REQUEST FOR PROPOSAL (RFP)
Leon County School Board
Purchasing Department

Release Date:	March 1, 2018
RFP No.:	431-2018
RFP Title:	Group Health Insurance
Contact:	June Kail: kailj@leonschools.net
Phone:	850-488-1206

The Leon County Board ("the Board") solicits your company to submit a proposal on the above referenced goods or services. All terms, specifications and conditions set forth in this request are incorporated by this reference into your response. The proposal must be submitted to The Leon County School Board, Purchasing Department, 3397 W. Tharpe St, Tallahassee, Florida 32303, no later than **2:00 p.m**. local time on **March 29, 2018** and plainly marked **RFP No. 431-2018**. Proposals are due and will be opened at this time.

REQUIRED SUBMITTAL CHECKLIST - *For each item below, insert bidder Authorized Agent initials verifying that forms are accurately completed, signed by an officer of the business and returned with the proposal.* **Failure to provide all requested documents may result in your proposal being declared non-responsive.**

___ Bidder Acknowledgement Form
___ Dispute Contact – pg. 6, item 23
___ Proposal Response – Section VI, pg. 17-20
___ Conflict Of Interest Certificate (Exhibit A)
___ Vendor Application (Exhibit B)
___ Request for Taxpayer ID Number & Certification (Exhibit C)
___ Customer Reference (Exhibit D)
___ Vendor Questionnaire (Exhibit E)
___ Drug Free Workplace Certification (Exhibit F)
___ Certification Regarding Debarment (Exhibit G)
___ Sworn Statement / Jessica Lunsford Act (Exhibit H)
___ Affidavit For Claiming Local Purchasing Preference (Exhibit I)
___
___

THE FOLLOWING MUST BE COMPLETED, SIGNED AND RETURNED AS PART OF YOUR PROPOSAL.
PROPOSALS WILL NOT BE ACCEPTED WITHOUT THIS FORM, SIGNED BY AN AUTHORIZED AGENT OF THE BIDDER.

Authorized Representative's Name/Title _____ Authorized Representative's Signature _____ Date _____

Company's Name _____ Telephone Number _____ FAX Number _____

Address _____ City _____ State _____ Zip Code _____

Area Representative _____ Telephone Number _____ FAX Number _____

Federal Employer's Identification Number (FEIN) _____ Email _____

Signature of Authorized Officer/Agent: _____ Typed or Printed Name _____

*(Proposal **must** be signed by an officer or employee having authority to legally bind the bidder)*

I certify that I have not divulged, discussed, or compared this proposal with any other Proposers and have not colluded with any other proposer in the preparation of this proposal in order to gain an unfair advantage in the award of this contract. I acknowledge that all information contained herein is part of the public domain as defined in the Public Records Act, Chapter 119, F.S.

By signing and submitting this proposal I certify that I am authorized to sign this proposal for this vendor and further certify unconditional acceptance of the contents of this RFP, all Attachments, Worksheets, Appendices, Supplemental Materials, and the contents of any Addendum released hereto.

NO RESPONSE – I HEREBY SUBMIT THIS AS A "NO RESPONSE" FOR THE REASON(S) CHECKED BELOW

☐ Remove our name from this bid list only
☐ Our product schedule would not permit us to perform
☐ Keep our company on bid list for future bids
☐ Insufficient time to respond to the RFP
☐ We do not offer the product or service requested.
☐ Other _____
☐ Could not meet insurance requirements
☐ Could not meet specifications

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BID IDENTIFICATION LABEL

NOTICE TO ALL BIDDERS: A label has been provided to properly identify your RFP. Place the proposal in a sealed envelope, type the name and address of the bidder on the label and affix the label to the front of the envelope.

The School Board Purchasing office is open from 8:00 a.m. - 5:00 p.m. Monday through Friday. If you are hand delivering a proposal, a Purchasing representative will be available to time/date stamp your submittal during these hours.

Cut out the label below and attach it to your envelope.

Sealed Bid – DO NOT OPEN **Sealed Bid – DO NOT OPEN**

RFP Title: **Group Health Insurance**

RFP No.: **431-2018**

RFP Due: **March 29, 2018 @ 2:00 P.M.**

From: _____

Address: _____

_____

Deliver To: Leon County Schools
Purchasing Department
3397 West Tharpe Street
Tallahassee, Florida 32303

Sealed Bid – DO NOT OPEN **Sealed Bid – DO NOT OPEN**

I. GENERAL TERMS AND CONDITIONS

1. INTRODUCTION: The Leon County School Board (the Board) is soliciting proposals for the purpose of identifying qualified companies to provide a health benefits program, all in accordance with Conditions, Specifications, and/or Special Provisions attached hereto.

2. SCHOOL BOARD CONTACT: All questions for additional information regarding this RFP must be directed to the designated Purchasing Agent noted on the title page.

All contact and requests for clarifications should be submitted via e-mail to: **kailj@leonschools.net** no later than **March 14, 2018**. Responses will be distributed no later than **March 16, 2018**.

Prospective bidders shall not contact any member of the Leon County School Board, Superintendent or staff regarding this RFP prior to posting of the final tabulation and award recommendation on the website and in the Purchasing Office. Any such contact shall be cause for rejection of your proposal.

3. DEFINITIONS: The term "Bidder" as used within this Request for Proposal (RFP) refers to the person, company or organization responding to this RFP. The Bidder is responsible for understanding and complying with the terms and conditions herein. The term "School Board" refers to the School Board of Leon County, Florida.

4. BIDDER'S RESPONSIBILITY: It is the responsibility of the bidder to obtain all pages of the RFP package and all attachments thereto, together with any addenda to the RFP package that may be issued prior to the RFP due date. RFP package and addenda as well as general information can be found at **www.leonschools.net/Page/4411**.

Before submitting their proposal, each bidder is required to carefully examine the RFP specifications and to completely familiarize themselves with all of the terms and conditions that are contained within this request. Ignorance on the part of the bidder will in no way relieve them of any of the obligations and responsibilities which are a part of this RFP.

5. AWARD In the event of contract award, this contract shall be awarded to the responsible and responsive bidder(s) whose bid is determined to be the most advantageous to the District, taking into consideration price and other requirements as set forth in the RFP. **Low cost proposal is but one of the evaluation parameters and does not guarantee contract award**. The awarded contractor(s) understands and agrees that the contract shall not be construed as an exclusive agreement and further agrees that the District may secure identical and/or similar services or products from other sources at any time in conjunction with or in replacement of the contractor's services.

