MONTAGE OF SHOTS SHOWING DIVERSITY OF PUBLIX EMPLOYEES AND WORK ENVIRONMENTS

FLY IN GRAPHICS:

A. GROUP
HEALTH
BENEFIT
PLAN

B. HMO
SELF-INSURED

C. BCBS LOGO

D. PUBLIX LOGO

1. MCU OF TALENT

2.PULL OUT TO MS LEFT, GRAPHICS RIGHT

GRAPHICS:

A. GROUP
HEALTH
BENEFIT
PLAN

B. YOU AND PUBLIX SHARE COST

C. PUBLIX PAYS FOR MAJORITY

D. YOUR CONTRIBUTION VARIES

ANNOUNCER:

VO:

PUBLIX IS COMMITTED TO PROVIDING EVERY ELIGIBLE ASSOCIATE WITH THE HIGHEST QUALITY HEALTH CARE AT AN AFFORDABLE PRICE. BECAUSE OF THIS COMMITMENT, WE HAVE THE PUBLIX GROUP HEALTH BENEFIT PLAN. UNDER THIS PLAN THE MAJORITY OF ASSOCIATES ARE GIVEN A CHOICE OF TWO OPTIONS. EITHER A FULLY INSURED HEALTH MAINTENANCE ORGANIZATION, COMMONLY CALLED AN HMO, OR OUR SELF-INSURED PLAN ADMINISTERED IN PARTNERSHIP WITH BLUE CROSS BLUE SHIELD.

ON CAMERA:

1. THE ACTUAL PLANS THAT ARE OFFERED MAY DIFFER FROM AREA TO AREA DEPENDING ON WHAT IS AVAILABLE. REMEMBER, EACH PLAN OFFERED HAS BEEN, AND WILL CONTINUE TO BE, REVIEWED AND ANALYZED TO ENSURE HIGH QUALITY STANDARDS AND VALUE ARE BEING ACHIEVED.

2. LET'S TAKE A QUICK LOOK AT HOW OUR GROUP HEALTH BENEFIT PLAN WORKS. BASICALLY YOU AND PUBLIX SHARE THE TOTAL COST OF HEALTH CARE. WITH PUBLIX PAYING THE MAJORITY OF THE TOTAL COST. YOUR CONTRIBUTION VARIES BASED ON THE LEVEL OF COVERAGE YOU NEED AND THE HEALTH

E. PUBLIX CONTRIBUTION REMAINS THE SAME

F. YOU PAY THE BALANCE OF PREMIUM COST

3. FULL SCREEN GRAPHICS
A. GROUP HEALTH BENEFIT PLAN

B. PREMIUMS PAID THROUGH PAYROLL DEDUCTION

4. MCU OF TALENT

5. FULL SCREEN GRAPHICS

PRE-TAX		AFTER-TAX
$300	GROSS INCOME	$300
-$24	GHBP-ECP	0
$276	TAXABLE INCOME	$300
-$21	FICA	-$23
-$41	INCOME TAX	-$45
0	GHBP-NO ECP	-$24
$214	TAKE HOME PAY	$208

$6 EXTRA EACH PAYDAY
$312 ANNUAL TAKE HOME PAY INCREASE

PLAN PROVIDER YOU CHOOSE. REGARDLESS OF WHETHER YOU CHOOSE OUR SELF INSURED PLAN OR AN HMO, PUBLIX'S CONTRIBUTION IS THE SAME. YOU PAY THE BALANCE OF THE PREMIUM COST.

VO:

3. AN ADDED ADVANTAGE OF THE GROUP HEALTH BENEFIT PLAN IS THAT YOUR PREMIUMS ARE PAID THROUGH PAYROLL DEDUCTION AS PART OF THE ELECTIVE COMPENSATION PLAN.

ON CAMERA:

4. BECAUSE OF THIS, YOUR CONTRIBUTION IS DEDUCTED PRIOR TO PAYROLL TAXES BEING COMPUTED. THE RESULT, YOU GET TO PUT MORE MONEY IN YOUR POCKET EACH PAY DAY. WATCH. LET'S LOOK AT AN EXAMPLE OF PREMIUMS PAID IN PRE TAX AND THEN AFTER TAX DOLLARS.

VO:

5. EACH HAVE A GROSS INCOME OF $300 PER WEEK. IN THE FIRST EXAMPLE THE CONTRIBUTION IS TAKEN THROUGH PAYROLL DEDUCTION. THE OTHER DOES NOT. AS YOU CAN SEE THE FIRST EXAMPLES TAXABLE INCOME HAS BEEN REDUCED BY $24 FOR THEIR HEALTH COVERAGE. NOW SEE WHERE THE SAVINGS SHOW UP. NEXT SUBTRACT FICA FROM EACH OF THE EXAMPLES TAXABLE INCOME. THEN IN THE SECOND EXAMPLE, THE

ONE NOT PARTICIPATING IN AN ELECTIVE COMPENSATION PLAN, SUBTRACT PREMIUMS FOR HEALTH CARE COVERAGE . LOOK AT THAT, THE FIRST EXAMPLE RESULTS IN AN EXTRA $6 EACH PAY DAY. OVER A ONE YEAR PERIOD, YOU'RE LOOKING AT AN EXTRA $312 IN TAKE HOME PAY.

