ADDENDUM #001
486-2022 Employee Benefits Brokerage and Consulting Services

Documents/Reports

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Bd. Approved 1/23/18

Purchasing Department

LEON COUNTY SCHOOLS

CONTRACT BETWEEN THE SCHOOL BOARD OF LEON COUNTY, FLORIDA AND ROGERS, GUNTER, VAUGHN INSURANCE, A HUB INTERNATIONAL COMPANY

This contract entered into this 23rd day of January, 2018, between THE SCHOOL BOARD OF LEON COUNTY, FLORIDA, a political subdivision of the state of Florida, (hereinafter referred to as the "School Board ") and ROGERS, GUNTER, VAUGHN INSURANCE, A HUB INTERNATIONAL COMPANY , located at 1117 Thomasville Rd., Tallahassee, Florida 32303, (hereinafter referred to as the "Contractor") to provide EMPLOYEE BENEFITS BROKERAGE AND CONSULTING SERVICES.

Section I – Term of Contract

This contract shall be for the period beginning January 24, 2018 through December 31, 2020 (Initial Term). At the conclusion of the Initial Term, the contract may be renewed for up to three (3) additional one (1) year terms (Renewal Terms), provided that the parties mutually agree in writing no less than 60 days before the conclusion of any Term (Initial or Renewal). .

Section II – Services

The Contractor shall provide EMPLOYEE BENEFITS BROKERAGE AND CONSULTING SERVICES as defined in Exhibit A per the specifications in **RFQ No. 415-2018** and the corresponding proposal submitted by the Contractor, which by reference herein becomes part of this contract. All addenda issued to **RFQ No. 415-2018**, if any, are also made a part of this contract.

Section III – Cost of Services

The Contractor shall be paid for services as negotiated and approved by the School Board. Fees for the cost of services are provided for in EXHIBIT B of this document, which by reference herein becomes part of this contract.

Section IV – Termination

The Contractor shall have the option to terminate the contract upon written notice to the Director of Purchasing. Such notice must be received at least ninety (90) days prior to the effective date of termination. The School Board shall have the option to terminate the contract without cause upon written notice to the authorized representative of the Contractor. Such notice must be received at least thirty (30) days prior to the effective date of termination and the Contractor shall only be entitled to compensation up to the date of current policies renewal. The Contractor shall not be entitled to lost profits.

Early termination of the contract by the Contractor may subject the Contractor to the debarment provision of this contract.

There shall be no assignment of the contract or compensation to be derived therefrom by the Contractor without approval from the School Board.

This section will survive the termination of this contract.

Section V – Insurance and Indemnification

Each party agrees to be fully responsible for its acts of negligence or its agents' acts of negligence when acting within the scope of this contract and agrees to be liable for any damages resulting from said negligence to the extent allowable pursuant to Section 768.28, Florida Statutes.

The Contractor will maintain comprehensive general liability insurance, including contractual and product liability coverage, with minimum limits acceptable to the School Board, throughout the entire term (to include Initial and any Renewal Terms) of this Contract. **The Contractor will supply certificates**

evidencing such coverage and listing the Leon County School Board as "Additional Insured" on said policies.

The insurance coverage's and limits shall meet, at a minimum, the following requirements:

1. Commercial General Liability Insurance in an amount not less than $1,000,000 combined single limit per occurrence for bodily injury and property damage.

2. Automobile Liability Insurance covering all owned, non-owned and hired vehicles used in connection with the operation of the Contractor, in an amount not less than $1,000,000 combined single limit per occurrence for bodily injury and property damage.

3. Workers' Compensation Insurance for all employees of the Contractor as required by Florida Statutes.

The insurance coverage required shall include those classifications, as listed in standard liability insurance manuals, which most nearly reflect the operations of the Contractor.

All insurance policies shall be issued by companies with either of the following qualifications:

a. The company must be:

   1. authorized by subsisting certificates of authority by the Department of Insurance of the State of Florida or

   2. an eligible surplus lines insurer under Florida Statutes. In addition, the insurer must have a Best's Rating of "A" or better and a Financial Size Category of "IV" or better according to the latest edition of Best's Key Rating Guide, published by A.M. Best Company.

And

b. With respect only to the Workers' Compensation insurance, the company must be:

1. authorized as a group self-insurer pursuant to Florida Statutes or

2. authorized as a commercial self-insurance fund pursuant to Florida Statutes

Neither approval nor failure to disapprove the insurance furnished by the Contractor to the School Board shall relieve the Contractor of the Contractor's full responsibility to provide insurance as required by this Contract. The Contractor shall be responsible for assuring that the insurance remains in force for the duration of the contractual period; including any and all option years that may be granted to the Contractor. The certificate of insurance shall contain the provision that the School Board be given no less than thirty (30) days written notice of cancellation. If the insurance is scheduled to expire during the contractual period, the Contractor shall be responsible for submitting new or renewed certificates of insurance to the School Board at a minimum of thirty (30) calendar days in advance of such expiration. **The Contractor may be in default of this Contract for failure to maintain the insurance as required by this Contract. Any questions and/or inquiries should be directed to Janet Heath at (850) 487-7113.**

Section VI - Default

In the event that the Contractor should breach this contract, the School Board reserves the right to seek remedies in law and/or in equity.

Sections VII – Debarment

The Board shall have the authority to debar Contractor from consideration or award of future contracts. The debarment shall be for a period commensurate with the seriousness of the causes, generally not to exceed three (3) years from the date of termination. When the offense is willful or blatant, a longer term of debarment may be imposed up to an indefinite period.

Section VIII – Federal and State Tax

The School Board is exempt from federal and state taxes for tangible personal property. The Purchasing Director will sign an exemption certificate submitted by the Contractor. The Contractor doing business with the School Board will not be exempted from paying sales tax to their suppliers for

materials to fulfill contractual obligations with the School Board, nor will the Contractor be authorized to use the School Board's Tax Exemption Number in securing such materials.

Section IX - Amendment

This contract shall only be amended or modified in writing executed by both parties.

Section X – Strict Performance

The failure of either party to insist on strict performance of any covenant or conditions herein shall not be construed as a waiver of such covenants or conditions for any instance.

Section XI – Governing Law; Venue

This contract shall be construed in accordance with the laws of the State of Florida. If any litigation shall result from this agreement, venue shall lie in Leon County, Florida.

This agreement shall not be construed against the party who drafted the same as both parties have had experts of their choosing review the same.

Section XII - Effect

This agreement is binding on the parties hereto, their heirs, successor and/or assigns.

Section XIII - Required Public Records Acknowledgement

Contractor is required to comply with the Florida Public Records Law, Chapter 119, Florida Statutes, in the performance of its duties under this contract, as follows:

A. Keep and maintain public records required by LCSB to perform the service.

B. Upon request from LCSB's custodian of public records, provide LCSB with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in the Chapter 119, Florida Statutes or as otherwise provided by law.

C. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the

duration of the contract term and following completion of the Agreement if Contractor does not transfer the records to LCSB.

D. Upon completion of the Agreement, transfer, at no cost to LCSB, all public records in possession of the Contractor or keep and maintain public records required by LCSB to perform the service. If Contractor transfers all public records to LCSB upon completion of the Agreement, Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If Contractor keeps and maintains public records upon completion of the Agreement, Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to LCSB, upon request of LCSB's custodian of public records, in a format that is compatible with the information technology systems of LCSB.

E. The failure of the Contractor to comply with the provisions set forth herein shall constitute a default and material breach of this Agreement, which may result in immediate termination, with no penalty to LCSB.

PUBLIC RECORDS NOTICE

IF CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS, JULIE JERNIGAN, AT JERNIGANJ@LEONSCHOOLS.NET, (850)487-7363, 520 SOUTH APPLEYARD DRIVE, TALLAHASSEE, FLORIDA 32304

In witness whereof, this contract has been executed on the day and year first above written.

Rogers, Gunter, Vaughn Insurance, a HUB International Co.

By: Bart Gunter

Bart Gunter, Executive Vice President

Date: 1/15/2018

The School Board of Leon County, Florida

By:

Alva Striplin, Board Chair

Date: 1/23/18

EXHIBIT A

EMPLOYEE BENEFITS BROKERAGE AND CONSULTING SERVICES

- Develop short and long range employee benefit goals and strategies.
- Partner with the Benefits team in the administration of all group insurance plans including responding to questions from and providing information to staff, and providing other benefits-related advisory services throughout the plan year.
- Review and analyze claims experience, claim service, and claim administration to ensure maximum benefit to the Board.
- Determine and recommend the most cost efficient funding methods for benefit programs.
- Prepare bid specifications and solicit proposals, as needed, from insurance markets that specialize in group insurance plans.
- Evaluate bids and bidders, including administration, coverage, claim payment procedures, customer service, networks, reserve establishment policies and financial solvency.
- Provide the Board with in-depth analysis of proposed alternatives and assist with the process of selecting the most favorable annual renewal options.
- Apprise the Board of local and national benefit trends and provide benchmark survey data to help calibrate program offerings with employee and employer costs compared to similar organizations.
- Meet with and provide reports and presentations to various Board representatives if requested.
- Assist the Board with the implementation and communication of new programs or changes to existing programs, which may include attending and presenting information at Open Enrollment meetings when requested.
- Work closely with the benefits team to develop and execute the benefits communication strategy.
- Partner with the Board to effectively performance manage the vendors that provide insurance or related services to the Board.
- Act as advisor on issues such as discrimination testing, 5500 filing, Section 125, COBRA, HIPAA, Medicare, FMLA, ACA etc. Provide overall guidance to the Board with Health and Welfare regulatory compliance.
- Research and report any new developments in the employee benefits arena on an ongoing basis.
- Recommend innovative ideas and new products, programs and services to ensure a competitive, valued and cost effective benefits program.
- Introduce proven programs and ideas to aggressively manage healthcare costs.
- Introduce proven programs and ideas to enhance the Boards culture and improve employee productivity and morale.
- Educate and advise on Healthcare Reform, specifically PPACA, and the key strategic decisions that the Board should consider.

EXHIBIT B

Cost of Services

This is a standard commissions only agreement. All commissions received from carriers and solution partners will offset any consulting fees for the services detailed in this agreement. The current 1% commission on the Group Health Plans will be reduced to .5% (one half a percent) as of October 1, 2018. Standard commissions will be charged for all other employee paid products.