Once proposals are evaluated, the Purchasing Department will post a Notice of Intent to Award by electronic posting at **www.leonschools.net/Page/4411** on or about **April 30, 2018** for a period of 72 hours or three business days, whichever is later. Failure to file a protest within the time prescribed in section 120.57 (3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under chapter 120, Florida Statutes.

It is anticipated that a recommendation for award will be presented to the School Board for consideration at its **May 8, 2018** meeting.

6 ORIGINAL AND RENEWAL TERM: Unless otherwise indicated in the detailed specifications the award resulting from this RFP shall be in effect for fourteen (14) months and will begin after School Board approval**, on or about May 9, 2018 through May 8, 2020**. The award resulting from this RFP (or any portion thereof) has the option of being renewed for three (3) additional years through **May 8, 2023**, or extended for a period up to 180 days beyond the current term, including the final term, upon mutual agreement of both parties, under the same terms and conditions as the original award. The School Board, through its Purchasing Department, will, if considering a renewal or extension, request a letter of intent to renew or extend from one or more awardees, prior to the end of the current contract period. The awardees will be notified when the recommendation has been acted upon by The School Board. The Bidder agrees to these conditions by signing its proposal.

7. RESERVATION FOR REJECTION OR AWARD: The School Board reserves the right to reject any or all proposals, to waive irregularities or technicalities, and to request rebids. The School Board reserves the right to award on an individual item basis, any combination of items, total low proposal or, if an alternate proposal is accepted, on such terms as are specified for the alternate proposal, whichever manner is in the best interest of the School Board.

8. CONTRACT: The submission of your proposal constitutes a firm offer by the bidder. Upon acceptance by the School Board, the Purchasing Department will issue a notice of award and purchase order(s) for any supplies, equipment and/or services as a result of this RFP. The RFP and the corresponding purchase order(s) will constitute the complete agreement between the successful bidder and the School Board. Unless otherwise stipulated in the RFP documents or agreed to in writing by both parties, no other contract documents shall be issued or accepted.

9. FIRM OFFER: Any proposal may be withdrawn until the date and time set for the opening of the RFP. Any proposal not so withdrawn shall constitute an irrevocable offer to provide the School Board the services/products set forth in this RFP. Such offer shall be held open for a period of sixty (60) days from RFP opening date or until one of the proposals has been awarded by the School Board.

10. CONFIDENTIALITY: Bidders shall be aware that all proposals provided with a RFP are subject to public disclosure and will not be afforded confidentiality with the exception of "sealed" financial statements.

11. PREQUALIFICATION OF CONTRACTORS FOR EDUCATIONAL FACILITIES CONSTRUCTION: In accordance with State Requirements for Educational Facilities (S.R.E.F.), 2014, Chapter 4, Section 4.1, Prequalification of Contractors for Educational Facilities Construction: **ONLY** contractors who hold a current Leon County School Board - Prequalification Certificate may submit their qualifications.

On April 14, 2015, the Leon County School Board revised and adopted **Policy 6334**, *Prequalification of Contractors for Educational Facilities & Construction.* The School Board will prequalify contractors for a one-year period pursuant to the criteria set forth in Florida Statutes 1013.46, and State Requirements for Educational Facilities, Chapter 4, Section 4.1 (1). Certificates will be valid for one year from the date of School Board approval and must be renewed annually. Submittals for work from firms not prequalified at the time of submittal will be deemed nonresponsive and will not be considered.

Instructions for completion and submission of the Qualifications Statement may be obtained on our website at **www.leonschools.net/Page/4815** or request assistance from Leon County School Board, Facilities and Construction, 3420 West Tharpe Street, Suite 100, Tallahassee, Florida 32303, 850- 617-5900.

12. PUBLIC RECORDS LAW: Pursuant to Florida Statutes Chapter 119.071(1), proposals received as a result of this RFP will not become public record until thirty (30) days after the date of opening or until posting of a recommendation for award, whichever occurs first. Thereafter, all proposal documents or other materials submitted by all bidders in response to this RFP will be open for inspection by any person and in accordance with Chapter 119, Florida Statutes. To the extent a Bidder asserts any portion of its proposal is exempt or confidential from

disclosure under Florida's public records, the burden shall be on the bidder to obtain a protective order from a jurisdictional court protecting such information from disclosure under Florida's public records laws and also timely provide a certified copy of such protective order to the School Board prior to the School Board's release of such information into the public domain.

13. USE OF OTHER CONTRACTS: The School Board reserve the right to utilize any other District contract, any State of Florida Contract, any contract awarded by any other City or County governmental agencies, any other School Board, any other Community College/State University system, any cooperative bid agreement, or to directly negotiate/purchase per School Board policy and/or State Board Rule 6A-1.012(6) in lieu of any offer received or award made as a result of this RFP, If it is in the best interest to do so. The School Board also reserves the right to separately bid any single order or to purchase any item on this RFP if it is in its best interest to do so.

14. JOINT-BIDDING, COOPERATIVE PURCHASING AGREEMENT: All bidders submitting a response to this RFP agree that such response also constitutes a proposal to all State Agencies and Political Subdivisions of the State of Florida under the same conditions, for the same prices and for the same effective period as this RFP, should the bidder(s) deem it in the best interest of their business to do so. This agreement in no way restricts or interferes with any state agency or political subdivision of the State of Florida to rebid any or all items.

State agencies wishing to make purchases from this agreement are required to follow the provisions of s. 287.042(16) (a), F.S. This statute requires the Department of Management Services to determine that the requestor's use of the contract is cost-effective and in the best interest of the State.

Pursuant to their own governing laws, and subject to the agreement of the Contractor, other entities may be permitted to make purchases at the terms and conditions contained herein. Non-Customer purchases are independent of the agreement between Customer and Contractor, and Customer shall not be a party to any transaction between the Contractor and any other purchaser.

The purchasing agreements and state term contracts available under s. 287.056 have been reviewed.

15. RFP PREPARATION COSTS: Neither the School Board nor its representatives shall be liable for any expenses incurred in connection with the preparation of a response to this RFP.