6. MS LEFT GRAPHICS RIGHT
GRAPHICS
A. PUBLIX LOGO

6. PART OF PUBLIX'S COMMITMENT IS TO EDUCATE OUR ASSOCIATES IN ORDER FOR YOU TO MAKE INFORMED DECISIONS ON WHAT IS RIGHT FOR YOU AND YOUR FAMILY. TO THAT END, THIS VIDEO WILL ATTEMPT TO EXPLAIN THE DIFFERENCES BETWEEN THE HEALTH MAINTENANCE ORGANIZATION PLAN, THE PREFERRED PROVIDER ORGANIZATION PLAN AND POINT OF SERVICE PLAN OFFERED UNDER PUBLIX'S GROUP HEALTH BENEFIT PLAN. BEFORE WE BEGIN, I WOULD LIKE TO POINT OUT ALL OF THESE PLANS ARE FORMS OF MANAGED CARE.

B. HEALTH MAINTENANCE ORGANIZATION

C. PREFERRED PROVIDER ORGANIZATION/PREFERRED PATIENT CARE PLAN

D. POINT OF SERVICE

VO:

7. FULL SCREEN GRAPHICS
GRAPHICS:
A. HMO'S
B. FULLY INSURED
C. MANAGED CARE SYSTEMS
D. PREVENTATIVE MEDICINE
E. HELP CONTROL COSTS
F. FULLY INSURED
G. HEALTH PLAN INSURANCE COMPANY
H. FINANCIAL RESPONSIBILITY
I. YOU PAY PREMIUMS & CO-PAYMENTS
J. THERE IS NO ADDITIONAL COST TO YOU

7. THE HMO's OFFERED THROUGH PUBLIX ARE FULLY INSURED, MANAGED CARE SYSTEMS WITH AN EMPHASIS ON PREVENTATIVE MEDICINE AND DESIGNED TO HELP CONTROL COSTS. BY FULLY INSURED IT MEANS THAT THE HEALTH PLAN INSURANCE COMPANY HAS THE FINANCIAL RESPONSIBILITY AFTER YOU PAY YOUR PREMIUMS AND ANY CO-PAYMENTS. THERE IS

NO ADDITIONAL COST TO YOU FOR YOUR CARE.

ON-CAMERA:

8. MS TALENT LEFT GRAPHIC RIGHT GRAPHICS:
   B. NO PRE-EXISTING CONDITION LIMITATION CLAUSE
   C. MUST SELCT A PRIMARY CARE PHYSICIAN

8. THE HMO PLANS OFFERED THROUGH OUR GROUP HEALTH BENEFIT PLAN DO NOT HAVE A PRE-EXISTING CONDITION LIMITATION CLAUSE. TO RECEIVE CARE THROUGH AN HMO YOU MUST SELECT A PRIMARY CARE PHYSICIAN FROM THAT PLAN'S NETWORK.

9. PAN TO MCU OF TALENT

9. THIS PRIMARY CARE PHYSICIAN MANAGES YOUR CARE AND ALL SERVICES YOU RECEIVE MUST BE PROVIDED OR REFERRED BY YOUR PRIMARY CARE PHYSICIAN. ANY SERVICES YOU RECEIVE OUTSIDE OF THE HMO REFERRAL SYSTEM WILL BE TOTALLY YOUR FINANCIAL RESPONSIBILITY. REMEMBER, YOU ONLY HAVE COVERAGE WHEN USING THE PLAN'S NETWORK OF PROVIDERS. WE ENCOURAGE YOU TO CAREFULLY REVIEW THE INDIVIDUAL HMO NETWORK PROVIDER LISTINGS AND PLAN DESIGNS.

10. TURN TO MS LEFT GRAPHICS RIGHT GRAPHICS:
   A. YOU KNOW YOUR OUT-OF-POCKET EXPENSES
   B. PAY CO-PAYMENT WHEN CARE IS RECEIVED

10. A DISTINCT FEATURE OF AN HMO IS THAT YOU KNOW YOUR OUT OF POCKET COSTS BEFORE RECEIVING CARE. IN MOST CASES YOU ONLY PAY A FIXED CO-PAYMENT WHEN CARE IS RECEIVED.

