RESOLUTION 11-257

A RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS OF MANATEE COUNTY, FLORIDA, ADOPTING REVISIONS TO THE MANATEE COUNTY HEALTH PLAN DOCUMENT FOR EMPLOYEE BENEFITS BEGINNING PLAN YEAR 2012.

WHEREAS, pursuant to the authority granted in Florida Statutes § 112.08, the Manatee County Board of County Commissioners sponsors the self-insured Manatee County Government Employee Benefit Plan (the Plan); and

WHEREAS, the Plan is set forth in a Plan Document, which describes all medical and dental benefits and Plan levels, including covered and non-covered services, deductibles and co-payments, and other provisions necessary to effectively and efficiently administer the Plan and its related source of funds; and

WHEREAS, the County Commission adopted the basis of its current Plan Document on January 1, 1994, and has thereafter amended it in 1995, 1996, 1997, 2000, 2004, 2005, and 2010; and

WHEREAS, from time to time, and in reaction to changes in claim history, costs, available resources and legal developments, the administrators of the Plan recommend to the County Commission substantive changes to the Plan Document, including adding or deleting coverage, programs and/or amending fee schedules; and

WHEREAS, the County's Administration, in cooperation with the County Attorney's Office, has reviewed the Plan Document recently and has identified several modifications or clarifications to that document and recommends these be adopted by the Commission; and

WHEREAS, the County's Administration has determined that certain clarifications in the Plan Document are necessary in order to ensure accurate implementation and adherence to the Plan rules and guidelines as well as to comply with applicable federal regulations; and

WHEREAS, the Board of County Commissioners of Manatee County finds that it is in the County's best interest to approve and adopt the proposed revisions to the Plan Document as set forth below.

NOW, THEREFORE, BE IT RESOLVED by the Board of County Commissioners of Manatee County, Florida, that:

1. The Plan shall be revised to make clear that the Manatee County Port Authority, a distinct legal entity created by the Florida Legislature, has been, and shall continue to be, covered by the Plan, and Port Authority employees and eligible dependants are entitled to participate in the Manatee County Employee Benefit Plan in the same manner, and under the same terms and conditions, as employees of the other entities covered by the Plan. This provision does not add a new entity into Plan coverage, but is intended only to clarify the Plan Document inasmuch as the Document inadvertently failed to reflect in written form such coverage, though same has existed and been provided by the Commission since the Plan's inception.

2. **Termination for Failure to Cooperate:** This section of the Plan, found on page two, is amended to include the following language:

   Item #6: If a Covered Person has a disease or injury for which benefits are paid or payable under Workers' Compensation due to any employment of the Covered Person, treatment cannot be sought under the Health Plan, including the Pharmacy Benefit. If such treatment is sought and received under the Health Plan and/or the Pharmacy Benefit, the Covered Person will be responsible for all costs for those benefits received.

Item#8: Effective January 1, 2011, any employee or retiree who, after receiving notice of outstanding premium payment, and who thereafter continues to owe premiums, shall be dropped from the Plan 45 days from initial notice. Members who wish to re-enroll in the Plan at a later date must wait until a qualifying status change or the next annual enrollment period and will be considered as a new enrollee and will be required to follow all of the guidelines outlined in the Plan Document. Retirees will have only 1 (one) opportunity to return to the plan and must show continuous coverage to be eligible.

3. **Section 1.01.02 Dependent Coverage** the words "living in the household of the employee" are deleted from the definition of a spouse dependent.

4. **Section 1.05 Changes in Coverage-Family Status Change** the words "a change in the residence of the participant, spouse or dependent" are deleted as a change in status.

5. **Paragraphs 2 and 4 of Section 2.01 Plan Design-Medical Benefits.** Strikethrough text is removed and italicized text is added):

- The Plan provides reimbursement for covered services and supplies at two levels:
  - Covered services and supplies provided to a covered person by Manatee Health Network Providers and selected PPO Network(s). In-Network Providers will be reimbursed at a premium level of reimbursement as described in the schedule of benefits.
  - All other covered services and supplies provided to a covered person *by Out of Network Providers* will be reimbursed at a reduced level of reimbursement and/or higher level of covered persons' responsibility for payment as described in the schedule of benefits.