16. BID BONDS AND PERFORMANCE BONDS: Bid bonds, **when required** shall be submitted with the bid in the amount specified in the detailed specifications. Bid bonds will be returned to unsuccessful bidders. After Acceptance of a bid, the School Board will notify the successful bidder to submit a recorded payment and performance bond in the amount specified in the detailed specifications**.**

17. RFP OPENING AND FORM: Proposal openings will be public on the date and time specified on the Bidder's Acknowledgement Form. All Proposals received after the time indicated will be rejected as non-responsive and returned unopened to sender. Proposals by Email, fax, telegram, or verbally by telephone or in person will not be accepted. The School Board is not responsible for lost or late delivery of proposals by the U.S. Postal Service or other delivery services used by the Bidder.

18. CLARIFICATIONS AND INTERPRETATIONS: The School Board reserves the right to allow for clarification of questionable entries, and for the bidder to withdraw items with obvious mistakes. In the event of a conflict between the General Bid Terms and Conditions and any Special terms and Conditions attached hereto, the Special Terms and Conditions shall have precedence. Any questions concerning terms, conditions or specifications will be directed to the designated Purchasing Agent referenced on the RFP Acknowledgement. Any ambiguities or inconsistencies shall be brought to the attention of the designated Purchasing Agent in writing at least seven workdays prior to the opening date of the proposal. Failure to do so, on the part of the bidder will constitute an acceptance by the bidder of consequent decision. An addendum to the RFP shall be issued and posted for those interpretations that may affect the eventual outcome of this RFP. It is the bidder's responsibility to assure the receipt of all addendum issued. No person is authorized to give oral interpretations of, or make oral changes to the RFP. Therefore, oral statements given before the RFP opening date will not be binding. The School Board will consider no interpretations binding unless provided for by issuance of an addendum. Addenda will be made available at least five workdays prior to the opening date at www.leonschools.net/Page/4411. The bidder shall acknowledge receipt of all addenda by signing and enclosing said addenda with their proposal.

19. EVALUATION CRITERIA: Primary factors used to decide the award hereunder will be price, availability and responsiveness. Other factors that may be used in the evaluation of this RFP will be: (1.) administrative costs incurred by the School Board in association with the discharge of any subsequent award; (2.) alternative payment terms; (3.) Bidder's past performance. The School Board reserves the right to evaluate by lot, by partial lot, or by item, and to accept or reject any proposal in its entirety or in part, and to waive minor irregularities if the proposal is otherwise valid. In the event of a price extension error, the unit price will be accepted as correct. The School Board has sole discretion in determining testing and evaluation methods.

20. DEFAULT: In the event that the awarded bidder should breach this contract, the School Board reserves the right to seek all remedies in law and/or in equity.

21. FUNDING OUT/CANCELATION OR TERMINATION WITH OR WITHOUT CAUSE:

A. **WITH CAUSE:** In the event any of the provisions of the Contract are violated by the bidder, the Superintendent or designee shall give written notice to the bidder stating the deficiencies and unless the deficiencies are corrected within ten days, recommendation will be made to the School Board or its designee for immediate cancellation. Upon cancellation, hereunder the School Board may pursue any and all legal remedies as provided herein and by law. In the event that it is subsequently determined that a cancellation under this paragraph was incorrect, the termination shall be converted to a termination for convenience pursuant to the next paragraph.

B. **WITHOUT CAUSE:** The School Board or its designee reserves the right to terminate any contract resulting from this RFP at any time and for no reason whatsoever, upon giving 30 days prior written notice to the bidder. If the Contract should be terminated for convenience as provided herein, the School Board shall be relieved of all obligations under said Contract. The School Board or its designee shall only be required to pay to the successful bidder that amount of the Contract actually performed to the date of termination.

C. **FUNDING OUT:** Florida School Laws prohibit the School Board or its designee from creating obligations on anticipation of budgeted revenues from one fiscal year to another without year-to-year extension provisions in the contracts. It is necessary that fiscal funding out provisions be included in all RFPs in which the terms are for periods of longer than one year. Therefore, the following

funding out provisions are an integral part of this RFP and must be agreed to by all bidders:

The School Board or its designee may, during the contract period, terminate or discontinue the items covered in this RFP for lack of appropriated funds upon the same terms and conditions. Such prior written notice will state:

1. That the lack of appropriated funds is the reason for termination, and
2. School Board agrees not to replace the equipment or services being terminated with equipment and services with functions similar to those performed by the equipment covered in this RFP from another vendor in the succeeding funding period.

"This written notification will thereafter release the School Board of Leon County, Florida of all further obligations in any way related to such equipment covered herein".

22. TIE BID: According to FS 287.087, tie bid preference shall be awarded to Bidders with Drug Free Work Place programs. Whenever two or more are equal with regard to price, quality, and service, a proposal received from a business that certifies that it has implemented a Drug Free Work Place program shall be given preference in the award process. In the event both Bidders have a Drug Free Work Place, preference shall be awarded in the following order: Local Vendors as specified in School Board Policy 6450, SBE certified as specified in School Board Policy 6325. If both Bidders meet all requirements, according to standard purchasing practice, the Director of Purchasing will flip a coin to break the tie. Bidder's company name closest to the letter "A" will always be assigned heads in the coin toss.

23. DISPUTE: In case of any doubt or difference of opinion as to the items to be furnished hereunder, the decision of the School Board shall be final and binding on both parties. In the event a dispute occurs, or a clarification of contract terms becomes necessary, please indicate your company representative for arbitration proceedings.

Representative's Name:_____

Telephone Number:_____

Our School Board Representative will be:

Opal McKinney-Williams
Ausley & McMullen
(850) 224-9115

24. PROTESTING BID SPECIFICATIONS: Any person desiring to protest the conditions/specifications in this RFP or any Addenda thereto, shall file a written notice of protest within 72 hours after receipt of the RFP or Addendum and shall file a formal written protest within ten days after the date the notice of protest was filed. Saturdays, Sundays and legal holidays or days during which the School Board administration is closed shall be excluded in the computation of the 72-hour period. If the tenth calendar day falls on a Saturday, Sunday or legal holiday, the formal written protest must be received on or before 4:30 p.m. of the next calendar day that is not a Saturday, Sunday, legal holiday, or day during which the School Board administration is closed.

Failure to file a protest within the time prescribed in section 120.57 (3), Florida Statutes, or failure to post the bond or other security required by law within the time allowed for filing a bond shall constitute a waiver of proceedings under chapter 120, Florida Statutes and School Board Policy 6320.02. Failure to follow any other requirements in the bid protest procedures established by the School Board of Leon County, Florida shall constitute a waiver of all protest rights.