11. PUSH IN TO MCU

11. NOW LET'S TAKE A LOOK AT OUR SELF-INSURED PLAN, ADMINISTERED BY BCBS. EVERY TIME A COVERED PERSON USES THE PLAN, PUBLIX PAYS THE TOTAL COST. YOUR

CONTRIBUTION TO THE PLAN REPAYS PUBLIX A PORTION OF THE TOTAL COST.

VO:

12. FULL SCREEN GRAPHICS
GRAPHICS:
A. BCBS IS PAID AN ADMINISTRATIVE FEE
B. ACCESS TO BCBS' NETWORK OF PROVIDERS
C. CLAIMS PROCESSING
D. CUSTOMER SERVICE REPRESENTATIVES
E. SELF INSURED PLAN
F. TWO PROGRAMS
G. PREFERRED PROVIDER ORGANIZATION- PPO
H. IN FLORIDA- PREFERRED PATIENT CARE PPC
I. POINT OF SERVICE PROGRAM
J. DUAL OPTION AREA

12. TO ADMINISTER THE SELF INSURED PLAN, BLUE CROSS BLUE SHIELD IS PAID AN ADMINISTRATIVE FEE. WHICH ALLOWS PUBLIX ACCESS TO BCBS' NETWORK OF PROVIDERS, CLAIMS PROCESSING AND CUSTOMER SERVICE REPRESENTATIVES. WITHIN THE SELF INSURED PLAN THERE ARE TWO DIFFERENT TYPES OF PROGRAMS. THE FIRST TYPE IS THE PREFERRED PROVIDER ORGANIZATIONS OR PPO. IF YOU LIVE IN FLORIDA THE PPO IS CALLED PREFERRED PATIENT CARE OR PPC. THE SECOND TYPE IS A POINT OF SERVICE PROGRAM. DEPENDING ON WHERE YOU LIVE YOU MAY HAVE ONE OR THE OTHER OR BOTH. IF YOU LIVE IN AN AREA WHERE BOTH ARE AVAILABLE YOU ARE IN A DUAL OPTION AREA.

ON-CAMERA:

13. MS OF TALENT LEFT GRAPHICS RIGHT
GRAPHICS:
A. PPO/PPCs
B. OPEN ACCESS NETWORKS
C. IN-NETWORK PROVIDERS
D. 90% BENEFIT LEVEL
E. $250 DEDUCTIBLE
F. OUT OF NETWORK PROVIDERS
G. 70% BENEFIT LEVEL
H. $250 DEDUCTIBLE

13. PREFERRED PROVIDER ORGANIZATIONS OR PPO/PPCs ARE OPEN ACCESS NETWORKS. THAT MEANS YOU CAN RECEIVE CARE FROM ANY NETWORK DOCTOR OR FACILITY. WHILE IT IS RECOMMENDED TO HAVE ONE PROVIDER MANAGE YOUR CARE IT IS NOT A REQUIREMENT AND AS LONG AS YOU USE IN-NETWORK PROVIDERS YOU CAN TAKE ADVANTAGE OF THE HIGHER 90% BENEFIT LEVEL AFTER YOU HAVE MET A $250

DEDUCTIBLE. THIS OPEN ACCESS ALSO ALLOWS YOU TO USE OUT OF NETWORK PROVIDERS AT A LOWER, 70%, BENEFIT LEVEL AFTER YOU MEET YOUR $250 DEDUCTIBLE.

VO:

14. FULL SCREEN GRAPHICS

GRAPHICS:

A. JANUARY 1, 1997
B. PRIMARY CARE TYPE DOCTORS
C. FAMILY PRACTICE
D. INTERNAL MEDICINE
E. GENERAL PRACTICE
F. PEDIATRICIANS
G. $15 CO-PAYMENT
H. COPAYMENT IS NOT SUBJECT TO NOR DOES IT APPLY TO YOUR DEDUCTIBLE.
I. ANNUAL MAXIMUM OUT OF POCKET EXPENSE LEVEL
J. $1,250 PER PERSON
K. $3,750 PER FAMILY

14. AS OF JANUARY FIRST 1997 IF YOU USE A NETWORK PRIMARY CARE TYPE DOCTOR, SUCH AS FAMILY PRACTICE, INTERNAL MEDICINE, GENERAL PRACTICE OR PEDIATRICIANS FOR YOUR CARE, YOU PAY A $15 COPAYMENT PER VISIT FOR ALL SERVICES RECEIVED IN THEIR OFFICE. THIS CO-PAYMENT IS NOT SUBJECT TO, NOR DOES IT APPLY TOWARD YOUR DEDUCTIBLE. TO HELP PROTECT YOU THERE IS AN ANNUAL MAXIMUM OUT OF POCKET EXPENSE LEVEL OF $1,250 PER PERSON AND $3,750 PER FAMILY.