- The *maximum* level of reimbursement for all other covered services and supplies *outside of the Manatee Health Network and selected PPO Networks is 75% of the reasonable and customary fee of the area where the services are performed or the UCR schedule utilized by a contracted out of network bill review company* ~~is no more than the Manatee Network Fee Schedule.~~ The Covered Person is responsible to the Provider for the difference between the ~~Manatee Network Fee Schedule~~ *amount reimbursed by the plan* and the provider's billed amount

6. **Section 2.07 Employee/Retiree Other Insurance.** (Italicized text was added):
An Employee and/or a Dependent Spouse enrolled in another Medical Plan, except a Government Plan exempt by Federal Statute, is primary and the County's Plan is secondary. *Any member eligible for Medicare Part A and B benefits must enroll in Medicare prior to their 65th birthday or upon eligibility in order to receive any benefits under the medical plan or the supplemental plans. This includes employees eligible due to End Stage Renal Disease, employees under 65 on disability and retirees age 65 and older. Medicare is the primary insurer for those Retirees and Spouses age 65 and over or employees/retirees under 65 enrolled in Medicare disability and employees with end stage renal disease after the coordination period.*

7. **Section 2.09 Family Status Change** was replaced with the following language:

- An employee adding eligible adult dependent(s) through a Family Status Change is/are eligible to qualify for the Better Health Plan following the benefits waiting period. Enrollees will be eligible to qualify for the Ultimate, Best or Better Plan during a specified six month period by completing all of the required Qualifying Events for the Ultimate, Best or Better Plan. The enrollees must submit the supporting documentation to Employee Health Benefits at least 30 days prior to the upgrade effective date to be placed in the Ultimate, Best or Better health plan. Enrollees who do not complete any Qualifying Events during their upgrade waiting period will be placed in the Basic Plan effective the first day of the seventh month of

eligibility.

8. **Section 2.09.02 Family Status Change** italicized text was added:
   - An employee adding a newborn to a Child (ren) Group will be automatically enrolled in the same plan as the other Child (ren) within the eligible Family group *in the same household.*

9. **Section 3.0 Schedule of Benefits** was amended to reflect the following:
   - Removal of Specialist Physician Office Visit benefit for the Ultimate Plan where enrollees pay $25 copay for the first 5 visits per calendar year and then no copay for subsequent visits. Plan now reflects every specialty visit for the Ultimate Plan requires a $25 copay.
   - Nutritional Therapy benefit is $0 copay for visits 1-5 and $25 copay for subsequent visits for all plan levels.
   - Routine Eye Exam-Children-1 time per plan year paid at the reimbursement level of enrolled plan at the time of service.
   - Out of Network Preventative and Wellness Exams are eligible benefits and subject to out of Network Deductible and Coinsurance.

10. Section 3.01 **Covered Services and Supplies** was amended to clarify or add the following:

Durable Medical Equipment (DME): Italicized text was added:

- Durable Medical Equipment means equipment which meets all of the following: It is for repeated use and is not a consumable or disposable item. It is used primarily for a medical purpose; and it is appropriate for use in the home.
- Some examples of Durable Medical Equipment *(DME)* are:
  - Appliances which replace a lost body organ or part or help an impaired one to work.
  - Orthotic devices such as arm, leg, neck and back braces.
  - Hospital-type beds.
  - Equipment needed to increase mobility, such as a wheelchair. Respirators or other equipment for the use of oxygen and monitoring devices.
  - DME greater than $500 must be pre-approved by Medical Management.
- *DME items are eligible for replacement, if appropriate, after 5 years, unless other wise approved by Utilization Management.*
- *Medicare guidelines are adhered to regarding DME purchase and replacement.*

End Stage Renal Disease-this section is an addition to the Plan Document (per Medicare Guidelines):