25. PROTESTS TO CONTRACT AWARD: The School Board shall provide notice of a decision or intended decision concerning a solicitation, contract award, or exceptional purchase by electronic posting which can be accessed at the Purchasing Department's website at www.leonschools.net/Page/4411 . Any person desiring to protest the intended decision shall file a written notice of protest, within 72 hours after the official posting in the Purchasing Department office of the Notice of Intent to Award concerning this RFP, and shall file a formal written protest within ten days after filing the notice of protest. Saturdays, Sundays, legal holidays and days during which the School Board administration is closed shall be excluded in the computation of the 72-hour period. If the tenth calendar day falls on a Saturday, Sunday or legal holiday, the formal written protest must be received on or before 4:30 p.m. of the next calendar day that is not a Saturday, Sunday, legal holiday or day during which the School Board administration is closed. Section 120.57(3) (b), Florida Statutes, states that "the formal written protest shall state with particularity the facts and law upon which the protest is based." Any person who files an action protesting an intended award shall post with the Purchasing Department, at the time of filing the formal written protest, a bond payable to the Leon County School Board consistent with F.A.C. Rule 28-110.005(2), and School Board Policy 6320.02. The bond shall be conditioned upon the payment of all costs which may be adjudged against protester in an Administrative hearing in which the action is brought and any subsequent appellate court proceeding. **For the purpose of calculating a protest bond, this contract is valued at approximately $50,000**. This is only an estimate and actual volume could vary up or down. Failure to file a notice of protest within the time prescribed by Section 120.57(3), Florida Statutes, shall constitute a waiver of proceedings under Chapter 120, Florida Statutes and School Board Policy 6320.02.

26. GOVERNING LAW AND VENUE: All legal proceedings brought in connection with this contract shall only be brought in a state or federal court located in the state of Florida. Venue in state court shall be in Leon County, Florida. Venue in federal court shall be in the United States District Court, Northern District of Florida, Tallahassee division. Each party hereby agrees to submit to the personal jurisdiction of these courts for any lawsuits filed there against such party arising under or in connection with this contract. In the event that a legal proceeding is brought for the enforcement of any term of the contract, or any right arising there from, the parties expressly waive their respective rights to have such action tried by jury trial and hereby consent to the use of non-jury trial for the adjudication of such suit. All questions concerning the validity, operation, interpretation, construction and enforcement of any terms, covenants or conditions of this contract shall in all respects be governed by and determined in accordance with the laws of the State of Florida without giving effect to the choice of law principles thereof and unless otherwise preempted by federal law.

27. COMPLIANCE WITH STATE/FEDERAL REGULATIONS: All contracts involving federal funds will contain certain provisions required by applicable sections of CFR 34, Section 80.36(l) and Part 85.510, Florida Statute 257.36, or Florida Administrative Code Chapter 1B. The bidder certifies by signing the RFP that the bidder and his/her principals are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in federally funded transactions and may, in certain instances, be required to provide a separate written certification to this effect.

During the term of any contract with the School Board, in the event of debarment, suspension, proposed debarment, declared ineligible or voluntarily excluded from participation in federally funded transactions, the Bidder shall immediately notify the Director of Purchasing, in writing. Bidders will also be required to provide access to records, which are

directly pertinent to the contract and retain all required records for three (3) years after the School Board makes final payment.

For all contracts involving Federal funds in excess of $10,000, the School Board reserves the right to terminate the contract for cause, as well as for convenience, by issuing a certified notice to the Bidder.

28. COMPLIANCE WITH SCHOOL CODE: Bidder agrees to comply with all sections of the Florida K-20 Education Code, Title XLVIII, Florida Statutes as it presently exists and further as it may be amended from time to time. Further, Contractor agrees that failure to comply with the Florida K-20 Education Code shall constitute a material breach of this Contract and may result in the termination of this Contract by the School Board.

29. NONDISCRIMINATION NOTIFICATION AND CONTACT INFORMATION: No person shall on the basis of gender, marital status, sexual orientation, race, religion, national origin, age, color, pregnancy or disability be denied employment, receipt of services, access to or participation in school activities or programs if qualified to receive such services, or otherwise be discriminated against or placed in a hostile environment in any educational program or activity including those receiving federal financial assistance, except as provided by law." No person shall deny equal access or a fair opportunity to meet to, or discriminate against, any group officially affiliated with the Boy Scouts of America, or any other youth group listed in Title 36 of the United States Code as a patriotic society.

An employee, student, parent or applicant alleging discrimination with respect to employment, or any educational program or activity may contact:

Dr. Kathleen L. Rodgers
Equity Coordinator and Title IX Compliance Officer
Leon County School District
2757 West Pensacola Street
Tallahassee, Florida 32304
(850) 487-7306 / rodgersk@leonschools.net

A student or parent alleging discrimination as it relates to Section 504 of the Rehabilitation Act may contact:

Dr. Alan Cox, 504 Specialist
Leon County School District
2757 W. Pensacola Street, Tallahassee, FL 32304
(850) 487-7190 / coxa@leonschools.net

30. SBDO PROGRAM: The School Board established the Small Business Development Office to support innovative race and gender neutral strategies to promote qualified small business participation as specified in School Board Policy 6325.

31. LOCAL PREFERENCE: This RFP is subject to the local preference provisions as specified in School Board Policy 6450.

32. FLORIDA PREFERENCE: This RFP is subject to §287.084 Florida Statutes, which requires, among other things, the following: "A vendor whose principal place of business is outside this state must accompany any written bid, proposal, or reply documents with a written opinion of an attorney at law licensed to practice law in that foreign state, as to the preferences, if any or none, granted by the law of that state to its own business entities whose principal places of business are in that foreign state in the letting of any or all public contracts." Any bidder, regardless of whether its principal place of business is located inside or outside of this state, who submits any written bid, proposal or reply documents is responsible for understanding and complying with the requirements of §287.084 Florida Statutes.

33. CHARTER SCHOOLS: Items or services awarded under this contract shall be made available to Charter Schools approved by the School Board. The School Board is not responsible or liable for purchases that may be made by Charter Schools.

II. LICENSURE, INSURANCE AND LIABILITY

1. OCCUPATIONAL LICENSE: The contractor shall be responsible for obtaining and maintaining throughout the contract period any required occupational license and other licenses required pursuant to the laws of Leon County, the City of Tallahassee, or the State of Florida.

2. WORKER'S COMPENSATION: Bidders shall obtain and maintain during the life of the contract Workers' Compensation Insurance in compliance with Chapter 440, Florida Statutes for all of his employees employed on the project. In case any work is sublet, bidder shall require subcontractors similarly to provide Workers' Compensation Insurance.