ON-CAMERA:

15. MCU OF TALENT

15. NOW THAT WAS A LOT OF NUMBERS SO LETS SEE HOW IT WORKS.

16. PAN RIGHT TO MS TALENT LEFT GRAPHICS RIGHT

GRAPHICS:

A. FAMILY PRACTICE DOCTOR
B. TOTAL CHARGE $500
C. BCBS ALLOWED LIMIT $400
D. IN NETWORK VS. OUT OF NETWORK
E. IN NETWORK
$15 COPAYMENT
F. OUT OF NETWORK
$395

16. FOR THIS EXAMPLE WE WILL TAKE A VISIT TO A FAMILY PRACTICE DOCTOR. THE TOTAL CHARGE FOR THE VISIT WAS $500, AND THE BCBS ALLOWED LIMIT IS $400. ONE ASSOCIATE GOES TO A FAMILY PRACTICE DOCTOR IN THE NETWORK AND ANOTHER GOES TO A DOCTOR OUT OF THE NETWORK.

THE ASSOCIATE WHO WENT TO A FAMILY PRACTICE DOCTOR IN THE NETWORK PAYS THE $15 COPAYMENT FOR THE VISIT. THE

17. FULL SCREEN GRAPHICS

GRAPHICS:

A. TOTAL CHARGE $500
BCBS ALLOWABLE $400

B. OUT OF NETWORK PROVIDER
C. NO CO-PAYMENT
D. 70% BENEFIT LEVEL AFTER $250 DEDUCTIBLE
E.

IN-NETWORK	VS.	OUT-OF-NETWORK
	TOTAL CHARGE $500	
	BCBS ALLOWED AMOUNT	$400
$15	CO-PAYMENT	--------
	DEDUCTIBLE	$250
	BALANCE	$150
	70% BENEFIT	-$105
	ASSOCIATES 30%	$45
	ASSOCIATES RESPONSIBILITY	$295
	DIFFERENCE BETWEEN TOTAL CHARGE & ALLOWED AMOUNT	$100
$15	TOTAL OUT OF POCKET EXPENSE	$395

SECOND ASSOCIATE, GOING TO AN OUT OF NETWORK PROVIDER DROPS NEARLY $400 OUT OF POCKET. SEEMS LIKE A BIG DIFFERENCE DOESN'T IT? LET ME EXPLAIN.

VO:

17. THE CHARGE WAS $500, HOWEVER BLUE CROSS-BLUE SHIELD'S ALLOWED AMOUNT FOR THE SERVICE WAS $400. THE IMPORTANCE OF THIS DIFFERENCE WILL BE EVIDENT IN A MOMENT. BECAUSE IT WAS AN OUT OF NETWORK PROVIDER, THERE IS NO CO-PAYMENT AND THE PLAN ONLY PAYS 70% OF THE ALLOWED AMOUNT. AFTER THE DEDUCTIBLE, THERE IS A BALANCE OF $150. THE PLAN PAYS ITS 705 BENEFIT LEAVING THE ASSOCIATE RESPONSIBLE FOR $45. ADD THIS TO THE DEDUCTIBLE AND THE ASSOCIATE IS OUT $295. BUT WAIT THERE'S MORE. BECAUSE AN OUT OF NETWORK PROVIDER WAS USED, THE ASSOCIATE IS ALSO FINANCIALLY RESPONSIBLE FOR AN ADDITIONAL $100, WHICH IS THE DIFFERENCE BETWEEN THE TOTAL CHARGE AND THE BCBS ALLOWED AMOUNT. SO THE TOTAL OUT OF POCKET EXPENSE FOR THIS ASSOCIATE IS $395. THIS EXAMPLE EMPHASIZES THE IMPORTANCE OF USING DOCTOR'S WITHIN THE BCBS' NETWORK.

18. MS TALENT LEFT GRAPHICS RIGHT GRAPHICS:
    A. PPO/PPC PLAN
    B. PREVENTATIVE CARE
       CHILDREN UP TO AGE 16
    C. MAMMOGRAMS
    D. WAITING PERIOD FOR PRE-EXISTING CONDITIONS

19. TURN TO MCU OF TALENT

20. FULL SCREEN GRAPHICS
    GRAPHICS:
    A.FLORIDA-
       CARE MANAGER
    B. GEORGIA-
       BLUE CHOICE
    C. SOUTH CAROLINA-
       HMO BLUE
    D. HMO BLUE
       NOT AN HMO
    E. HMO BLUE
       SELF INSURED, MANAGED CARE PLAN

21. MS TALENT LEFT GRAPHICS RIGHT GRAPHICS:
    A. SELECT A PRIMARY CARE PHYSICIAN
    B. ALLOWS PREVENTATIVE CARE
    C. COORDINATE CARE THROUGH PRIMARY CARE PHYSICIAN

ON-CAMERA:

18. THE PPO/PPC PLAN ONLY COVERS PREVENTIVE CARE FOR CHILDREN UP TO AGE 16 AND FOR MAMMOGRAMS. IF YOU HAVE A PRE-EXISTING CONDITION THERE IS A WAITING PERIOD BEFORE YOU ARE ELIGIBLE FOR BENEFITS RELATED TO THAT CONDITION.