- *Members diagnosed with End Stage Renal Disease (ESRD) may become entitled to Medicare based on this condition. Benefits on the basis of ESRD are for all covered services, not only those related to the kidney failure condition. Medicare is secondary to your group health plan for individuals entitled to Medicare based on ESRD for a coordination period of 30 months.*
- *Under this medical plan, members are provided coverage for end state renal disease (ESRD). ESRD is a medical condition covered by Medicare. While covered under this medical plan, Medicare will be the secondary payer for months 4 through 33 while members are receiving dialysis treatments. As of 11/1/2011, member's ESRD benefits will be covered and paid above the Medicare payment levels. Member's ESRD medical claims and drug related reimbursement will be repriced and paid at 150% of Medicare's reimbursement level.*

Medicare Law prohibits any provider from balance billing members for charges over these reimbursement amounts. Members with ESRD must notify the Utilization Management when diagnosed with ESRD by a Physician and notify the Health Plan if or when they begin to receive dialysis treatments and enroll in Parts A&B of Medicare.

Hospital Services: Paragraphs 5 and 6 were amended as follows (italicized text was added and strikethrough text was removed):

- When Emergency Care results in a confinement, the Covered Person (or representative or Physician) must call Utilization Management ~~within two working days of the date the confinement~~ *for Inpatient authorization on day one of the confinement. If the confinement occurs on a weekend or observed holiday, Utilization Management must be notified by the next business day.* ~~It may not be reasonably possible to notify Medical Management within two working days. In this case, Medical Management must be notified as soon a reasonably possible.~~

- ~~When Emergency Care has ended, a referral from Medical Management, when applicable, is required before any additional services are received.~~

Nurse-Practitioner Services: italicized text was added:

- Services of a licensed or certified Nurse Practitioner acting within the scope of that license or certification *is payable at the same level of the Physician allowable.*

Orthotics: italicized text in paragraph 2 was added:

- Covered conditions/*items* for orthotics limited to paralysis, spasticity, fracture, scoliosis or spinal surgery, diabetes, peripheral vascular disease, *TMJ splints, prosthesis of the head* and plantar fasciitis.

Vision Screening and Treatment: italicized text was added and strikethrough text was removed:

- Vision exam related to a medical condition.
- ~~Initial~~ Contact lenses or glasses required following cataract surgery. *Enhancements to contact lenses or glasses such as tint, UV protection and progressive lenses are not covered.*
- ~~One regular vision care exam.~~ *Routine eye exam (glasses)*-every two years.
- ~~One~~-*Routine eye exam (contact lenses)-annually.* ~~Contact lens exam annually~~.
- *Routine eye exam (Diabetes Preventative)-annually*

11. **Section 5.07 Pain Management.** Item 1 (c):amended section to incorporate clinical requirements (italicized wording was added).
    - Prior authorization *and additional program requirements are* required for selected pain medications when the prescribed quantity exceeds the listed quantity limits *and exceeds the 90 day timeframe for acute pain.*

12. **Section 6.00 Medical Management**:
    - Updated the procedures and services that require precertification:

The Medical Management Program ~~(MMP Program)~~ is a program administered by the Plan's Member Advocates. It provides Pre-admission review, Concurrent Review, and Discharge Planning on Hospital Admissions, Prescription, Medical Management, Preventive Care and Wellness.

1. Inpatient confinements:
    - *All confinements at day 1, all out of network referrals*
    - *All ICU confinements*
    - *Skilled nursing facility*
    - *Rehabilitation facility*

- *Pregnancies (for notification please call after the first prenatal visit)*
- *All Behavioral Health hospitalizations*
- *All out-of-network providers (POS 21) rendering services at an In-Network Facility*

2. *Reconstructive procedures and procedures that may be considered cosmetic:*
   - *Blepharoplasty **(15820-15823 ; 67900-67912)***
   - *Botox injections*
   - *Breast Reconstruction **(19357-19369)***
   - *Excision of excess skin due to weight loss*
   - *Rhinoplasty **(30400-30462)***
   - *Septoplasty **(30520)***
   - *Sclerotherapy or surgery for varicosities **(36468-36471)***
   - *Other Cosmetic Surgery as covered by the plan document*