3. LIABILITY: Where bidders are required to enter or go onto School Board property to deliver materials, perform work or provide services as a result of a RFP award, the bidder assumes full duty, obligation and expense of obtaining all necessary licenses, permits and insurance, and shall be fully responsible for its own negligent or willful acts or omissions.

4. INSURANCE AND INDEMNIFICATION: This General Condition is NOT subject to negotiation and any Bidder submitting a proposal that fails to accept these conditions will be rejected as "non-responsive", unless bidder is entitled to sovereign immunity by action of the Florida Legislature. Each party agrees to be fully responsible for its acts of negligence, or its agents' acts of negligence when acting within the scope of their employment and agrees to be liable for any damages resulting from said negligence to the extent allowable pursuant to Section768.28, Florida Statutes. Nothing herein is intended to serve as a waiver of sovereign immunity by the School Board. Nothing herein shall be construed as consent by the School Board to be sued by third parties in any matter arising out of any contract. Bidder shall hold harmless and defend the School Board and its agents and employees from all suits and actions, including attorney's fees and all costs of litigation and judgments of any name and description arising out of or incidental to the performance of this contract or work performed there under. This provision shall also pertain to any claims brought against the School Board by an employee of the named Bidder, any Subcontractor, or anyone directly or indirectly employed by any of them. The bidder's obligation under this provision shall not be limited in any way by the agreed upon contract price as shown in this Contract or the bidder's limit of, or lack of, sufficient insurance protection.

5. RISK OF LOSS: The bidder assumes the following risks: (1.) all risks of loss or damage to all goods, work in process, materials and equipment until the delivery thereof as herein provided; (2.) all risks of loss or damage to third persons and their property until delivery of all goods as herein provided; (3.) all risks of loss or damage to any property received by the bidder or held by the bidder or its suppliers for the account of the School Board, until such property has been delivered to the School Board; (4) all risks of loss or damage to any of the goods or part thereof rejected by the School Board, from the time of shipment thereof to bidder until redelivery thereof to the School Board.

7. PUBLIC ENTITY CRIMES: Pursuant to Florida Statute 287.133 a Bidder, person, or affiliate who has been placed on the convicted Vendors list following a conviction for a public entity crime may not submit a RFP on a contract to provide any goods or services to a public entity for the construction or repair of a public building or public work, may not submit RFPs on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business

with any public entity in excess of the threshold amount provided in Florida State Statute, Section 287.017, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list.

8. PATENTS AND COPYRIGHTS: Bidders agree to indemnify and save harmless the School Board, its officers, employees, agents, or representatives using the goods specified herein from any loss, damage or injury arising out of a claim or suit at law or equity for actual or alleged infringement of letters of patent by reason of the buying, selling or using the goods supplied under this RFP, and will assume the defense of any and all suits and will pay all costs and expenses thereto.

9. PUBLIC RECORDS LAW: Pursuant to Florida Statutes Chapter 119.071(1), proposals received as a result of this RFP will not become public record until thirty (30) days after the date of opening or until posting of a recommendation for award, whichever occurs first. Thereafter, all proposal documents or other materials submitted by all bidders in response to this RFP will be open for inspection by any person and in accordance with Chapter 119, Florida Statutes. To the extent a Bidder asserts any portion of its proposal is exempt or confidential from disclosure under Florida's public records, the burden shall be on the bidder to obtain a protective order from a jurisdictional court protecting such information from disclosure under Florida's public records laws and also timely provide a certified copy of such protective order to the School Board prior to the School Board's release of such information into the public domain.

AUDITS, RECORDS, AND RECORDS RETENTION: REQUIRED PUBLIC RECORDS ACKNOWLEDGEMENT

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

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)487-7177, 520 SOUTH APPLEYARD DRIVE, TALLAHASSEE, FLORIDA 32304

III. GOODS AND SERVICES

1. WARRANTY: All goods and services furnished by the bidder, relating to and pursuant to this RFP will be warranted to meet or exceed the Specifications contained herein. In the event of breach, the bidder will take all necessary action, at bidder's expense, to correct such breach in the most expeditious manner possible.

2. PRICING: All pricing submitted will include all packaging, handling, shipping charges and delivery to any point within Leon County, Florida to a secure area or inside delivery. **The School Board is exempt and does not pay Federal Excise and State of Florida sales taxes.**

3. PRICE ESCALATION: In the event of unforeseen circumstances that directly impact the pricing and/or servicing of this contract, the School Board reserves the right to negotiate the established prices with the contractor at any time during the duration of this contract after completion of the initial contract term. Price negotiations will be at the sole discretion of the School Board.

The School Board may consider pricing increases of the item(s) if the following conditions occur:

- **A.** There is a verifiable price increase of the bid item(s) to the contract supplier.
- **B.** The contractor submits to the School Board, in writing, notification of price increases.
- **C.** The price increase shall be comparable to documented manufacturers' or distributors' price changes or changes in industry related indices.
- **D.** The contractor shall submit the above information to the Director of Purchasing thirty (30) calendar days prior to the effective date of the price increase. Requests for price increases may only be made after the first term of the contract.

When the contractor complies with the abovementioned conditions, the Director of Purchasing will review the information to determine if it is in the best interest of the School Board to adjust the pricing on the products proposal, in conjunction with the contractor's effective date of price increase. The School Board reserves the right to deny any requests for price increases. The contractor must receive written notification from the Director of Purchasing that the School Board is in acceptance of the new prices before processing any orders with the new costs.

4. QUANTITIES: Quantities listed in the RFP are estimates provided for bidder information purposes only. No guarantee is given or implied as to the exact quantities, which will be purchased from this RFP. The School Board reserves the right to increase or decrease all estimated quantities during the term of this contract or to delete any item or items as it deems appropriate, without affecting the pricing or the terms and conditions of the RFP.

5. MOST FAVORED CUSTOMER STATUS: The awarded bidder shall afford the School Board the most favored customer status for all items herein. Accordingly, if during the term of this contract, the contractor offers more favorable promotional or contract pricing to another entity for the same specification with similar quantities and conditions, the price under this contract shall be immediately reduced to the lower price. Additionally, if a current state of Florida contract, or other viable piggy-back contract contains more favorable pricing for the same specification with similar quantities and conditions, the contractor will be afforded an opportunity to adjust its contract price to match that of the state of Florida contract. Should the contractor decline, LCSB reserves the right to purchase the item(s) from the state of Florida or alternate piggy-back contract.