19. OKAY THAT WAS THE PPO/PPC, NOW LET'S MOVE ON TO THE POINT OF SERVICE PLAN. POINT OF SERVICE PLANS ARE A MIDDLE GROUND BETWEEN THE HMOs AND PPO/PPC PLANS.

20. DEPENDING ON WHERE YOU LIVE YOUR POINT OF SERVICE PLAN IS KNOWN BY DIFFERENT NAMES. IN FLORIDA YOUR POINT OF SERVICE IS CALLED "CARE MANAGER". IN GEORGIA "BLUE CHOICE" AND IN SOUTH CAROLINA, "HMO BLUE." PLEASE DON'T GET CONFUSED, IN SOUTH CAROLINA "HMO BLUE" IS NOT AN HMO PLAN, IT IS A SELF INSURED , POINT OF SERVICE, MANAGED CARE PLAN THAT ALLOWS MORE CHOICE WITHIN THE PLAN.

ON-CAMERA:

21. POINT OF SERVICE PLANS REQUIRE THAT PARTICIPANTS UTILIZE A SELECTED PRIMARY CARE PHYSICIAN TO RECEIVE THE HIGHER LEVEL OF BENEFITS. POINT OF SERVICE PLANS ALSO ALLOW PREVENTATIVE CARE AND COORDINATION OF CARE THROUGH

A PRIMARY CARE PHYSICIAN.

D. SPECIALISTS' CARE MUST BE AUTHORIZED BY PRIMARY CARE PHYSICIAN

THROUGH THE POINT OF SERVICE PLAN YOUR PRIMARY CARE PHYSICIAN WILL MANAGE YOUR CARE. SHOULD YOU NEED TO SEE A SPECIALIST, THIS VISIT MUST FIRST BE AUTHORIZED BY YOUR PRIMARY CARE PHYSICIAN TO CONTINUE TO RECEIVE THE HIGHEST LEVEL OF BENEFITS. CHRONIC OR ON-GOING PROBLEMS ALSO REQUIRE ADDITIONAL AUTHORIZATIONS TO MAINTAIN THIS BENEFIT LEVEL.

E. CHRONIC PROBLEMS REQUIRE ADDITIONAL AUTHORIZATIONS

F. $15 CO PAYMENT

THERE IS A $15 CO PAYMENT FOR ALL SERVICES RECEIVED IN THE PRIMARY CARE PHYSICIAN'S OFFICE OR ANY SERVICES YOU ARE AUTHORIZED TO RECEIVE FROM A SPECIALIST. ADDITIONAL SERVICES ARE COVERED AT THE 90% LEVEL FOLLOWING A $250 DEDUCTIBLE. MUCH LIKE A PPO/PPC YOU CAN SELF REFER YOUR CARE, BUT SELF REFERED CARE IN THE POINT OF SERVICE PLAN IS SUBJECT TO A 70% BENEFIT LEVEL OF THE ALLOWABLE AMOUNT AFTER A $250 DEDUCTIBLE, EVEN IF YOU USE A BCBS NETWORK PROVIDER.

G. ADDITIONAL SERVICES COVERED AT 90% BENEFIT LEVEL

H. $250 DEDUCTIBLE

I. ALLOWED TO SELF-REFER CARE

J. 70% BENEFIT LEVEL OF ALLOWED AMOUNT AFTER DEDUCTIBLE

K. EVEN USING A NETWORK PROVIDER

22. TURN TO MCU OF TALENT

22. SO, WHEN YOU USE A PRIMARY CARE PHYSICIAN OR AUTHORIZED SPECIALIST IN A POINT OF SERVICE PLAN THE DOCTORS HAVE AGREED TO ACCEPT A $15 CO PAYMENT AS YOUR TOTAL PATIENT FINANCIAL RESPONSIBILITY FOR THAT VISIT.