Leon County Schools 30790-1886

Utilization from 10/1/2018 through 9/30/2021

Month Name	Coverage	Month	Cardholders	Members	Revenue	Claims
October, 2018	All	10/31/2018	1126	1918	$ 10,805.62	$ 2,418.93
November, 2018	All	11/30/2018	1138	1934	$ 10,902.27	$ 11,561.57
December, 2018	All	12/31/2018	1130	1930	$ 10,868.10	$ 8,780.53
January, 2019	All	01/31/2019	1131	1930	$ 10,874.63	$ 10,532.95
February, 2019	All	02/28/2019	1130	1931	$ 10,868.10	$ 5,146.91
March, 2019	All	03/31/2019	1131	1933	$ 10,892.92	$ 6,725.06
April, 2019	All	04/30/2019	1133	1939	$ 10,924.27	$ 10,656.79
May, 2019	All	05/31/2019	1129	1932	$ 10,885.81	$ 6,656.20
June, 2019	All	06/30/2019	1133	1937	$ 10,924.05	$ 6,304.30
July, 2019	All	07/31/2019	1127	1927	$ 10,866.58	$ 13,902.87
August, 2019	All	08/31/2019	1127	1927	$ 10,866.58	$ 11,155.29
September, 2019	All	09/30/2019	1127	1925	$ 10,866.58	$ 2,149.00
October, 2019	All	10/31/2019	1427	2443	$ 13,714.52	$ 13,669.29
November, 2019	All	11/30/2019	1420	2433	$ 13,656.69	$ 11,308.09
December, 2019	All	12/31/2019	1430	2444	$ 13,734.11	$ 9,637.12
January, 2020	All	01/31/2020	1434	2451	$ 13,778.52	$ 13,133.79
February, 2020	All	02/29/2020	1435	2437	$ 13,736.79	$ 5,899.92
March, 2020	All	03/31/2020	1427	2418	$ 13,647.97	$ 6,311.40
April, 2020	All	04/30/2020	1431	2427	$ 13,692.16	$ 6,767.98
May, 2020	All	05/31/2020	1433	2426	$ 13,686.93	$ 3,991.00
June, 2020	All	06/30/2020	1429	2421	$ 13,654.64	$ 8,328.56
July, 2020	All	07/31/2020	1428	2419	$ 13,641.94	$ 12,592.90
August, 2020	All	08/31/2020	1421	2410	$ 13,583.89	$ 15,479.25
September, 2020	All	09/30/2020	1436	2424	$ 13,688.01	$ 8,699.93
October, 2020	All	10/31/2020	1463	2494	$ 14,071.24	$ 8,114.92
November, 2020	All	11/30/2020	1457	2463	$ 13,928.71	$ 12,124.37
December, 2020	All	12/31/2020	1438	2434	$ 13,761.67	$ 11,637.77

January, 2021	All	01/31/2021	1434	2427	$ 13,723.21	$ 11,202.47
February, 2021	All	02/28/2021	1433	2422	$ 13,692.44	$ 9,446.93
March, 2021	All	03/31/2021	1427	2411	$ 13,634.97	$ 10,607.37
April, 2021	All	04/30/2021	1416	2393	$ 13,526.78	$ 6,911.32
May, 2021	All	05/31/2021	1415	2396	$ 13,544.49	$ 6,110.14
June, 2021	All	06/30/2021	1408	2379	$ 13,456.03	$ 10,456.56
July, 2021	All	07/31/2021	1395	2363	$ 13,359.02	$ 12,831.81
August, 2021	All	08/31/2021	1391	2355	$ 13,320.78	$ 8,972.38
September, 2021	All	09/30/2021	1389	2352	$ 13,301.55	$ 7,363.44
		Total All Groups			**$ 458,082.57**	**$ 327,589.11**

Monitoring by Utilization and Enrollment

Company: COUNTY OF LEON BOARD
Group: 78116
Current Paid Period: From 10/2018 to 09/2021

Florida Blue

	Enrollment		Premium	Capitation				Fee for Service Claims							
Paid Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Value Based Programs	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201810	70	93	$54,942.35	$0.00	$78.85	$78.85	$0.00	$4,815.00	$21,793.71	$17,792.38	$3,464.37	$47,865.46	$11,881.72	$59,826.03	108.89%
201811	70	93	$64,494.51	$0.00	$84.73	$84.73	$0.00	$59,260.44	$17,846.94	$12,720.48	$7,598.27	$97,426.13	$15,705.48	$113,216.34	175.54%
201812	67	90	$58,201.14	$0.00	$80.51	$80.51	$0.00	$0.00	$7,704.11	$7,845.14	$6,118.19	$21,667.44	$13,527.09	$35,275.04	60.61%
201901	67	90	$58,237.98	$0.00	$86.85	$86.85	$0.00	$0.00	$8,031.20	$6,502.21	$2,221.33	$16,754.74	$16,099.00	$32,940.59	56.56%
201902	66	89	$57,454.08	$0.00	$79.64	$79.64	$0.00	$0.00	$3,928.31	$8,759.63	$1,525.06	$14,213.00	$17,541.03	$31,833.67	55.41%
201903	63	86	$55,045.65	$0.00	$81.30	$81.30	$1.21	$47,939.03	$22,524.92	$10,382.26	$1,412.47	$82,258.68	$18,569.51	$100,910.70	183.32%
201904	63	86	$54,877.56	$0.00	$73.80	$73.80	$0.00	$40,282.41	$5,783.12	$15,654.63	$6,640.32	$68,360.48	$20,977.78	$89,412.06	162.93%
201905	63	86	$54,877.44	$0.00	$73.32	$73.32	$0.00	$46,014.71	$3,354.51	$9,101.83	$2,039.95	$60,511.00	$18,508.70	$79,093.02	144.13%
201906	64	87	$54,877.57	$0.00	$76.44	$76.44	$3.63	$20,796.68	$8,563.48	$9,916.38	$10,822.48	$50,099.02	$15,966.15	$66,145.24	120.53%
201907	64	87	$56,165.69	$0.00	$75.12	$75.12	$1.21	$99,620.55	$31,209.36	$17,841.86	$9,089.35	$157,761.12	$17,998.93	$175,836.38	313.07%
201908	63	86	$52,829.84	$0.00	$76.44	$76.44	$1.21	$69,937.44	$37,737.71	$24,171.66	$5,336.87	$137,183.68	$19,149.19	$156,410.52	296.06%
201909	63	86	$55,058.08	$0.00	$75.12	$75.12	$78.72	$1,364.00	$14,034.44	$5,278.10	$4,724.90	$25,401.44	$15,255.50	$40,810.78	74.12%
201910	100	128	$107,902.94	$0.00	$120.75	$120.75	$1.21	$18,837.53	$27,623.28	$20,383.97	$4,676.84	$71,521.62	$20,353.71	$91,997.29	85.26%
201911	96	122	$87,292.35	$0.00	$115.17	$115.17	$146.12	$170.50	$14,802.92	$18,099.34	$7,848.17	$40,920.93	$10,095.51	$51,277.73	58.74%
201912	96	122	$85,502.48	$0.00	$108.69	$108.69	$64.03	$4,433.00	$29,776.21	$23,006.68	$2,096.67	$59,312.56	$7,489.89	$66,975.17	78.33%
202001	95	121	$88,947.70	$0.00	$112.64	$112.64	$32.00	$1,364.00	$25,247.75	$4,862.67	$3,453.03	$34,927.45	$10,410.69	$45,482.78	51.13%
202002	96	122	$92,477.51	$0.00	$111.12	$111.12	$25.21	($17,976.53)	$3,644.77	$7,749.84	$4,109.67	($2,472.25)	$10,243.08	$7,907.16	8.55%
202003	95	121	$97,578.69	$0.00	$118.89	$118.89	$28.41	($1,860.18)	$1,756.75	$6,513.28	$1,796.81	$8,206.66	$11,772.40	$20,126.36	20.63%
202004	94	120	$89,173.37	$0.00	$115.70	$115.70	$31.46	$0.00	$1,666.86	$3,653.47	$3,368.37	$8,688.70	$13,684.25	$22,520.11	25.25%
202005	94	120	$96,667.99	$0.00	$110.22	$110.22	$36.52	($19,032.53)	($1,011.21)	$1,491.57	$496.77	($18,055.40)	$7,727.58	($10,181.08)	-10.53%
202006	94	120	$95,915.88	$0.00	$114.33	$114.33	$38.64	$0.00	$809.85	$8,284.62	$4,307.77	$13,402.24	$9,516.94	$23,072.15	24.05%
202007	93	119	$78,102.73	$0.00	$114.33	$114.33	$32.26	$71,642.46	$14,680.26	$13,279.01	$5,826.42	$105,428.15	$10,815.25	$116,389.99	149.02%
202008	94	122	$91,885.40	$0.00	$118.44	$118.44	$33.56	$0.00	$10,144.28	$8,820.15	$4,280.76	$23,245.19	$8,022.88	$31,420.07	34.19%
202009	97	124	$96,129.36	$0.00	$118.44	$118.44	$59.31	$0.00	$334.66	$7,399.90	$2,074.64	$9,809.20	$10,664.97	$20,651.92	21.48%
202010	80	98	$71,786.37	$0.00	$84.21	$84.21	$54.65	$13,903.82	($2,879.00)	$6,478.52	$3,501.86	$21,005.20	$9,116.11	$30,260.17	42.15%
202011	80	99	$74,738.41	$0.00	$91.06	$91.06	$54.65	$9,841.39	$19,222.90	$22,285.66	$4,002.64	$55,352.59	$8,685.18	$64,183.48	85.88%
202012	77	96	$71,624.30	$0.00	$83.74	$83.74	$62.81	$14,573.70	$12,599.44	$26,266.27	$5,939.54	$59,378.95	$8,315.88	$67,841.38	94.72%
202101	74	90	$69,161.21	$0.00	$81.88	$81.88	$60.34	$62,131.87	$14,078.62	$26,690.70	$3,523.61	$106,424.80	$6,268.29	$112,835.31	163.15%
202102	73	89	$68,352.38	$0.00	$78.63	$78.63	$43.05	$6,442.41	$11,205.03	$28,790.43	$2,637.49	$49,075.36	$5,991.24	$55,188.28	80.74%
202103	73	89	$66,238.49	$0.00	$76.83	$76.83	$85.78	$27,010.69	$5,852.79	$30,011.01	$12,154.45	$75,028.94	$9,235.00	$84,426.55	127.46%
202104	75	91	$70,732.59	$0.00	$80.06	$80.06	$85.78	$0.00	$16,269.14	$11,377.30	$2,927.51	$30,573.95	$7,522.92	$38,262.71	54.09%
202105	75	91	$66,830.61	$0.00	$80.06	$80.06	$25.62	$0.00	$21,563.73	$29,756.01	$3,911.91	$55,231.65	$7,351.10	$62,688.43	93.80%

