distribute to Covered Persons, the Certificate of Coverage and any amendments or endorsements to it, other coverage materials and notices applicable to all or any Covered Persons.

Changes to this Group Plan
FHCP may change this Group Plan from time to time as required by applicable state and federal laws and subject to Office approval. No change to this Group Plan will be effective unless made by an amendment or rider that has been signed by an officer of FHCP. No agent may change this Group Plan or waive any of its provisions.

If We increase the cost share for any benefit or delete, amend or limit any of the benefits to which a Covered Person is entitled to under this plan, We will give the Group forty-five (45) days written notice prior to renewal. The Group will not be notified if benefits are increased or if the Group requests any changes, deletions or limitations.

Misstatements
If information about a Covered Person is misstated, FHCP may adjust the Premium to correctly reflect the true information. If the misstatement affects the amount of the Covered Person's coverage, the true information may be used to determine the correct amount of coverage.

Worker's Compensation
This Plan does not affect or take the place of Workers' Compensation.

Assignment
Neither this Plan, nor the benefits provided under this Plan, may be assigned except as otherwise specifically described in this Plan.

Certificate Provisions made part of this Group Plan
The remainder of the Group Plan consists of the provisions shown in the certificate issued to Covered Employees under this Group Plan. These provisions are made a part of the Group Plan. Amendments, if any, changing the provisions of the certificate are also made a part of the Group Plan.

Service Area
The Service Area shall consist of the following counties: Volusia and Flagler Counties, FL.