22B. PULL OUT TO MS TALENT LEFT GRAPHICS RIGHT

GRAPHICS:

A. ANNUAL HEALTH ASSESSMENT

B. ANNUAL SELF REFERRAL TO A NETWORK OB/GYN

C. PLAN IS DESIGNED TO ENCOURAGE YOU TO USE PRIMARY CARE PHYSICIAN

D. HIGHEST BENEFIT LEVEL WHEN CARE IS COORDINATED

E. SELF REFERRED CARE IS COVERED AT 70% BENEFIT LEVEL AFTER DEDUCTIBLE IS MET

23. FULL SCREEN GRAPHICS

GRAPHICS:

A.CHIROPRATIC CARE
B. PODIATRY
C. MENTAL HEALTH
D. HOME CARE
E. DO NOT REQUIRE AUTHORIZATIONS
F. BENEFIT LEVEL IS DETERMINED BY USE OF IN-NETWORK VS. OUT OF NETWORK DOCTOR
G. WAITING PERIOD FOR PRE-EXISTING CONDITIONS
H. MAXIMUM ANNUAL OUT OF POCKET EXPENSE LEVEL
$1,250 PER PERSON
$3,750 PER FAMILY

22B. THE POINT OF SERVICE PLAN COVERS PREVENTATIVE CARE BY PROVIDING AN ANNUAL HEALTH ASSESSMENT THROUGH EACH MEMBER'S SELECTED PRIMARY CARE PHYSICIAN. ALSO, A COVERED FEMALE WHO HAS SELECTED A PRIMARY CARE PHYSICIAN, IS ENTITLED TO AN ANNUAL SELF-REFERRAL VISIT TO A NETWORK OB/GYN. AS YOU CAN SEE THE PLAN IS DESIGNED TO ENCOURAGE YOU TO USE YOUR PRIMARY CARE PHYSICIAN FOR ALL YOUR HEALTH CARE NEEDS BY PROVIDING THE HIGHEST LEVEL OF BENEFITS WHEN YOUR CARE IS COORDINATED THROUGH YOUR PRIMARY CARE PHYSICIAN. HOWEVER YOU STILL HAVE THE CHOICE TO SELF-REFER YOUR CARE AND COVERED SERVICES WOULD BE PAID AT THE 70% BENEFIT LEVEL AFTER YOUR ANNUAL DEDUCTIBLE HAS BEEN MET.

VO:

23. ON THE OTHER HAND SOME SERVICES, SUCH AS: CHIROPRACTIC CARE; PODIATRY; MENTAL HEALTH AND HOME CARE DO NOT REQUIRE AN AUTHORIZATION BY A PRIMARY CARE PHYSICIAN. IN THESE SELF REFERED CIRCUMSTANCES YOUR BENEFIT LEVEL UNDER THE PLAN WOULD DEPEND ON WHETHER A BCBS NETWORK PROVIDER OR AN OUT OF NETWORK DOCTOR WAS UTILIZED.

IF YOU HAVE A PRE-EXISTING CONDITION, THERE IS A WAITING PERIOD

BEFORE YOU ARE ELIGIBLE FOR BENEFITS RELATED TO THAT CONDITION. ALSO, TO HELP PROTECT YOU, THERE IS AN ANNUAL MAXIMUM OUT OF POCKET EXPENSE LEVEL OF $1,250 PER PERSON AND $3,750 PER FAMILY.

24. MCU OF TALENT

24B.

UP TO NOW WE HAVE BEEN TALKING STRICTLY ABOUT HEALTH CARE BUT WHAT ABOUT PRESCRIPTION MEDICATIONS YOUR DOCTOR SAYS YOU NEED. IF YOU CHOOSE AN HMO PLAN FOR YOUR HEALTH CARE COVERAGE, YOUR PRESCRIPTION MEDICATIONS WILL BE COVERED BY THAT PLAN. HOWEVER IF YOU HAVE COVERAGE THROUGH EITHER OF THE SELF-INSURED OPTIONS, THEN I'D LIKE TO EXPLAIN HOW YOUR PHARMACY BENEFIT WILL BE HANDLED.

25. PAN TO TALENT LEFT, GRPAHICS RIGHT
GRAPHICS:
A. YOU AND PUBLIX SPLIT THE TOTAL COST FOR HEALTH CARE

B. USING PAYROLL DEDUCTION REDUCES YOUR TAXABLE INCOME

FULL SCREEN GRAPHICS
PHARMACY BENEFIT
JANUARY 1, 1997

PCS HEALTH SYSTEMS

24C.

EFFECTIVE JANUARY FIRST 1997 THE PHARMACY BENEFIT THROUGH OUR SELF INSURED PLAN WILL BE ADMINISTERED BY PCS HEALTH SYSTEMS. IF YOU ARE CURRENTLY ENROLLED IN THE SELF INSURED PLAN, BLUE CROSS BLUE SHIELD WILL CONTINUE TO PROCESS ALL CLAIMS FOR PRESCRIPTIONS FILLED PRIOR TO DECEMBER 31ST, 1996.

BLUE CROSS BLUE SHIELD WILL CONTINUE TO PROCESS ALL CLAIMS FOR PRESCRIPTIONS FILLED PRIOR TO DECEMBER 31, 1996

24D.