202106	74	85	$64,959.67	$0.00	$71.23	$71.23	$10.71	$2,915.41	$55,552.67	$21,507.21	$4,319.08	$84,294.37	$10,796.80	$95,173.11	146.51%
202107	74	90	$62,796.19	$0.00	$70.33	$70.33	$18.36	$0.00	$10,852.33	$6,565.62	$2,603.79	$20,021.74	$8,622.59	$28,733.02	45.76%
202108	75	91	$68,612.02	$0.00	$83.25	$83.25	$19.92	$0.00	$7,954.13	$21,648.38	$3,313.41	$32,915.92	$5,911.47	$38,930.56	56.74%
202109	79	97	$71,295.09	$0.00	$87.91	$87.91	$29.39	$5,222.05	$70,930.34	$12,465.36	$2,133.59	$90,751.34	$12,545.43	$103,414.07	145.05%
Total	**2,836**	**3,626**	**$2,611,765.62**	**$0.00**	**$3,290.03**	**$3,290.03**	**$1,165.77**	**$589,649.85**	**$555,190.31**	**$513,353.53**	**$156,298.36**	**$1,814,492.05**	**$432,339.24**	**$2,251,287.09**	**86.20%**
Grouping Avg	**79**	**101**	**$72,549.05**	**$0.00**	**$91.39**	**$91.39**	**$32.38**	**$16,379.16**	**$15,421.95**	**$14,259.82**	**$4,341.62**	**$50,402.56**	**$12,009.42**	**$62,535.75**	**86.20%**
Monthly Avg	**79**	**101**	**$72,549.05**	**$0.00**	**$91.39**	**$91.39**	**$32.38**	**$16,379.16**	**$15,421.95**	**$14,259.82**	**$4,341.62**	**$50,402.56**	**$12,009.42**	**$62,535.75**	**86.20%**

Notes:
- Grand Total includes Medical FFS, Pharmacy FFS, Incentives and Capitation.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.
- Enrollment is recast to reflect retroactive adjustments.
- FFS = Fee For Service.
- MLR = Medical Loss Ratio.

LEON COUNTY SCHOOL DISTRICT

PLAN	AMMS	MONTH/ YEAR	CONTRACTS	MEMBERS	CLAIMS PAID	PREMIUM BILLED	PREMIUM PAID
Choice Plus	25Y017303	October 2018	41	105	$0.00	$9,573.58	$1,365.35
Choice	25E067902	October 2018	8	16	$1,043.60	$1,138.34	$1,483.22
Choice Plus	25Y017302	October 2018	1	1	$0.00	$98.32	$124.22
Choice	25E068002	October 2018	3	3	$0.00	$76.28	$612.59
Choice	25E067903	October 2018	48	148	$0.00	$9,055.18	$3,013.12
Choice	25E068003	October 2018	23	57	$0.00	$2,070.69	$2,203.14
Choice Plus	25Y017300	October 2018	501	918	$26,035.71	$81,756.54	$8,511.67
Choice	25E068001	October 2018	109	159	$2,422.24	$6,158.96	$1,134.71
Choice	25E067901	October 2018	291	405	$9,295.62	$28,850.16	$11,519.65
Choice	25E068000	October 2018	804	1457	$10,063.70	$57,288.50	$65,274.72
Choice Plus	25Y017301	October 2018	306	443	$11,201.24	$42,663.14	$16,783.57
Choice	25E067900	October 2018	1232	2454	$35,331.72	$168,705.81	$49,536.96
Choice Plus	25Y017300	November 2018	500	914	$23,964.03	$30,516.85	$0.00
Choice	25E067902	November 2018	7	15	$409.20	$645.03	$0.00
Choice	25E067900	November 2018	1242	2463	$41,729.60	$75,622.75	$0.00
Choice	25E068000	November 2018	817	1479	$15,488.24	$22,547.10	$0.00
Choice	25E067901	November 2018	290	404	$8,023.70	$12,980.35	$0.00
Choice	25E068001	November 2018	109	159	$2,103.07	$2,871.89	$0.00
Choice	25E068002	November 2018	2	2	$0.00	$36.32	$0.00
Choice Plus	25Y017302	November 2018	1	1	$0.00	$35.75	$0.00
Choice Plus	25Y017301	November 2018	307	445	$14,749.24	$16,127.32	$0.00
Choice	25E068003	November 2018	23	57	$0.00	$770.72	$0.00
Choice	25E067903	November 2018	48	148	$0.00	$4,115.94	$0.00
Choice Plus	25Y017303	November 2018	42	106	$0.00	$3,509.79	$0.00
Choice	25E067903	December 2018	48	148	$0.00	$4,115.94	$4,115.80
Choice Plus	25Y017301	December 2018	306	443	$10,359.88	$19,567.56	$16,379.11
Choice	25E068003	December 2018	23	57	$0.00	$941.17	$941.17
Choice Plus	25Y017303	December 2018	42	106	$0.00	$4,376.02	$4,375.85
Choice	25E068000	December 2018	817	1489	$16,797.95	$26,605.39	$26,187.99
Choice Plus	25Y017302	December 2018	1	1	$0.00	$44.69	$37.24
Choice	25E068001	December 2018	109	159	$2,201.38	$2,908.21	$2,375.11
Choice	25E068002	December 2018	2	2	$0.00	$36.32	$15.13
Choice	25E067901	December 2018	290	405	$5,328.80	$13,019.55	$10,747.46

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Choice	25E067900	December 2018	1231	2444	$47,296.41	$76,206.64	$76,416.83
Choice	25E067902	December 2018	8	20	$871.00	$517.42	$702.96
Choice Plus	25Y017300	December 2018	499	916	$27,199.73	$38,600.13	$37,998.49
Choice Plus	25Y017300	January 2019	500	918	$24,613.21	$37,401.22	$37,875.64
Choice	25E067902	January 2019	7	13	$334.00	$262.20	$0.00
Choice	25E067900	January 2019	1236	2454	$54,461.87	$76,077.89	$75,736.45
Choice	25E068000	January 2019	817	1485	$18,598.40	$25,914.40	$26,314.39
Choice	25E067901	January 2019	290	405	$13,613.50	$13,122.61	$10,754.55
Choice	25E068001	January 2019	109	159	$2,534.62	$2,853.73	$2,473.52
Choice	25E068002	January 2019	2	2	$0.00	$36.32	$0.00
Choice Plus	25Y017302	January 2019	1	1	$47.70	$44.69	$0.00
Choice Plus	25Y017301	January 2019	306	440	$12,930.69	$19,493.14	$16,479.90
Choice	25E068003	January 2019	23	57	$0.00	$941.17	$941.17
Choice Plus	25Y017303	January 2019	42	106	$0.00	$4,376.02	$4,375.85
Choice	25E067903	January 2019	48	148	$0.00	$4,115.94	$4,115.80
Choice	25E067903	February 2019	48	148	$0.00	$4,115.94	$4,446.56
Choice Plus	25Y017303	February 2019	42	106	$0.00	$4,376.02	$4,705.51
Choice	25E068003	February 2019	23	57	$0.00	$941.17	$1,012.44
Choice	25E067900	February 2019	1228	2441	$38,048.94	$75,816.65	$82,603.89
Choice Plus	25Y017301	February 2019	308	442	$15,207.78	$20,024.32	$35,025.50
Choice	25E068000	February 2019	814	1485	$13,572.61	$25,939.78	$28,172.62
Choice Plus	25Y017300	February 2019	498	913	$23,749.39	$36,392.06	$40,909.21
Choice	25E068002	February 2019	1	1	$96.80	$36.32	$76.10
Choice Plus	25Y017302	February 2019	2	2	$0.00	$220.25	$78.89
Choice	25E068001	February 2019	110	160	$1,823.95	$2,853.73	$5,075.97
Choice	25E067901	February 2019	293	408	$11,566.20	$13,220.78	$22,969.74
Choice	25E067902	February 2019	7	13	$0.00	$488.60	$575.22
Choice Plus	25Y017300	March 2019	497	910	$29,522.21	$37,315.23	$60,162.72
Choice	25E067902	March 2019	6	8	$166.80	$422.74	$991.11
Choice	25E067900	March 2019	1223	2427	$46,985.64	$75,821.46	$136,307.17
Choice	25E068000	March 2019	816	1481	$17,642.53	$26,116.04	$49,445.08
Choice	25E067901	March 2019	294	409	$11,030.30	$13,253.71	$25,724.73
Choice	25E068001	March 2019	110	160	$2,555.33	$2,853.73	$6,097.25
Choice	25E068002	March 2019	1	1	$0.00	$36.32	$129.23
Choice Plus	25Y017302	March 2019	2	2	$0.00	$132.47	$165.64
Choice Plus	25Y017301	March 2019	306	439	$11,602.34	$19,086.47	$32,752.22