3. *Surgical Procedures:*
   - *Bariatric Surgery (Roux-en-Y and Lap Band) **(43644-43645 ;43770-43774; 43842-43848; 43886-43888)***
   - *All spinal surgeries*
   - *All implantable stimulators and pumps*
   - *Uvulopalatopharyngoplasty, including laser-assisted procedures **(42145)***
   - *Any TMJ surgery/appliances*

4. *Selected durable medical equipment:*
   - *Any single equipment or Prosthetic greater than $500.00 (purchase) **(L5000-L9999)***
   - *C-PAP or BI-PAP equipment **(E0601;***
   - *Any single orthotic greater than $500.00 (purchase) **(L0000-L4999)***
   - *Apnea Monitors **(E0618-E0619)***
   - *TENS Units **(A4595; E0720-E0749)***
   - *Dynasplints **(E1700, E1800, E1802, E1805, E1810, E1815, E1825, E1830, E1840, E1399, E1820)***

Note: Claims for Nebulizer (E0570-E0585) rental must be denied and a request made to have the claim rebilled as a purchase.

5. *Specialty Pharmacy Medications and Infusion Services:*
   - *Any single injectable: office, outpatient and home administration greater than $500 **(J0000-J9999)***
   - *Pain Management pumps*
   - *Infusion Services: office, outpatient, or home administration to include all infusion claims from Bach & Godofsky, FL Cancer and Sarasota ID*

6. *Outpatient Services:*
   - *Ambulance transfers between facilities*
   - *Berkley Heartlab testing. Note: **VAP- not covered***
   - *CT Calcium Scoring **(75571)***
   - *Chemotherapy and Radiation therapy*
   - *Hospice Services*
   - *Home Health Services: limited to 120 visits per calendar year*
   - *Invasive Pain Management Procedures; neck and back injections, **any Provider**. Include CPT codes-**62310, 62311, 62318, 62319, 27096, 76005, 64400-64680***

- *Dialysis Treatment* ***(90935-90999)***
- *Sleep Studies* ***(95803-95811)***
- *Speech Therapy* ***(92507-92508)***
- *Physical & Occupational Therapy 2* ***(97001-97546)***
- *PET scans* ***(78811-78999)***
- *Holter Monitors* ***(93224-93227)***
- *SmartPill Capsule Motility* ***(91299)***
- *All Behavioral Health services*
- *BRAC Analysis (Genetic testing)*
- *Refraction* ***(92015)*** *associated with a medical condition or a disease of the eye such as Corneal Ulcers/Infections; Macular Degeneration; Retinal detachment; Retinal Vessel Occlusion; Retinitis Pigmentosa etc.*

Note: Refraction is not a covered benefit for Routine Eye Exam; Diabetes; Glaucoma; Myopia; Presbyopia; Astigmatism and Hyperopia

Charges that are determined by Medical Management not to be medically indicated are not covered comprehensive medical charges, and no benefits will be paid for such charges.

Procedures that require precertification are subject to change throughout the plan year.

13. **Section 6.01 Scheduled Admissions**: removed strikethrough language and added italicized language:
When a Covered Person is scheduled for admission to any Hospital ~~over 3 days or as a result of a diagnosis requiring authorization~~, notification of the need for certification must be received by Medical Management prior to Hospital Admission. ~~This may be done by: (a) telephoning the Medical Management. (a). Completing a Pre-Admission Review Request when applicable; or (b). Having the admitting Physician contact the Medical Management.~~

The responsibility of notifying Medical Management lies with the ~~Covered Person~~ Network Provider. Individuals are advised to contact the Medical Management directly to verify that the admitting Physician or Hospital has made notification, *particularly when Out of Network Providers are utilized.*

14. **Section 6.01.01 Non-Scheduled Admissions**: removed the strikethrough text and added italicized text:
- When a covered Person is admitted to any hospital on a non-scheduled basis, Medical Management must be notified ~~as soon as it is reasonably possible if the admission is to an ICU service or if the Hospital stay exceeds three days~~ *immediately.* Failure to provide notification within the above guidelines will result in application of ~~the Additional Per Confinement Deductible or increased amounts payable by the Covered Person~~ *a 50% reduction of the allowable charge that cannot be balanced billed to the patient.*