CU OF TALENT

FULL SCREEN GRAPHICS
FILE EXTRA PAPERWORK
WAIT TO BE REIMBURSED

NO ADDITIONAL PAPERWORK
KNOW OUT OF POCKET EXPENSES

ANNUAL DEDUCTIBLE
$50 PER PERSON
$150 PER FAMILY

TALENT ON CAMERA

SO HOW DOES THIS WORK? UNDER THE OLD PLAN YOU HAD TO FILE EXTRA PAPERWORK AND WAIT TO BE REIMBURSED FOR MEDICATION EXPENSES, BUT UNDER THIS NEW PHARMACY BENEFIT PLAN THERE IS NO ADDITIONAL PAPERWORK AND YOU KNOW YOUR OUT OF POCKET COSTS UP FRONT.

24E.

THERE IS AN ANNUAL PHARMACY DEDUCTIBLE OF $50 PER COVERED PERSON UP TO $150 PER FAMILY.

24F.

FOR EACH PRESCRIPTION YOUR DOCTOR WRITES FOR YOU, THERE IS A $7 CO-PAYMENT IF YOU ALLOW A GENERIC EQUIVALENT OF THE MEDICATION TO BE DISPENSED. IF THERE IS NO GENERIC EQUIVALENT, THEN YOUR CO-PAYMENT GOES UP TO $14. NOW WHAT IF YOU GET A PRESCRIPTION FOR A BRAND NAME MEDICATION AND THERE IS A GENERIC EQUIVALENT BUT YOU WANT THE BRAND MEDICATION DISPENSED. SIMPLE. UNLESS YOUR DOCTOR CLARIFIES TO, "DISPENSE AS WRITTEN" YOU WILL PAY THE $7 CO-PAYMENT PLUS THE DIFFERENCE BETWEEN THE GENERIC AND BRAND MEDICATIONS. LET'S SEE HOW THIS WORKS.

CHALK TALK RAPHICS TO SHOW DIFFERENCES

24G.

TWO ASSOCIATES RECEIVE PRESCRIPTIONS FOR THE SAME BRAND MEDICATION. THE BRAND MEDICATION COSTS $30. THE GENERIC EQUIVALENT COSTS $14. THE FIRST ASSOCIATE'S DOCTOR WRITES ON THE PRESCRIPTION, "DISPENSE AS WRITTEN." THE SECOND ASSOCIATE CHOOSES THE BRAND MEDICATION OVER THE GENERIC EQUIVALENT. THE FIRST ASSOCIATE PAYS THE $14 CO-PAYMENT AND THAT IS IT. THE SECOND ASSOCIATES PAYS THE $7 CO-PAYMENT PLUS AN ADDITIONAL $16 FOR A TOTAL OF $23 FOR THE SAME MEDICATION.

FULL SCREEN GRAPHIC
UNDER NO CIRCUMSTANCE WILL CO-PAYMENT BE HIGHER THAN ACTUAL COST OF PRESCRIPTION MEDICATION

24H.

UNDER NO CIRCUMSTANCES WILL YOUR CO-PAYMENT BE HIGHER THAN THE ACTUAL COST OF THE PRESCRIPTION MEDICATION.

TALENT ON CAMERA

24I. IN THE LAST FEW MINUTES WE HAVE QUICKLY COVERED SOME VERY IMPORTANT INFORMATION THAT YOU NEED TO UNDERSTAND IN ORDER TO MAKE AN INFORMED DECISION ABOUT YOUR GROUP HEALTH BENEFIT COVERAGE.

25. LETS REVIEW A FEW KEY POINTS.

* TOGETHER YOU AND PUBLIX PAY FOR THE TOTAL COST OF YOUR HEALTH CARE

26. FULL SCREEN GRAPHICS

A. HMOs

B. PREMIUMS AND CO-PAYMENTS COVER ALL SERVICES

C. CARE OUTSIDE HMO WILL BE TOTALLY AT YOUR EXPENSE

D. SELF INSURED

E. PPO/PPC AND POS PROGRAMS

F. ADMINISTERED BY BCBS

G. PPO/PPC

H. OPEN ACCESS NETWORK

I. LOWER BENEFIT LEVEL FOR OUT OF NETWORK CARE

J. $15 CO PAYMENT

COVERAGE.

* MAKING YOUR CONTRIBUTION THROUGH PAYROLL DEDUCTION HELPS REDUCE YOUR TAXABLE INCOME.

26. HMOs

* YOUR PREMIUMS AND ANY REQUIRED CO-PAYMENTS COVERS ALL OF THE SERVICES PROVIDED BY OR REFERRED BY YOUR PRIMARY CARE PHYSICIAN INCLUDING PREVENTIVE CARE.

* CARE YOU RECEIVE OUTSIDE OF THE HMO REFERRAL SYSTEM WILL BE TOTALLY AT YOUR EXPENSE.