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Choice	25E068003	March 2019	23	57	$0.00	$941.17	$1,764.23
Choice Plus	25Y017303	March 2019	42	106	$0.00	$4,376.02	$6,929.30
Choice	25E067903	March 2019	48	148	$0.00	$4,115.94	$7,406.32
Choice	25E067903	April 2019	48	148	$0.00	$4,115.94	$4,258.18
Choice Plus	25Y017303	April 2019	42	106	$0.00	$4,376.02	$4,780.23
Choice	25E067902	April 2019	3	4	$388.00	$160.54	$441.52
Choice	25E068003	April 2019	23	57	$0.00	$941.17	$939.90
Choice Plus	25Y017300	April 2019	495	909	$21,571.94	$36,802.00	$40,386.15
Choice	25E067900	April 2019	1227	2434	$55,043.84	$74,891.79	$77,641.19
Choice Plus	25Y017301	April 2019	307	440	$14,281.92	$19,582.52	$29,607.24
Choice	25E068000	April 2019	816	1479	$16,678.10	$25,929.86	$26,695.57
Choice	25E068002	April 2019	1	1	$0.00	$36.32	$37.68
Choice	25E068001	April 2019	110	160	$2,559.00	$2,819.23	$4,367.38
Choice Plus	25Y017302	April 2019	2	2	$0.00	$132.47	$239.30
Choice	25E067901	April 2019	293	407	$8,521.75	$13,220.78	$18,994.81
Choice Plus	25Y017300	May 2019	493	906	$27,785.82	$37,085.05	$34,972.44
Choice	25E067902	May 2019	2	3	$0.00	($37.67)	$147.94
Choice	25E067900	May 2019	1221	2430	$46,514.42	$75,354.04	$69,627.62
Choice	25E068000	May 2019	815	1480	$15,030.19	$25,974.66	$27,685.86
Choice	25E067901	May 2019	292	406	$15,155.20	$13,447.06	$13,740.83
Choice	25E068001	May 2019	109	159	$1,983.20	$2,835.54	$2,905.74
Choice	25E068002	May 2019	1	1	$0.00	$36.32	$20.79
Choice Plus	25Y017302	May 2019	2	2	$0.00	$132.47	$145.82
Choice Plus	25Y017301	May 2019	307	441	$17,112.37	$20,287.13	$20,325.87
Choice	25E068003	May 2019	23	57	$0.00	$941.10	$998.84
Choice	25E067903	May 2019	48	148	$0.00	$4,115.80	$3,803.86
Choice Plus	25Y017303	May 2019	42	106	$0.00	$4,376.02	$4,092.25
Choice	25E067903	June 2019	48	148	$0.00	$4,115.94	$5,077.76
Choice Plus	25Y017303	June 2019	42	106	$0.00	$4,376.02	$5,225.86
Choice	25E068003	June 2019	23	57	$0.00	$941.17	$948.52
Choice Plus	25Y017301	June 2019	307	441	$17,967.30	$19,627.21	$77.09
Choice	25E068002	June 2019	1	1	$0.00	$36.32	$36.13
Choice Plus	25Y017302	June 2019	2	2	$156.03	$132.47	$0.49
Choice	25E068001	June 2019	109	159	$2,368.40	$2,835.57	$2,832.31
Choice	25E067901	June 2019	292	403	$15,239.33	$13,220.78	$40.23
Choice	25E068000	June 2019	811	1474	$22,404.11	$26,012.66	$26,420.36

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Choice	25E067900	June 2019	1220	2426	$50,865.88	$75,487.06	$92,863.12
Choice	25E067902	June 2019	2	3	$0.00	$225.78	$0.68
Choice Plus	25Y017300	June 2019	493	905	$29,369.87	$36,827.54	$44,250.48
Choice Plus	25Y017300	July 2019	489	901	$25,031.52	$0.00	$37,781.77
Choice	25E067902	July 2019	2	3	$121.00	$0.00	$179.75
Choice	25E067900	July 2019	1215	2422	$55,585.55	$0.00	$77,026.10
Choice	25E067901	July 2019	293	404	$10,390.90	$0.00	$0.00
Choice	25E068001	July 2019	109	159	$3,108.13	$0.00	$0.00
Choice	25E068000	July 2019	807	1471	$21,415.40	$0.00	$23,353.59
Choice	25E068002	July 2019	1	1	$96.80	$0.00	$0.19
Choice Plus	25Y017302	July 2019	2	2	$0.00	$0.00	$101.86
Choice Plus	25Y017301	July 2019	306	438	$14,319.04	$0.00	$0.00
Choice	25E068003	July 2019	23	57	$0.00	$0.00	$845.13
Choice Plus	25Y017303	July 2019	43	107	$0.00	$0.00	$4,465.36
Choice	25E067903	July 2019	48	148	$0.00	$0.00	$4,217.94
Choice	25E068003	August 2019	23	57	$0.00	$0.00	$1.08
Choice	25E067903	August 2019	48	148	$0.00	$0.00	$5.58
Choice Plus	25Y017303	August 2019	43	107	$0.00	$0.00	($13.91)
Choice Plus	25Y017301	August 2019	305	437	$17,455.90	$0.00	$34,345.04
Choice	25E068001	August 2019	109	158	$2,470.50	$0.00	$1,204.90
Choice	25E068002	August 2019	1	1	$0.00	$0.00	$0.12
Choice Plus	25Y017302	August 2019	2	2	$0.00	$0.00	$61.95
Choice	25E068000	August 2019	807	1471	$16,815.30	$0.00	$120.63
Choice	25E067901	August 2019	293	404	$10,610.30	$0.00	$23,700.42
Choice	25E067900	August 2019	1216	2424	$48,244.94	$0.00	$287.16
Choice Plus	25Y017300	August 2019	489	901	$23,191.02	$0.00	$386.18
Choice	25E067902	August 2019	2	3	$0.00	$0.00	$109.34
Choice Plus	25Y017300	September 2019	489	901	$18,652.86	$0.05	$161.85
Choice	25E067902	September 2019	1	1	$0.00	($638.04)	$26.91
Choice	25E068000	September 2019	807	1471	$11,432.70	($275.39)	$39.61
Choice	25E067900	September 2019	1215	2423	$35,451.38	($193.84)	$35.14
Choice	25E067901	September 2019	293	404	$10,876.50	$521.49	$11,008.10
Choice	25E068001	September 2019	108	156	$1,339.95	($10.74)	$2,316.06
Choice Plus	25Y017302	September 2019	2	2	$0.00	$268.14	$47.71
Choice	25E068002	September 2019	1	1	$0.00	($109.55)	$5.19
Choice Plus	25Y017301	September 2019	305	437	$10,410.57	($288.81)	$16,092.55

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Choice	25E068003	September 2019	23	57	$0.00	$0.07	$1.22
Choice	25E067903	September 2019	48	148	$0.00	$0.14	$5.70
Choice Plus	25Y017303	September 2019	43	107	$0.00	$44.69	$10.15
Choice Plus	25Y017303	October 2019	71	182	$0.00	($1.61)	$304.98
Choice	25E067903	October 2019	73	222	$0.00	($1.27)	$258.49
Choice	25E068003	October 2019	39	98	$0.00	($0.23)	$58.99
Choice Plus	25Y017301	October 2019	325	464	$19,013.43	$0.00	($4,914.50)
Choice	25E068002	October 2019	2	2	$0.00	$0.00	($78.40)
Choice Plus	25Y017302	October 2019	3	3	$0.00	($526.68)	$362.82
Choice	25E068001	October 2019	108	155	$1,559.05	$0.00	($668.39)
Choice	25E067901	October 2019	314	434	$10,732.60	$0.00	($2,823.60)
Choice	25E068000	October 2019	884	1564	$18,047.11	($2.10)	$1,402.65
Choice	25E067900	October 2019	1026	2068	$41,288.70	$11.48	$4,541.77
Choice	25E067902	October 2019	1	1	$0.00	$0.00	($421.65)
Choice Plus	25Y017300	October 2019	582	1056	$29,009.18	($11.14)	$2,263.84
Choice Plus	25Y017300	November 2019	585	1061	$27,192.09	($1,375.71)	$0.00
Choice	25E067902	November 2019	1	1	$0.00	$0.00	$0.00
Choice	25E067900	November 2019	1030	2074	$35,888.79	($2,788.07)	$0.00
Choice	25E067901	November 2019	312	431	$10,705.67	$461.02	$0.00
Choice	25E068000	November 2019	882	1555	$10,483.31	($982.41)	$0.00
Choice	25E068001	November 2019	108	155	$1,506.19	$0.00	$0.00
Choice Plus	25Y017302	November 2019	3	3	$0.00	$526.68	$0.00
Choice	25E068002	November 2019	2	2	$0.00	$0.00	$0.00
Choice	25E068003	November 2019	39	98	$0.00	($35.51)	$0.00
Choice Plus	25Y017301	November 2019	324	463	$7,160.00	$0.00	$0.00
Choice Plus	25Y017303	November 2019	71	182	$0.00	($176.00)	$0.00
Choice	25E067903	November 2019	74	223	$0.00	($153.64)	$0.00
Choice	25E067903	December 2019	74	223	$0.00	$24,916.97	$18,330.61
Choice Plus	25Y017303	December 2019	71	182	$0.00	$30,159.84	$22,219.64
Choice Plus	25Y017301	December 2019	324	463	$12,021.74	$82,381.43	$51,277.09
Choice	25E068003	December 2019	39	98	$0.00	$6,601.22	$4,858.60
Choice	25E068002	December 2019	2	2	$0.00	$145.28	$86.75
Choice	25E068001	December 2019	108	155	$1,347.79	$11,059.85	$6,878.44
Choice Plus	25Y017302	December 2019	4	4	$106.53	$357.52	$213.50
Choice	25E068000	December 2019	888	1562	$13,979.04	$112,033.82	$82,532.41
Choice	25E067901	December 2019	312	431	$10,578.50	$56,181.83	$34,909.99