15. **Section 6.01.02 Non-preapproved Notification**: removed the strikethrough text and added the italicized text:
- Failure to provide notification *at day of admission or prior* ~~within 72 hours (3 days~~ (not including Saturday and/or Sunday) ~~from the time of~~ *for* inpatient admission or outpatient care will result in application of *a 50% reduction of allowable charges that cannot be balanced billed to the patient.* ~~(1) Confinement deductible of $200 pe3r day. (2) Outpatient office visit of $25 additional copay per visit in addition to the deductible, coinsurance and/or copay and not included in the annual maximum out of pocket expense.~~

16. **Section 7.00.01 Exclusions**: removed the strikethrough text and added the italicized text:

- Item 19-In vitro fertilization, infertility, embryo transfer procedures; artificial insemination; sex-change surgery; reversal of sterilization; or charges for birth control, *and* injectibles *(except IUD).*

- Item 21-Care, treatment services or supplies not prescribed by a Physician; or not medically indicated and/or evidence-based ~~necessary~~; or which are experimental as recognized in the United States, *including clinical trials.* (This will not apply to bone marrow transplants if recommended by the referring Physician and the treating Physician, and if the procedure follows the rules adopted by the Secretary of Health and Rehabilitative Services); or

- Item 29-~~Any loss due to an intentionally self-inflicted injury, while sane or insane~~.

- Item 36: ~~Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances.~~

- Item 40- Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another disease unless specifically covered ~~in the Schedule of Benefits~~ *under enrollment of the Plan's disease management program.* Medically indicated charges for Morbid Obesity will be covered. Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. Tables for a person of the same height, age and mobility as the covered person.

- Item 41- Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines *(except those covered under the Pharmacy benefit),* and first-aid supplies, lift chairs, *ramps, car lifts,* and non-hospital adjustable beds.

- Item 44: ~~Charges excluded by the Plan Design, as~~

- Item 48: Care and treatment for tobacco cessation programs, including smoking deterrent patches, unless medically indicated due to a severe active lung illness such as emphysema or asthma, unless such care is specifically covered ~~in the Schedule of Benefits~~ *under enrollment of the Plan's disease management program.*

- Item 52: Genetic testing *including Berkeley Lab, Harvard Heart Test, and VAP lab testing* ~~without evidence of symptomatology~~, *unless approved by UM.*

17. **Section 8.00.01 Plan Design**: Paragraph 5 was removed:
~~The Lifetime Benefits for Behavioral Health and Substance Abuse Services in included in the Medical Plan's Total Lifetime Benefits~~.

18. **Section 9-Prescription Retail or Mail Order**
Replaced previous benefit schedule for prescriptions with the benefit schedule that will be in effect on 1/1/2012 per Board of County Commissioners approved item dated 10/11/11

BE IT FURTHER RESOLVED that the effective date of these revisions to the Plan Document shall be December 20th 2011.

BE IT FURTHER RESOLVED that any existing Resolution or portion thereof of the Board of County Commissioners which contains terms or provisions which are in direct conflict with and cannot be harmonized with the provisions of this Resolution shall, as to such terms or provisions, be deemed as superseded by this Resolution.

BE IT FURTHER RESOLVED that the provisions of this Resolution are severable such that the invalidity of any one provision shall not operate to invalidate any other provision.

PASSED AND DULY ADOPTED by the Board of County Commissioners of Manatee County, Florida, with a quorum present and voting, this 20th day of December, 2011.

ATTEST:

R.B. SHORE
CLERK OF THE CIRCUIT COURT

By: _____
Deputy Clerk

BOARD OF COUNTY COMMISSIONERS SEAL MANATEE CO., FLA.

BOARD OF COUNTY COMMISSIONERS
MANATEE COUNTY, FLORIDA

By: _____
Carol Whitmore, Chairman