6. TERMS OF PAYMENT / INVOICING: The normal terms of payment will be Net 30 Days from receipt and acceptance of goods or services and contractor's invoice. Itemized invoices, each bearing the Purchase Order Number must be mailed on the day of shipment. Invoicing subject to cash discounts will be mailed on the day that they are dated.

7. PURCHASING CARDS: The School Board may choose to use a "Purchasing Card" for ordering of goods and materials or payment of invoices under this contract. The bidder, by submitting a proposal, agrees to accept this manner of payment and may not add additional handling charges or service fees to purchases made with the School Board's Purchasing Card(s). Refusal to accept this condition may cause the proposal to be declared non-responsive, or result in revocation of the contract, if already awarded. No third party payment, i.e. Pay pal will be considered

8. TRANSPORTATION AND TITLE: (1) Title to the goods will pass to the School Board upon receipt and acceptance at the destination indicated herein. Until acceptance, the Bidder retains the sole insurable interest in the goods. (2) The shipper will prepay all transportation charges. The School Board will not accept collect freight charges. (3) No premium carriers will be used for the School Board's account without prior written consent of the Director of Purchasing.

IV. BIDDER REQUIREMENTS

1. REFERENCES: Each Bidder is required to submit a list of three (3) customer references using the format on the attached "Customer Reference Form" see Exhibit D. The Bidder must be the prime contractor for each customer/contract referenced. All references shall be for work performed over the last year at commercial, multi-residential developments and/or institutional complexes for contracts of comparable size. Newly formed companies, corporations, joint ventures; etc. may use an incorporator as a referenced entity. At least one contract/customer shall have been serviced for a minimum of one year. Failure to provide verifiable references may result in the bidder not being considered for award. Unsatisfactory references may result in the bidder not being considered for award.

2. LEVEL 2 SCREENING REQUIREMENTS: The following provisions, which implement the requirements of School Board Policy 8475, Florida Statute Sections 1012.315, 1012.32, 1012.465 (Jessica Lunsford Act), 1012.467 and 1012.468 are included as additional terms and conditions of the contract.

Finger Printing and Background Check:

The bidder/contractor agrees to comply with all requirements of School Board Policy 8475 and Florida Statute Sections 1012.315, 1012.32, 1012.465 (Jessica Lunsford Act), 1012.467 and 1012.468 by certifying that any/all employees have completed the mandatory background screenings as required by the referenced policy and statutes and shall provide the School Board with proof of compliance. These certifications will be provided to the Leon County School Board, Safety & Security Department in advance of the Bidder/contractor providing any/all services as required herein. The Bidder/contractor will bear the cost of acquiring the background screening required and any/all fees imposed by the Florida Department of Law Enforcement and or the School Board to maintain the fingerprints provided with respect to Bidder/contractor and its employees. Contractor agrees to indemnify and hold harmless the School Board, its officers, agents and employees from any liability in the form of physical injury, death, or property damage resulting from the Contractor's failure to comply with the requirements of these cited policies and statutes. The Bidder/contractor will follow procedures for obtaining employees background screening as established by the Leon County School Board, Safety & Security Department.

Where:	Leon County School Board – Safety & Security Department 2757 W. Pensacola St. Tallahassee, Florida 32304
When:	Monday-Friday 8:00 a.m. – 5:00 p.m.
Point of Contact:	Donald Kimbler @ 850-487-7293

LCSB Policy 8475 is subject to review and change. As a provision of this contract, if awarded, any changes made to this policy will automatically become a part of and be incorporated in this contract. It is the responsibility of the awardee(s) to be aware of any changes that may occur.

3. RECIPROCITY OF FLORIDA SCHOOL I.D. BADGES: If contractor has a Level II clearance registered with another Florida School Board, they may be able to obtain a Leon County School Board vendor I.D. badge. Contractor should check with the Safety & Security Department Fingerprint Services office to verify clearance and obtain a vendor I.D. badge.

4. IDENTIFICATION: All personnel employed by the bidder, including any subcontractor and subcontractor's employees when applicable, shall display at all times an identification badge which shall include the employee's name, the employer's name and either a physical description or a photograph of the employee. Employees without proper identification shall not be permitted to work under the terms of this Agreement.

5. CONTACT WITH STUDENTS: No employees or independent contractors, material men, suppliers or anyone involved in any manner with projects resulting from this proposal shall have direct or indirect contact with students at project sites. A violation of this provision shall result in immediate termination of the offender and issuance of a trespass notice from the School Board. Bidder/Proposer shall be responsible for insuring compliance by all employees, independent contractors and sub-contractors or other persons involved in any manner with projects resulting from this proposal.

6. WEAPONS AND FIREARMS: The School Board prohibits any contractor from possessing, storing, making, or using a weapon, including a concealed weapon, on School Board property and any setting that is under the control and supervision of the School Board as specified

in School Board Policy 7217. Violations will be subject to the immediate termination of the contract.

7. SMOKING AND TOBACCO PRODUCTS: Smoking and the use of tobacco products are prohibited on school property, including all buildings and grounds. A warning will be assessed for the first offense and termination of the Agreement may be imposed for any second or additional offense.

8. ATTIRE: Proper attire shall be worn at all times.

A. Shirts shall be worn awhile on school property at all times. (No tank tops or undershirts will be permitted).

B. Clothing displaying nudity, obscene language, obscene symbols or pro-drug slogans is prohibited.

C. Proper shoes to insure the individual's safety shall be worn at all times.

9. INSPECTIONS AND TESTING: The School Board will have the right to inspect and test any of the goods or services covered by this RFP. All goods or services are subject to the School Board's inspection and approval upon arrival or completion. If rejected, goods will be held for disposal at the bidder's risk. Such inspection, or the waiver thereof, however, will not relieve the bidder from full responsibility for furnishing goods or services conforming to the requirements of this RFP or the RFP Specifications, and will not prejudice any claim, right, or privilege the School Board may have because of the use of defective or unsatisfactory goods or service. All deficiencies noted by the School Board will be submitted to the contractor for correction within ten (10) calendar days after submission of deficiencies to the contractor. An additional inspection of the goods or service may be conducted to insure corrective action was taken.

10. STOP WORK ORDER: The School Board may at any time, by written notice to the Bidder stop all or any part of the work for this contract award. Upon receiving such notice, the bidder will take all reasonable steps to minimize additional costs during the period of work stoppage. The School Board may subsequently either cancel the stop work order resulting in an equitable adjustment in the delivery schedule and/or the price, or terminate the work in accordance with the provisions of the RFP terms and conditions.