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Choice	25E067900	December 2019	1031	2083	$42,174.63	$263,717.47	$193,563.06
Choice	25E067902	December 2019	0	0	$0.00	$131.72	$78.65
Choice Plus	25Y017300	December 2019	597	1077	$30,203.64	$179,116.35	$131,624.60
Choice Plus	25Y017300	January 2020	596	1074	$40,560.69	$44,755.49	$44,730.36
Choice	25E067902	January 2020	0	0	$0.00	$32.93	$0.00
Choice	25E067900	January 2020	1032	2087	$51,486.73	$63,900.37	$63,862.40
Choice	25E067901	January 2020	313	433	$13,321.53	$14,161.28	$11,741.76
Choice	25E068000	January 2020	885	1559	$21,895.20	$27,745.02	$27,536.61
Choice Plus	25Y017302	January 2020	3	3	$156.00	$89.38	$0.00
Choice	25E068001	January 2020	108	155	$1,589.86	$3,064.94	$2,423.76
Choice	25E068002	January 2020	1	1	$0.00	$0.00	$0.00
Choice Plus	25Y017301	January 2020	322	459	$18,633.34	$20,597.31	$17,150.28
Choice Plus	25Y017303	January 2020	71	182	$0.00	$7,539.96	$7,464.83
Choice	25E067903	January 2020	74	223	$0.00	$6,237.34	$6,172.71
Choice	25E068003	January 2020	39	98	$0.00	$1,650.20	$1,633.35
Choice Plus	25Y017303	February 2020	72	184	$0.00	$7,884.40	$7,475.46
Choice	25E067903	February 2020	74	223	$0.00	$6,237.34	$6,115.75
Choice Plus	25Y017301	February 2020	324	462	$20,042.90	$20,731.38	$17,191.84
Choice	25E068003	February 2020	39	98	$0.00	$1,650.20	$1,617.66
Choice	25E068002	February 2020	2	5	$251.40	$159.08	$35.13
Choice Plus	25Y017302	February 2020	3	3	$502.80	$268.14	$125.35
Choice	25E068001	February 2020	109	156	$2,368.54	$2,889.20	$2,399.57
Choice	25E067901	February 2020	314	434	$10,779.00	$14,064.37	$11,739.91
Choice	25E068000	February 2020	884	1553	$16,184.50	$27,692.88	$27,382.76
Choice	25E067902	February 2020	0	0	$0.00	($98.79)	$46.18
Choice	25E067900	February 2020	1033	2077	$41,753.57	$65,360.80	$64,252.67
Choice Plus	25Y017300	February 2020	594	1065	$29,821.43	$44,709.20	$44,046.77
Choice Plus	25Y017300	March 2020	588	1057	$34,260.79	$43,667.92	$43,814.82
Choice	25E067902	March 2020	0	0	$0.00	$0.00	($58.97)
Choice	25E067900	March 2020	1031	2075	$46,038.53	$64,083.60	$64,158.38
Choice	25E068000	March 2020	878	1546	$17,713.60	$27,255.04	$27,446.61
Choice	25E067901	March 2020	315	436	$8,797.50	$14,030.54	$11,740.81
Choice Plus	25Y017302	March 2020	3	3	$0.00	($89.38)	$142.79
Choice	25E068002	March 2020	3	6	$0.00	$88.63	$55.34
Choice	25E068001	March 2020	110	158	$2,231.50	$2,889.24	$2,411.18
Choice	25E068003	March 2020	39	98	$0.00	$1,650.34	$1,629.87

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Choice Plus	25Y017301	March 2020	325	463	$10,464.15	$20,463.24	$17,111.04
Choice Plus	25Y017303	March 2020	73	188	$0.00	$7,796.62	$7,681.67
Choice	25E067903	March 2020	74	223	$0.00	$6,237.52	$6,159.90
Choice Plus	25Y017303	April 2020	73	188	$0.00	$0.00	$7,769.19
Choice	25E067903	April 2020	74	223	$0.00	$0.00	$6,220.50
Choice Plus	25Y017301	April 2020	324	462	$2,220.42	$0.00	$17,320.06
Choice	25E068003	April 2020	39	98	$0.00	$0.00	$1,646.09
Choice	25E068001	April 2020	110	158	$275.28	$0.00	$2,420.72
Choice	25E068002	April 2020	2	5	$0.00	$0.00	$117.68
Choice Plus	25Y017302	April 2020	2	2	$0.00	$0.00	$89.39
Choice	25E067901	April 2020	315	436	$1,757.90	$0.00	$11,829.21
Choice	25E068000	April 2020	873	1536	$3,011.30	$0.00	$27,201.03
Choice	25E067900	April 2020	1032	2071	$11,434.68	$0.00	$63,853.91
Choice Plus	25Y017300	April 2020	591	1072	$10,817.51	$0.00	$43,810.80
Choice Plus	25Y017300	May 2020	592	1073	$18,429.00	$45,172.79	$44,267.21
Choice	25E067900	May 2020	1031	2074	$23,252.92	$65,263.02	$63,982.48
Choice	25E068000	May 2020	869	1530	$10,024.60	$27,404.66	$26,857.60
Choice	25E067901	May 2020	314	435	$6,988.30	$13,428.29	$11,410.07
Choice	25E068001	May 2020	110	158	$419.90	$2,554.66	$2,210.63
Choice	25E068002	May 2020	2	5	$867.60	$143.11	$193.79
Choice Plus	25Y017302	May 2020	2	2	$0.00	$44.69	$102.89
Choice	25E068003	May 2020	39	98	$227.20	$1,650.34	$1,615.78
Choice Plus	25Y017301	May 2020	323	460	$6,995.44	$20,167.96	$17,101.24
Choice	25E067903	May 2020	75	229	$805.90	$6,365.13	$6,220.16
Choice Plus	25Y017303	May 2020	73	188	$4,110.50	$7,796.62	$7,618.98
Choice Plus	25Y017303	June 2020	73	189	$7,779.42	$15,505.46	$6,559.81
Choice	25E067903	June 2020	76	231	$3,460.33	$12,860.74	$5,470.54
Choice Plus	25Y017301	June 2020	323	460	$16,775.77	$41,120.11	$17,024.27
Choice	25E068003	June 2020	39	98	$696.40	$3,300.68	$1,391.29
Choice	25E068001	June 2020	110	158	$2,846.56	$5,817.78	$2,394.14
Choice	25E068002	June 2020	2	5	$0.00	$213.58	$162.48
Choice Plus	25Y017302	June 2020	2	2	$0.00	$89.38	$44.59
Choice	25E067901	June 2020	314	435	$11,107.90	$28,898.29	$11,971.94
Choice	25E067900	June 2020	1027	2070	$45,431.16	$130,838.63	$65,461.55
Choice	25E068000	June 2020	868	1526	$20,672.00	$54,863.80	$27,297.56
Choice Plus	25Y017300	June 2020	592	1072	$40,744.14	$89,448.21	$44,392.93

LEON COUNTY SCHOOL DISTRICT

Choice Plus	25Y017300	July 2020	590	1068	$47,787.30	$0.00	$44,544.18
Choice	25E067900	July 2020	1024	2068	$57,167.49	$323.10	$65,049.71
Choice	25E068000	July 2020	867	1525	$23,505.80	$0.00	$27,381.67
Choice	25E067901	July 2020	317	438	$10,151.50	$226.11	$12,213.63
Choice Plus	25Y017302	July 2020	2	2	$147.00	$0.00	$61.09
Choice	25E068002	July 2020	2	5	$78.00	$0.00	$145.98
Choice	25E068001	July 2020	111	159	$3,036.87	$0.00	$2,429.17
Choice Plus	25Y017301	July 2020	325	464	$10,253.78	$0.00	$17,449.25
Choice	25E068003	July 2020	39	98	$839.60	$0.00	$1,382.69
Choice	25E067903	July 2020	76	231	$3,679.46	$0.00	$5,444.96
Choice Plus	25Y017303	July 2020	72	187	$12,913.46	$0.00	$6,471.37
Choice	25E067903	August 2020	74	227	$2,859.96	$0.00	$4,633.78
Choice Plus	25Y017303	August 2020	72	187	$4,558.91	$0.00	$6,021.16
Choice Plus	25Y017301	August 2020	325	464	$12,023.60	$0.00	$16,979.66
Choice	25E068003	August 2020	38	95	$2,721.40	$0.00	$1,203.50
Choice	25E068002	August 2020	2	5	$0.00	$0.00	$87.37
Choice Plus	25Y017302	August 2020	2	2	$10.00	$0.00	($19.87)
Choice	25E068001	August 2020	112	160	$1,724.56	$0.00	$2,363.40
Choice	25E067901	August 2020	316	438	$9,560.04	$0.00	$11,832.94
Choice	25E067900	August 2020	1023	2067	$42,863.42	$0.00	$111.73
Choice	25E068000	August 2020	867	1525	$15,316.70	$0.00	$43.37
Choice Plus	25Y017300	August 2020	589	1067	$28,812.41	$0.00	$137.99
Choice Plus	25Y017300	September 2020	596	1080	$22,812.72	$43,135.93	$3,966.38
Choice	25E068000	September 2020	880	1541	$13,067.81	$27,909.82	$2,320.49
Choice	25E067901	September 2020	315	436	$13,428.95	$14,508.97	$12,078.53
Choice	25E067900	September 2020	1030	2077	$38,856.18	$64,353.96	$5,620.90
Choice Plus	25Y017302	September 2020	2	2	$0.00	$491.59	$0.00
Choice	25E068002	September 2020	2	5	$0.00	($265.89)	$244.31
Choice	25E068001	September 2020	111	159	$3,990.00	$2,872.54	$2,458.31
Choice Plus	25Y017301	September 2020	326	465	$11,473.92	$20,182.12	$17,109.78
Choice Plus	25Y017303	September 2020	72	187	$8,468.48	$7,879.32	$6.13
Choice	25E067903	September 2020	74	227	$3,990.66	$6,174.96	$19.82
Choice	25E068003	September 2020	38	95	$1,566.00	$1,282.95	$99.88
Choice	25E068003	October 2020	36	96	$1,062.00	$1,631.24	$0.00
Choice	25E067903	October 2020	76	224	$2,046.08	$6,294.56	$0.00
Choice Plus	25Y017303	October 2020	74	194	$5,588.83	$7,879.32	$0.00