SELF-INSURED

* OUR SELF INSURED PLAN OFFERS A PPO/PPC PROGRAM AND A POINT OF SERVICE PROGRAM.

* BOTH PROGRAMS ARE ADMINISTERED BY BLUE CROSS BLUE SHIELD.

PPO/PPC

* THE PPO/PPC IS AN OPEN ACCESS NETWORK AS LONG AS YOU RECEIVE CARE FOR COVERED SERVICES FROM A NETWORK PROVIDER YOU RECEIVE THE MAXIMUM BENEFIT LEVEL.

* YOU ARE FREE TO CHOOSE A PROVIDER OUTSIDE OF THE NETWORK BUT THEN YOUR BENEFIT LEVEL DROPS TO A LOWER LEVEL .

* A $15 CO-PAYMENT FOR

K. PRIMARY CARE TYPE DOCTORS
FAMILY PRACTICE
GENERAL PRACTICE
INTERNAL MEDICINE
PEDIATRICIANS

SERVICES RECEIVED IN THE OFFICE OF A NETWORK PRIMARY CARE TYPE DOCTOR. REMEMBER PRIMARY CARE TYPE DOCTORS ARE FAMILY PRACTICE, GENERAL PRACTICE, INTERNAL MEDICINE AND PEDIATRICIANS.

L. DOES NOT COVER PREVENTATIVE CARE

* THE PPO/PPC DOES NOT COVER PREVENTIVE CARE EXCEPT FOR CHILDREN UP TO 16 AND MAMMOGRAMS

M. POINT OF SERVICE (POS)

POINT OF SERVICE

N. PROVIDES PREVENTATIVE CARE THROUGH PRIMARY CARE PHYSICIAN

* THE POINT OF SERVICE PLAN IS A MANAGED CARE PLAN THAT PROMOTES PREVENTATIVE CARE BY COVERING AN ANNUAL HEALTH ASSESSMENT THROUGH A PRIMARY CARE PHYSICIAN.

O. $15 CO-PAYMENT

* A $15 CO PAYMENT IS ALL YOU PAY YOUR PRIMARY CARE PHYSICIAN AND FOR AUTHORIZED SPECIALTY CARE.

P. PRIMARY CARE PHYSICIAN COORDINATES TOTAL CARE

* SELECT A PRIMARY CARE PHYSICIAN FOR COORDINATION OF YOUR TOTAL HEALTH CARE NEEDS.

Q. USE PRIMARY CARE PHYSICIAN FOR MAXIMUM BENEFITS

* UTILIZE YOUR PRIMARY CARE PHYSICIAN TO OBTAIN THE HIGHEST LEVEL OF BENEFITS.

R. ALLOWS SELF REFERRALS AT LOWER BENEFIT LEVEL

* THE POINT OF SERVICE PLAN ALLOWS YOU TO SELF REFER YOUR CARE; HOWEVER, AT A LOWER LEVEL OF BENEFITS.

S. PPO/PPC AND POS
WAITING PERIOD FOR PRE-EXISTING CONDITIONS

REMEMBER THROUGH THE PPO/PPC AND POINT OF SERVICE PROGRAMS THERE IS A WAITING PERIOD FOR PRE-EXSISTING MEDICAL

27.MCU OF TALENT

FULL SCREEN GRAPHIC:
GROUP BENEFIT DEPARTMENT
INFORMATION

AT END FADE TO GROUP BENEFIT
DEPARTMENT CONTACT INFORMATION

CONDITIONS.

ON CAMERA:

27. NO ONE CAN TELL YOU WHICH PLAN IS BEST FOR YOU. YOU NEED TO REVIEW THE MATERIALS AVAILABLE AND DECIDE WHICH ONE BEST FITS YOUR SITUATION.

IF YOU HAVE ANY QUESTIONS YOU SHOULD CONTACT YOUR MANAGER, TRAINING COORDINATOR OR DEPARTMENT HEAD. THEY SHOULD BE ABLE TO GET YOU THE INFORMATION YOU NEED. IF YOU STILL HAVE QUESTIONS, PLEASE CALL THE GROUP BENEFITS DEPARTMENT AT THE CORPORATE OFFICE IN LAKELAND, FLORIDA. BY THE WAY WHEN YOU CALL OUR OFFICE, YOU MAY REACH OUR AUTOMATED VOICE MAIL SYSTEM. PLEASE LEAVE A MESSAGE. IT IS OUR GOAL TO RESPOND TO EVERY CALL WITHIN 24 HOURS BUT WE CAN ONLY ACCOMPLISH THIS IF YOU LEAVE US A MESSAGE .

NOW IT IS UP TO YOU. USE THIS INFORMATION AND MAKE YOUR DECISION WORK FOR YOU AND YOUR LIFESTYLE.