A. Materials or work are not in conformance with applicable codes, standards, School Board specifications and/or accepted practices.

B. The contractor's activities result in damage to School board property.

C. The contractor's activities interfere with the normal operation of the facility.

D. Contractor's personnel are not properly licensed to perform the work or as it pertains to school facilities, the contractor's personnel have not received their Level II background clearances.

E. Any other condition, situation, or circumstance, which in the opinion of the School Board Authorized Representative would be a detriment to the best interests of the School Board if allowed to persist.

11. SAFETY: The bidder shall be responsible for instructing their employees in all safety measures. All equipment used by the bidder shall be free from defects or wear that may in any way constitute a hazard to any person or persons on School Board property. At no time shall equipment be operated without guards, shields, or other manufactures recommended safety accessories in place and functioning as intended by the manufacturer. All current OSHA safety standards shall be reinforced including, but not limited to, the following rules:

A. All OSHA and Federal required safety equipment shall be installed and functioning on all equipment.

B. All equipment shall be in sound working condition and must meet all OSHA Safety Standards. All workers shall be aware of and trained in the operation of all safety equipment required for this project.

C. The Bidder shall ensure that employees are equipped with proper safety items such as glasses, hard hats, gloves, etc.

D. All incidents on campus involving School Board property or personnel shall be reported to the Director of Maintenance Services Department and the Campus Administrator immediately upon occurrence.

E. All debris shall be removed to an environmentally approved landfill or recycling center.

12. EMERGENCIES: In any emergency affecting the safety of persons and property, the awarded contractor shall act immediately to prevent threatened damage, injury or loss. Any emergency must be reported to an authorized School Board representative immediately and no later than twenty-four (24) hours from the time that the emergency is discovered by the contractor

13. DAMAGE TO SCHOOL BOARD OWNED PROPERTY: Any damage to property, equipment, grounds, buildings, etc. that is caused by the awarded contractor will be reported to the School Board within twenty-four (24) hours of discovery. The awarded contractor will have ten (10) working days after report to present its written response to the claimed damages. The awarded contractor, upon approval by an authorized School Board representative, may make repairs that are deemed within its capability. The School Board reserves the right to make immediate repairs to correct damages that are safety hazards or that pose a detrimental effect to the School Board's operations. Costs of any replacement or repairs made by the School Board for damages caused by the awarded contractor shall be deducted from any monies due to the contractor. This shall not prevent the School Board from seeking damages should replacement/repair costs exceed the amount of monies owed to the awarded contractor. When requested, Bidder shall cooperate with any ongoing School Board investigation involving personal injury, economic loss or damage to The School Board's facilities or personal property therein.

14. SUBCONTRACTING: The awarded contractor(s) shall be the primary service provider(s) and shall perform all requested inspections and repairs. Subcontracting for these base services is not allowed.

A. The School Board, for work where the contractor(s) are requested to perform additional services, may allow subcontracting.

B. Any work or service to be performed by a subcontractor must have the prior approval of the School Board. The School Board reserves the right to reject any subcontractor. Rejection of any subcontractor shall not entitle the contractor to adjustment of RFP prices. The contractor shall inform the School Board Authorized Representative prior to scheduling any subcontractor's visit to any School Board facility.

C. Failure by the contractor to have a subcontractor approved by the School Board will not relieve the contractor of the responsibility to meet, comply with, and fulfill all of the terms and conditions of this Agreement.

D. The contractor(s) shall be held fully responsible and liable for the supervision and performance of all work performed by subcontractors. The School Board shall not be responsible for resolution of disputes between the Bidder and any subcontractor.

E. The personnel of all subcontractors shall meet all of the requirements as stated herein to include, but not limited to LCSB Policy 2.021 and the Jessica Lunsford Act.

15. ON-CAMPUS DIRECTIVES

A. Upon arrival and departure onto any School Board school campus, the contractor's employees shall enter their company information into the School Log Book provided in the Administrative office of each campus.

B. Contractor shall strictly limit its operations to the designated work areas and shall not permit any employees to enter any other portions of School Board property without School Board's expressed prior written consent.

C. All employees shall enter and leave School Board facilities only through the ingress and egress points designated, from time to time, by The School Board.

D. The contractor shall be responsible for the removal of all trash and debris occasioned by this contract. Failure to adhere to this requirement will result in the costs of the performance of this work by others being charged to the contractor.

E. Any existing surface or subsurface improvements, including, but not limited to, pavements, curbs, sidewalks, pipes, utilities, footings, structures, trees and shrubbery, not indicated in the contract documents to be removed or altered, shall be protected by contractor from damage during the prosecution of any project. Any such improvements so damaged shall be restored by contractor to condition at least equal to that existing at the time of contractor's commencement of any project.

F. Proper safety barricades, protective, and covering devices shall be used to divert traffic and protect personnel. Normal safety signs, necessary lighting and temporary fencing/barricades around work areas shall be installed and maintained in accordance with OSHA requirements while the work is in progress. Materials must be secured in accordance with OSHA regulations when not in use.

16. BIDDER ACCESSIBLITY: The successful bidder shall provide a liable and responsible representative to be accessible by a Leon County toll free local telephone call during regular business hours. Local off-hours answering service for emergencies shall be available for bidder notification twenty-four (24) hours a day, seven (7) days per week, all year, including holidays.

17. CONTACT PERSON: The successful Bidder shall be notified of the name and phone number of the School Board contact person. Only the School Board contact person may authorize changes to the scope of work.

THIS DOCUMENT IS CONTINUED ON THE NEXT PAGE

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V. SCOPE OF WORK

A. INTRODUCTION AND GENERAL INFORMATION: The Board is soliciting competitive proposals on behalf of the Employee Benefits Department from a qualified insurance company to provide fully insured group health insurance as described herein. Due to the large number of retirees and students who reside outside of Tallahassee, the benefits committee has determined that a PPO and an HMO option will only be acceptable. The scope of work as outlined in this RFP establishes the minimum requirements to be provided by the successful bidder.

The District and its governing board were created pursuant to Section 4. Article IX of the Constitution of the State of Florida. The District is an independent taxing and reporting entity managed, controlled, operated, administered, and supervised by District school officials in accordance with relevant provisions of the Florida K-20 Education Code, Chapters 1000 – 1013, Florida Statutes**.** The School Board consists of five elected officials responsible for the adoption of policies, which govern the operation of District public schools. The Superintendent of Schools is responsible for the administration and management of the schools within the applicable parameters of state laws, State Board of Education Rules and School Board policies.