LEON COUNTY SCHOOL DISTRICT

Choice Plus	25Y017301	October 2020	341	486	$11,945.23	$22,415.48	$17,551.17
Choice	25E068001	October 2020	117	169	$2,603.38	$3,264.98	$2,498.11
Choice	25E068002	October 2020	4	11	$0.00	$159.08	$0.00
Choice Plus	25Y017302	October 2020	4	4	$0.00	$44.69	$0.00
Choice	25E067901	October 2020	334	469	$11,720.85	$16,443.91	$12,797.75
Choice	25E067900	October 2020	1004	2007	$37,344.32	$63,850.21	$658.78
Choice	25E068000	October 2020	850	1504	$16,372.50	$28,013.28	$146.59
Choice Plus	25Y017300	October 2020	575	1042	$24,302.74	$44,507.38	($673.49)
Choice	25E067902	October 2020	2	3	$0.00	$0.00	$0.00
Choice Plus	25Y017300	November 2020	575	1044	$25,519.79	$43,113.06	$43,119.30
Choice	25E067902	November 2020	3	7	$0.00	$294.48	$0.00
Choice	25E067900	November 2020	1010	2008	$34,228.46	$63,340.40	$62,930.41
Choice	25E068000	November 2020	855	1513	$13,112.57	$27,145.70	$27,457.62
Choice	25E067901	November 2020	337	473	$9,265.65	$15,728.50	$12,753.22
Choice Plus	25Y017302	November 2020	4	4	$0.00	$312.83	$424.87
Choice	25E068001	November 2020	117	169	$3,525.30	$3,086.92	$2,517.42
Choice	25E068002	November 2020	4	11	$692.50	$706.85	($77.00)
Choice Plus	25Y017301	November 2020	343	490	$9,956.99	$22,243.40	$17,892.04
Choice	25E068003	November 2020	36	96	$2,384.70	$1,631.22	$993.01
Choice	25E067903	November 2020	76	224	$2,525.71	$6,240.19	$5,273.92
Choice Plus	25Y017303	November 2020	74	193	$6,758.78	$7,879.32	$6,509.25
Choice	25E067903	December 2020	75	222	$2,852.78	$6,076.80	$5,141.12
Choice	25E068003	December 2020	36	96	$1,849.00	$1,613.06	$1,314.55
Choice Plus	25Y017303	December 2020	74	193	$3,979.78	$7,636.02	$6,491.57
Choice Plus	25Y017301	December 2020	345	494	$21,653.58	$21,799.70	$17,951.95
Choice	25E068001	December 2020	120	172	$1,917.50	$3,123.24	$2,549.42
Choice	25E068002	December 2020	4	11	$167.20	$247.16	$64.40
Choice Plus	25Y017302	December 2020	4	4	$0.00	$134.07	$154.92
Choice	25E067901	December 2020	339	476	$10,389.42	$15,565.54	$12,799.97
Choice	25E067900	December 2020	1013	2012	$43,952.17	$63,963.95	$63,613.82
Choice	25E068000	December 2020	845	1499	$14,585.95	$27,290.84	$27,635.10
Choice Plus	25Y017300	December 2020	571	1039	$27,307.16	$43,850.24	$43,992.04
Choice	25E067902	December 2020	3	7	$343.00	$480.99	$104.80
Choice	25E067902	January 2021	3	7	$211.60	$225.77	$0.00
Choice Plus	25Y017300	January 2021	571	1040	$33,864.86	$43,116.50	$43,002.73
Choice	25E067901	January 2021	340	477	$10,027.45	$15,565.54	$54,718.64

LEON COUNTY SCHOOL DISTRICT

Choice	25E068000	January 2021	842	1498	$17,407.10	$27,437.39	$26,817.11
Choice	25E067900	January 2021	1013	2013	$47,021.73	$63,187.85	$62,639.80
Choice Plus	25Y017302	January 2021	4	4	$0.00	$134.07	$0.00
Choice	25E068002	January 2021	5	11	$251.40	$194.72	$0.00
Choice	25E068001	January 2021	118	169	$2,177.58	$3,123.24	$10,931.05
Choice Plus	25Y017301	January 2021	344	493	$20,505.31	$21,933.77	$77,097.58
Choice Plus	25Y017303	January 2021	73	191	$5,553.48	$7,622.66	$6,459.04
Choice	25E067903	January 2021	74	221	$2,895.66	$6,142.03	$5,167.25
Choice	25E068003	January 2021	35	95	$696.00	$1,577.42	$1,364.18
Choice Plus	25Y017303	February 2021	73	191	$7,253.29	$7,710.44	$0.00
Choice	25E068003	February 2021	34	93	$723.50	$1,577.42	$0.00
Choice	25E067903	February 2021	74	221	$5,817.16	$6,109.10	$0.00
Choice Plus	25Y017301	February 2021	345	494	$14,067.93	$21,933.77	$17,424.16
Choice	25E068001	February 2021	120	172	$1,451.82	$3,176.36	$2,566.62
Choice	25E068002	February 2021	5	11	$0.00	$176.56	$0.00
Choice Plus	25Y017302	February 2021	5	5	$0.00	$134.07	$0.00
Choice	25E067900	February 2021	1006	1996	$39,569.94	$62,766.10	$0.00
Choice	25E068000	February 2021	839	1495	$14,132.30	$26,763.76	$0.00
Choice	25E067901	February 2021	343	483	$11,210.65	$16,348.30	$13,410.41
Choice Plus	25Y017300	February 2021	570	1035	$26,740.06	$45,130.66	$0.00
Choice	25E067902	February 2021	4	9	$990.00	$356.23	$0.00
Choice	25E067902	March 2021	4	9	$286.00	$291.02	$0.00
Choice Plus	25Y017300	March 2021	563	1020	$39,196.23	$42,647.35	$86,537.91
Choice	25E067901	March 2021	344	485	$14,787.55	$15,827.59	$12,994.79
Choice	25E068000	March 2021	835	1488	$18,205.58	$26,098.31	$52,900.28
Choice	25E067900	March 2021	999	1987	$35,377.62	$61,745.18	$124,259.42
Choice Plus	25Y017302	March 2021	4	4	$549.00	$311.39	$0.00
Choice	25E068002	March 2021	5	11	$0.00	$285.54	$0.00
Choice	25E068001	March 2021	120	172	$1,693.10	$3,052.68	$2,481.91
Choice Plus	25Y017301	March 2021	345	493	$18,238.64	$21,981.66	$18,073.05
Choice	25E067903	March 2021	73	220	$3,626.36	$6,109.29	$10,122.53
Choice Plus	25Y017303	March 2021	73	191	$5,673.36	$7,541.56	$12,718.27
Choice	25E068003	March 2021	34	93	$652.80	$1,577.57	$2,628.71
Choice Plus	25Y017302	April 2021	3	3	$0.00	$89.38	$151.57
Choice	25E068003	April 2021	34	93	$1,227.90	$1,432.14	$1,317.38
Choice Plus	25Y017301	April 2021	347	495	$16,031.98	$21,790.01	$18,081.34

LEON COUNTY SCHOOL DISTRICT

Choice Plus	25Y017303	April 2021	72	187	$4,159.03	$7,139.35	$6,585.82
Choice	25E067903	April 2021	73	220	$4,080.26	$6,046.72	$5,464.53
Choice	25E068002	April 2021	5	11	$189.60	$212.88	$174.25
Choice	25E068001	April 2021	120	172	$1,686.20	$3,123.24	$2,595.19
Choice	25E067900	April 2021	992	1979	$42,360.48	$60,496.96	$64,368.17
Choice	25E068000	April 2021	830	1477	$13,977.40	$21,967.00	$24,970.16
Choice	25E067901	April 2021	344	485	$9,587.76	$15,924.62	$13,252.65
Choice Plus	25Y017300	April 2021	560	1015	$29,877.33	$36,390.61	$41,038.10
Choice	25E067902	April 2021	4	9	$324.50	$291.00	$236.08
Choice	25E067902	May 2021	4	9	$62.50	$291.00	$186.58
Choice Plus	25Y017300	May 2021	559	1013	$30,424.94	$41,632.16	$0.00
Choice	25E067901	May 2021	344	484	$7,997.74	$16,052.23	$28,007.97
Choice	25E068000	May 2021	827	1470	$14,727.50	$26,140.81	$0.00
Choice	25E067900	May 2021	992	1986	$34,898.16	$62,239.84	$0.00
Choice	25E068002	May 2021	4	10	$124.80	$176.56	$137.44
Choice	25E068001	May 2021	121	173	$2,900.20	$3,123.92	$5,472.35
Choice Plus	25Y017302	May 2021	3	3	$0.00	$134.07	$112.27
Choice	25E067903	May 2021	74	223	$4,172.27	$6,301.94	$401.84
Choice Plus	25Y017303	May 2021	71	186	$6,618.31	$7,496.87	$498.78
Choice Plus	25Y017301	May 2021	347	494	$15,988.21	$21,773.17	$38,317.62
Choice	25E068003	May 2021	34	93	$1,546.60	$1,559.26	$102.83
Choice	25E068003	June 2021	34	93	$570.40	$1,559.26	$1,286.93
Choice	25E067903	June 2021	75	228	$4,641.77	$6,396.62	$5,055.03
Choice Plus	25Y017303	June 2021	72	187	$6,925.49	$7,496.87	$6,206.77
Choice Plus	25Y017301	June 2021	347	494	$12,353.64	$21,855.76	$18,217.29
Choice Plus	25Y017302	June 2021	3	3	$0.00	$134.07	$170.07
Choice	25E068001	June 2021	120	171	$3,135.41	$2,760.72	$2,224.61
Choice	25E068002	June 2021	4	10	$454.80	$194.72	$214.67
Choice	25E067900	June 2021	988	1978	$42,404.81	$61,698.07	$62,464.32
Choice	25E067901	June 2021	346	491	$11,542.80	$15,918.17	$13,525.35
Choice	25E068000	June 2021	823	1459	$16,984.50	$26,071.48	$26,306.61
Choice Plus	25Y017300	June 2021	557	1008	$26,457.43	$41,861.45	$42,140.46
Choice	25E067902	June 2021	3	8	$510.50	$225.14	$297.03
Choice	25E067902	July 2021	3	8	$366.50	$0.00	$244.45
Choice Plus	25Y017300	July 2021	553	1003	$31,244.86	$223.44	$41,686.09
Choice	25E068000	July 2021	818	1448	$21,390.50	$0.00	$25,967.93

LEON COUNTY SCHOOL DISTRICT

Choice	25E067900	July 2021	982	1962	$43,908.61	$1,276.10	$62,282.16
Choice	25E067901	July 2021	347	492	$8,183.90	$0.00	$13,277.42
Choice	25E068001	July 2021	120	171	$2,147.14	$0.00	$2,554.15
Choice Plus	25Y017302	July 2021	3	3	$0.00	$0.00	$137.53
Choice	25E068002	July 2021	4	10	$542.70	$0.00	$178.13
Choice	25E067903	July 2021	73	226	$4,408.57	$0.00	$5,186.37
Choice Plus	25Y017303	July 2021	72	187	$5,369.99	$0.00	$6,432.53
Choice	25E068003	July 2021	34	93	$1,771.10	$0.00	$1,517.52
Choice Plus	25Y017301	July 2021	347	494	$15,143.16	$0.00	$17,994.56
Choice Plus	25Y017301	August 2021	344	491	$14,198.42	$0.00	($39,846.36)
Choice	25E068003	August 2021	31	88	$839.40	$0.00	$1,309.83
Choice Plus	25Y017302	August 2021	3	3	$0.00	$446.90	$101.96
Choice Plus	25Y017303	August 2021	72	187	$4,139.26	$0.00	$6,680.00
Choice	25E067903	August 2021	73	226	$2,969.93	$0.00	$5,556.81
Choice Plus	25Y017300	August 2021	553	1003	$22,988.74	$0.00	$34,993.04
Choice	25E068002	August 2021	3	7	$0.00	$0.00	$132.04
Choice	25E068001	August 2021	121	173	$3,936.73	$0.00	($5,640.47)
Choice	25E068000	August 2021	818	1448	$12,181.60	$108.96	$21,735.20
Choice	25E067900	August 2021	984	1966	$38,401.18	$255.22	$52,375.13
Choice	25E067901	August 2021	346	491	$14,165.80	($391.05)	($29,576.25)
Choice	25E067902	August 2021	3	8	$62.50	$0.00	$181.21
Choice	25E067902	September 2021	3	8	$62.50	$322.08	$0.00
Choice Plus	25Y017300	September 2021	554	1005	$18,244.19	$63,586.48	$35,205.61
Choice	25E067901	September 2021	346	491	$14,870.39	$20,598.62	$4,910.80
Choice	25E067900	September 2021	986	1968	$31,943.69	$86,286.91	$5,479.46
Choice	25E068000	September 2021	818	1448	$12,473.40	$33,129.65	$2,700.59
Choice	25E068001	September 2021	121	173	$2,810.88	$3,988.64	$973.77
Choice	25E068002	September 2021	3	7	$0.00	$110.62	$0.00
Choice	25E067903	September 2021	73	226	$2,410.73	$126.33	$90,410.48
Choice Plus	25Y017303	September 2021	72	187	$4,694.06	($1,241.90)	$6,524.47
Choice Plus	25Y017302	September 2021	3	3	$0.00	($49.66)	$0.00
Choice	25E068003	September 2021	31	88	$704.80	$0.00	$1,489.77
Choice Plus	25Y017301	September 2021	344	491	$12,831.30	$28,472.52	$6,888.76
		Group Total	**125550**	**228869**	**$4,314,658.48**	**$5,876,523.48**	**$6,018,807.33**

LEON COUNTY SCHOOL DIST 10 – E4428298

PAID YR	Product	Claims	Paid
2017	Disability 1000	46	$88,286.67
2018	Disability 1000	61	$99,303.32
2019	Disability 1000	47	$100,979.97
Grand Total		**154**	**$288,569.96**

EXPERIENCE REPORT RUN DATE 10/25/2021

LEON COUNTY SCHOOL BOARD
Contract 164520

Term Life

From	01/01/2019	01/01/2020	01/01/2021	10/01/2018
To	12/31/2019	12/31/2020	09/30/2021	09/30/2021
Earned Premium	643,464	608,197	456,399	1,857,820
Incurred Claims				
.Paid Claims	922,000	872,000	624,500	2,523,500
.Change in IBNR Reserves	1,214	-6,931	-2,677	126,673
.Change in Reported Reserves	0	71,500	-71,500	0
.Conversion Charges	0	4,500	0	4,500
Incurred Claims	923,214	941,069	550,323	2,654,673
Expenses				
.Commissions	67,678	74,808	52,024	195,874
.Fees	0	0	0	0
.Premium Tax	11,261	10,645	7,986	32,512
.Other Expenses	137,751	125,595	93,511	502,125
Total Expenses	216,690	211,048	153,521	730,511
Result	-496,440	-543,920	-247,445	-1,527,364

YOUR PRODUCER MAY RECEIVE CONTINGENT COMPENSATION BASED ON THE AMOUNT OF PREMIUM YOU PAID. THE CONTINGENT COMPENSATION, IF ANY, IS NOT INCLUDED IN THIS REPORT BECAUSE THE STANDARD DOES NOT CHARGE TO YOUR EXPERIENCE THE AMOUNT PAID ON YOUR BEHALF. CONTINGENT COMPENSATION INFORMATION IS AVAILABLE UPON REQUEST.

Standard Insurance Company TMP

EXPERIENCE REPORT RUN DATE 10/25/2021

LEON COUNTY SCHOOL BOARD
Contract 164520

Dependent Life

From	01/01/2019	01/01/2020	01/01/2021	10/01/2018
To	12/31/2019	12/31/2020	09/30/2021	09/30/2021
Earned Premium	58,138	62,199	42,273	176,242
Incurred Claims				
.Paid Claims	0	25,000	115,000	150,000
.Change in IBNR Reserves	-4	5	-286	3,188
.Change in Reported Reserves	0	0	0	0
.Conversion Charges	0	0	250	250
Incurred Claims	-4	25,005	114,964	153,438
Expenses				
.Commissions	8,613	10,976	6,809	26,533
.Fees	0	0	0	0
.Premium Tax	1,018	1,087	742	3,085
.Other Expenses	11,150	11,882	9,519	45,781
Total Expenses	20,781	23,945	17,070	75,399
Result	37,361	13,249	-89,761	-52,595

YOUR PRODUCER MAY RECEIVE CONTINGENT COMPENSATION BASED ON THE AMOUNT OF PREMIUM YOU PAID. THE CONTINGENT COMPENSATION, IF ANY, IS NOT INCLUDED IN THIS REPORT BECAUSE THE STANDARD DOES NOT CHARGE TO YOUR EXPERIENCE THE AMOUNT PAID ON YOUR BEHALF. CONTINGENT COMPENSATION INFORMATION IS AVAILABLE UPON REQUEST.

Standard Insurance Company TMP

EXPERIENCE REPORT RUN DATE 10/25/2021

LEON COUNTY SCHOOL BOARD
Contract 164520

Accidental Death and Dismemberment

From	01/01/2019	01/01/2020	01/01/2021	10/01/2018
To	12/31/2019	12/31/2020	09/30/2021	09/30/2021
Earned Premium	46,201	60,907	51,819	168,537
Incurred Claims				
.Paid Claims	50,000	60,000	0	110,000
.Change in IBNR Reserves	137	-415	112	3,155
.Change in Reported Reserves	0	0	0	0
.Conversion Charges	0	0	0	0
Incurred Claims	50,137	59,585	112	113,155
Expenses				
.Commissions	4,831	8,124	6,594	19,611
.Fees	0	0	0	0
.Premium Tax	808	1,066	906	2,948
.Other Expenses	10,939	12,734	9,422	42,292
Total Expenses	16,578	21,924	16,922	64,851
Result	-20,514	-20,602	34,785	-9,469

YOUR PRODUCER MAY RECEIVE CONTINGENT COMPENSATION BASED ON THE AMOUNT OF PREMIUM YOU PAID. THE CONTINGENT COMPENSATION, IF ANY, IS NOT INCLUDED IN THIS REPORT BECAUSE THE STANDARD DOES NOT CHARGE TO YOUR EXPERIENCE THE AMOUNT PAID ON YOUR BEHALF. CONTINGENT COMPENSATION INFORMATION IS AVAILABLE UPON REQUEST.

Standard Insurance Company TMP

EXPERIENCE REPORT RUN DATE 10/25/2021

LEON COUNTY SCHOOL BOARD
Contract 164520

Short Term Disability

From	10/01/2019	01/01/2020	01/01/2021	10/01/2019
To	12/31/2019	12/31/2020	09/30/2021	09/30/2021
Earned Premium	65,740	271,581	190,914	528,235
Incurred Claims				
.Paid Claims	20,095	176,426	138,460	334,981
.Change in IBNR Reserves	29,450	-885	-1,489	27,076
.Change in Reported Reserves	0	0	0	0
.Employer Paid FICA	346	441	0	787
Incurred Claims	49,891	175,982	136,971	362,844
Expenses				
.Commissions	220	48,919	30,689	79,829
.Fees	95	41,198	13,299	54,592
.Premium Tax	1,150	4,753	3,341	9,244
.Other Expenses	72,489	87,536	62,641	222,666
Total Expenses	73,955	182,406	109,970	366,331
Result	-58,105	-86,807	-56,028	-200,940

YOUR PRODUCER MAY RECEIVE CONTINGENT COMPENSATION BASED ON THE AMOUNT OF PREMIUM YOU PAID. THE CONTINGENT COMPENSATION, IF ANY, IS NOT INCLUDED IN THIS REPORT BECAUSE THE STANDARD DOES NOT CHARGE TO YOUR EXPERIENCE THE AMOUNT PAID ON YOUR BEHALF. CONTINGENT COMPENSATION INFORMATION IS AVAILABLE UPON REQUEST.

Standard Insurance Company TMP

EXPERIENCE REPORT RUN DATE 10/25/2021

LEON COUNTY SCHOOL BOARD
Contract 164520

Long Term Disability

From	01/01/2019	01/01/2020	01/01/2021	10/01/2018
To	12/31/2019	12/31/2020	09/30/2021	09/30/2021
Earned Premium	127,671	103,663	82,080	342,717
Incurred Claims				
.Paid Claims	5,816	53,887	63,807	123,510
.Change in IBNR Reserves	614	-23,330	-572	22,042
.Change in Reported Reserves	15,401	265,354	-86,386	194,369
.Employer Paid FICA	0	0	0	0
Incurred Claims	21,831	295,911	-23,151	339,921
Expenses				
.Commissions	18,826	19,604	12,845	51,545
.Fees	0	0	0	0
.Premium Tax	2,234	1,815	1,436	5,998
.Other Expenses	36,486	33,462	28,461	133,487
Total Expenses	57,546	54,881	42,742	191,030
Result	48,293	-247,129	62,489	-188,234

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Standard Insurance Company TMP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, at www.capitalhealth.com/sbc. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-850-383-3311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $2,000 single coverage / $4,500 family coverage. Pharmacy: $4,600 single coverage $8,700 family coverage.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers.	Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Some specialists require a referral. For a list of specialists that require a referral go to capitalhealth.com/ReferralAndAuth	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: $15 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth–Services provided by network providers through remote access technology including web and mobile devices.
	Specialist visit	Office: $40 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth–Services provided by network providers through remote access technology including web and mobile devices.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$100 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://capitalhealth.com/members/about-your-	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
	Tier 2 drugs	$30/30-day supply $60/60-day supply $90/90-day supply (retail & mail order)	Not Covered	

medications	Tier 3 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
	Specialty drugs	$50 /30-day supply	Not Covered	Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $100 / visit Hospital: $250 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$40 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$300 / visit $250 / observation	$300 / visit $250 / observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status, an additional copayment may apply based on services rendered.
	Emergency medical transportation	$100 / transport	$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: $25 / visit Telehealth: $25 / visit Amwell: $15 / visit	Urgent care center: $25 / visit Telehealth: $25 / visit Amwell: $15 / visit	Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission $250 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted $40 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.

If you are pregnant	Office visits	$40 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$250 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, etc.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic care	• Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-383-3311, 1-877-247-6512.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other copayment	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other copayment	**$50**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 single coverage. $5,000 family coverage.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible. Amwell services and Retail pharmacy prescription drugs are not subject to the deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $4,000 single coverage / $8,500 family coverage. Pharmacy: $2,850 single coverage $5,200 family coverage.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.capitalhealth.com or call 850-383-3311 for a list of network providers.	Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to	Yes. Some specialists require a referral. For a list of specialists	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Important Questions	Answers	Why This Matters:
see a specialist?	that require a referral go to capitalhealth.com/ReferralAndAuth	

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office: $15 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Telehealth–Services provided by network providers through remote access technology including web and mobile devices.
	Specialist visit	Office: $75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc. Prior authorization required for certain specialist visits. Your benefits/services may be denied. Telehealth–Services provided by network providers through remote access technology including web and mobile devices.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$250 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown. Prior authorization and/or quantity limits may apply. Your

prescription drug coverage is available at https://capitalhealth.com/members/about-your-medications	Tier 2 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	benefits/services may be denied.
	Tier 3 drugs	$100/30-day supply $200/60-day supply $300/90-day supply (retail & mail order)	Not Covered	Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
	Specialty drugs	$100 /30-day supply	Not Covered	Limited to 30-day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limits may apply. Your benefits/services may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $250 / visit Hospital: $500 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$75 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$500 / visit $500 / observation	$500 / visit $500 / observation	Copayment is waived if inpatient admission occurs; however if moved to observation status an additional copayment may apply based on services rendered. .
	Emergency medical transportation	$250 / transport	$250 / transport	Covered if medically necessary.
	Urgent care	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 / visit	Urgent care center: $50 / visit Telehealth: $50 / visit Amwell: $15 / visit	Telehealth – Services are provided by network providers through remote access technology including the web and mobile devices.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 / admission $500 / observation	Not Covered	Prior authorization required. Your benefits /services may be denied.
	Physician/surgeon fees	No Charge if admitted $75 /provider for observation	Not Covered	————none————

If you need mental health, behavioral health, or substance abuse services	Outpatient services	$75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Inpatient services	$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you are pregnant	Office visits	$75 / visit	Not Covered	Cost share applies regardless of place of service, including office, telehealth, etc.
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$500 / admission	Not Covered	Prior authorization required. Your benefits /services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$75 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date. Cost share applies regardless of place of service, including office, telehealth, school, etc.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Capital Health Plan at 1-850-383-3311. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 850-383-3311, 1-877-247-6512.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-383-3311, 1-877-247-6512.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,500**
Specialist copayment	**$75**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,500**
Specialist copayment	**$75**
Hospital (facility) copayment	**$500**
Other copayment	**$100**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,320**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,500**
Specialist copayment	**$75**
Hospital (facility) copayment	**$500**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,000** Per Person. Out-of-Network: **$10,000** Per Person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,550** Per Person. Out-Of-Network: **$10,000** Per Person.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 10% Coinsurance/Virtual Visits: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance/Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Specialist visit	Deductible + 10% Coinsurance/Virtual Visits: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance/Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Preventive care/screening/ immunization	No Charge	20% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 10% Coinsurance	Ambulatory Surgical Center: Deductible + 20% Coinsurance/ Hospital: In-Network Deductible + 10% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
If you have a hospital	Facility fee (e.g., hospital room)	Deductible + 10%	Deductible + 20%	Inpatient Rehab Services limited to 30 days.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
stay		Coinsurance	Coinsurance	
	Physician/surgeon fees	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network designated providers.
	Inpatient services	Deductible + 10% Coinsurance	Physician Services: In-Network Deductible + 10% Coinsurance/ Hospital: Deductible + 20% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

——————————To see examples of how this plan might cover costs for a sample medical situation, see the next section.——————————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$10
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$3,670**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákoninzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: **$20,000** Per Person/**$20,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,850** Per Person/**$13,100** Family. Out-Of-Network: **$20,000** Per Person/**$20,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 10% Coinsurance/Virtual Visits: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance/Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Specialist visit	Deductible + 10% Coinsurance/Virtual Visits: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance/Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Preventive care/screening/ immunization	No Charge	20% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 10% Coinsurance	Ambulatory Surgical Center: Deductible + 20% Coinsurance/ Hospital: In-Network Deductible + 10% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	Deductible + 10% Coinsurance	Deductible + 10% Coinsurance	————none————
If you have a hospital	Facility fee (e.g., hospital room)	Deductible + 10%	Deductible + 20%	Inpatient Rehab Services limited to 30 days.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
stay		Coinsurance	Coinsurance	
	Physician/surgeon fees	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Deductible + 20% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network designated providers.
	Inpatient services	Deductible + 10% Coinsurance	Physician Services: In-Network Deductible + 10% Coinsurance/ Hospital: Deductible + 20% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	Deductible + 10% Coinsurance	Deductible + 20% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

——————————To see examples of how this plan might cover costs for a sample medical situation, see the next section.——————————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,870**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$5,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist Coinsurance	10%
Hospital (facility) Coinsurance	10%
Other Coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákoninzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$500** Per Person/**$1,500** Family. Out-of-Network: Combined with In-Network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$2,500** Per Person/**$7,500** Family. Out-Of-Network: Combined with In-Network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: No Charge/ Primary Care Visits: $15 Copay per Visit/ Virtual Visits: No Charge	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Specialist visit	Value Choice Specialist: $20 Copay per Visit/ Specialist: $30 Copay per Visit/ Virtual Visits: $40 Copay per Visit	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $20 Copay per Visit/ Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $75 Copay per Visit	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Physician Office: $30 Copay per Visit/ Independent Diagnostic Testing Center: $75 Copay per Visit	Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$15 Copay per Prescription at retail, $30 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$30 Copay per Prescription at retail, $60 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$50 Copay per Prescription at retail, $100 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $75 Copay per Visit/ Hospital Option 1: $100 Copay per Visit	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: $300 Copay per Visit	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 10% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	$100 Copay per Visit + 10% Coinsurance	$100 Copay per Visit + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	Value Choice Provider: No Charge - Visits 1-2 $45 Copay for	Value Choice Provider: Not Covered/ Urgent Care Visits: Deductible + $30	————none————

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		remaining Visits/ Urgent Care Visits: $30 Copay per Visit	Copay per Visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: $400 Copay per Admission	Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge/ Specialist Virtual Visits: No Charge	Physician Office: 40% Coinsurance/ Specialist Virtual Visits: Not Covered/ Hospital: $300 Copay per Visit	Virtual Visit services are only covered for In-Network designated providers.
	Inpatient services	No Charge	Physician Services: No Charge/ Hospital: 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$30 Copay on initial Visit	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: $400 Copay per Admission	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	$30 Copay per Visit	Physician Office: Deductible + 40% Coinsurance/ Outpatient Rehab Center: Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10%	Deductible + 40%	Coverage limited to 60 days.

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Coinsurance	Coinsurance	
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits

For more information about limitations and exceptions, see the plan or policy document at www.floridablue.com/plancontracts/group.

Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist Copayment	$30
Hospital (facility) Copayment	$400
Other No Charge	$0

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist Copayment	$30
Hospital (facility) Copayment	$400
Other Coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,130**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist Copayment	$30
Hospital (facility) Copayment	$400
Other Copayment	$100

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,000**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.

Section 1557 Notification: Discrimination is Against the Law

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO (collectively, "Florida Blue"), Florida Combined Life and the Blue Cross and Blue Shield Federal Employee Program® (FEP) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue, Florida Blue HMO, Florida Blue Preferred HMO, Florida Combined Life and FEP:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact:

- Florida Blue (health and vision coverage): 1-800-352-2583
- Florida Combined Life (dental, life, and disability coverage): 1-888-223-4892
- Federal Employee Program: 1-800-333-2227

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Florida Blue (including FEP members):
Section 1557 Coordinator
4800 Deerwood Campus Parkway, DCC 1-7
Jacksonville, FL 32246
1-800-477-3736 x29070
1-800-955-8770 (TTY)
Fax: 1-904-301-1580
section1557coordinator@floridablue.com

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
1-800-955-8770 (TTY)
civilrightscoordinator@fclife.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). FEP: Llame al 1-800-333-2227

ATANSYON: Si w pale Kreyòl ayisyen, ou ka resevwa yon èd gratis nan lang pa w. Rele 1-800-352-2583 (pou moun ki pa tande byen: 1-800-955-8770). FEP: Rele 1-800-333-2227

CHÚ Ý: Nếu bạn nói Tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho bạn. Hãy gọi số 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Gọi số 1-800-333-2227

ATENÇÃO: Se você fala português, utilize os serviços linguísticos gratuitos disponíveis. Ligue para 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Ligue para 1-800-333-2227

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-352-2583（TTY: 1-800-955-8770)。FEP：請致電1-800-333-2227

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-352-2583 (ATS : 1-800-955-8770). FEP : Appelez le 1-800-333-2227

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Tumawag sa 1-800-333-2227

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-352-2583 (телетайп: 1-800-955-8770). FEP: Звоните 1-800-333-2227

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

ATTENZIONE: Qualora fosse l'italiano la lingua parlata, sono disponibili dei servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-352-2583 (TTY: 1-800-955-8770). FEP: chiamare il numero 1-800-333-2227

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: +1-800-352-2583 (TTY: +1-800-955-8770). FEP: Rufnummer +1-800-333-2227

주의: 한국어 사용을 원하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-352-2583 (TTY: 1-800-955-8770) 로 전화하십시오. FEP: 1-800-333-2227 로 연락하십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-352-2583 (TTY: 1-800-955-8770). FEP: Zadzwoń pod numer 1-800-333-2227.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

ประกาศ:ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โดยติดต่อหมายเลขโทรฟรี **1-800-352-2583 (TTY: 1-800-955-8770)** หรือ **FEP** โทร **1-800-333-2227**

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-352-2583（TTY: 1-800-955-8770）まで、お電話にてご連絡ください。FEP: 1-800-333-2227

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی رایگان در دسترس شما خواهد بود.
با شماره (TTY: 1-800-955-8770) 1-800-352-2583 تماس بگیرید. FEP: با شماره 1-800-333-2227 تماس بگیرید.

Baa ákoninzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojį' hodíilnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį' hodíilnih 1-800-333-2227.