The Board has a staff of approximately 5,600 people, including instructional, instructional support, administrative, support positions, and temporary positions such as substitutes. Three bargaining units represent instructional and school related employees within the Board. Compensation and benefits for union employees are negotiated, subject to ratification by union membership and approval by the Board.

B. INSURANCE COMPANY REQUIREMENTS: Proposers must be licensed to do business in Florida subject to the provisions of the Florida Insurance Department.

C. BOARD'S BROKER AGENT OF RECORD: The Board's insurance broker of record is RGVI/HUB International. The agent of record is Walker Cutts. Walker.cutts@hubinternational.com.

D. INSURANCE COMPANY REPRESENTATIVE: Successful proposers shall appoint, by name, a company representative who shall be responsible for servicing the contract resulting from the award of this RFP. The appointed representative shall be responsible for functions as necessary to insure that the account will be maintained in a professional manner. The Board's insurance broker of record is RGVI/HUB International

E. CONTRACT PERIOD: It is the intent of the Board that the successful carrier will be the Health provider for a period of two (2) years with an option to renew for three (3) additional one (1) year periods. Policy periods are to commence on October 1st of each plan year.

F. RENEWAL: The proposer and the Board covenant and agree that this proposal or subsequent contract may, with the mutual approval of the awarded contractor and the Board be renewed under the same terms and conditions of this proposal or contract for three (3) additional contract periods of one year each for a total possible contract period not to exceed five (5) years. The District shall notify the proposer of its intent to exercise this option in writing prior to the termination of each contract period. Renewal is pursuant to Board approval.

G. ANNUAL RENEWAL RATES: The Board intends to provide the best affordable insurance coverage to its employees on an updateable basis utilizing cost containment strategies. Therefore, the contract will be reviewed annually and cost containment strategies will be explored with the awarded contractor. **June 15th** of each year will be the deadline for negotiating renewal rates. The Board reserves the right to cancel the contract after any annual review and rebid employee group health benefits.

H. PROPOSAL EVALUATION CRITERIA: The District will evaluate proposals and select a carrier based on all of the information available. While cost is an important factor, it should be understood that the District is not under any obligation to accept the lowest cost proposal. It is our desire that your proposal for plan benefits be based upon exact minimum requirements as described herein. Any deviation should be submitted as an **alternate proposal** and clearly explained. **ALL** proposals will be evaluated on the following criteria:

- Responsiveness to Request for Proposal
- Experience of the firm, insuring company, and agent with similar programs.
- Costs, including but not limited to, administrative, retention, commissions and liability risks to the District
- Overall plan (literature, administration requirements of District, enrollment requirements, etc.).

After the evaluation of proposals is completed, the most responsive proposer(s) may be required to make an oral presentation, if it is determined that it could benefit the District.

Oral presentations are for the purpose of explaining or clarifying significant elements of the proposal. Elaborate marketing presentations could confuse the issues at hand and are not desired. Proposers will be asked to address specific questions prepared by the Insurance Broker of Record and the District's Administration. In addition, proposers should be prepared to justify their proposed rates and possibly negotiate adjustments to the rates.

The Board will be the sole judge with respect to the evaluation of proposals. The proposals will be evaluated by the Board's insurance broker of record RGVI/HUB International.

I. PROPOSAL REQUIREMENTS: All proposers are required to return the attached proposal sheets (Pages 17 through and including 20) along with a benefit summary of the health insurance program(s) your proposing and corresponding rate quotation (original, (one hard copy and one electronic copy USB) and three (3) copies). All information must be furnished and then proposal **must** be signed by an authorized representative or officer of the proposing company.

A. Employee and employer requirements for settlement of claims should be included in your quotation.
B. A list of three (3) references of similar size groups which shall include:
   1. Clients name
   2. Individual contact
   3. E-mail address
   4. Phone number
C. Summary statement detailing the primary advantages of your plan and why the Board should choose your plan over all other plans. Be specific.
D. Provide a complete list in alphabetical order of the network providers located in Leon County, Florida and surrounding counties.

Proposals are to be prepared simply, providing a straight forward, concise description of the insurance company's capabilities to satisfy the requirements of this proposal. Emphasis should be on completeness and clarity of content. Repetition of the terms and conditions of this proposal request, without additional explanation, will not be considered sufficiently responsive. Your proposal document should duplicate the plan benefits as shown in this request and corresponding attachments. Comprehensive documentation and supplemental information should be enclosed as an attachment or exhibit to your proposal.

The absence of any of the required supporting information may be cause for declaring your proposal non-responsive. Any additional information the proposer feels will enhance their overall proposal evaluation may be included.

J. PRESENT COVERAGE/CENSUS DATA: Present coverage is with Capital Health Plan and Florida Blue. Schedules of current and desired benefits are provided as Attachments to this RFP. Current census data is available upon request.

K. RATES: Rates are being requested based on a three-tier structure and a ten month payment schedule. Rates are to be firm from the effective date of the contract, October 1st to the next anniversary date and no increase in premiums will be made during the interim. Proposer should specify if your rate guarantee is for longer than a twelve (12) month period. Rates may be negotiated between the Boards agent of record and the proposer prior to the initial contract inception. The Board requests that the proposer clearly identify if they are submitting their best and final offer for the initial contract period beginning October 1, 2018. **It is understood and agreed that all proposed premium changes will be submitted for approval no later than June 15th of each year**.

L. IMPLEMENTATION SCHEDULE:

The proposed schedule for selecting and awarding this contract is as follows:

Mailing of Request for Proposals	March 1, 2018
Final date for submission of questions by Bidders	March 14, 2018
Answers to all questions posted to web site	March 16, 2018
Opening of Proposals	March 29, 2018
Evaluation of Proposals	March 29 – April 27, 2018
Vendor Oral Presentations (if necessary)	
Posting of recommendation for award	April 30, 2018
Board consideration date	May 8, 2018
Contract inception date	May 9, 2018

M. SPECIFICATIONS

GENERAL

Proposals are being solicited for a group health insurance program according to the specifications of our existing plan as outlined below.

Proposals from insurance carriers with less than an AM Best Rating of 'A' will not be accepted.

Group health insurance coverage is available to eligible employees of the District as identified by the applicable collective bargaining agreement. Retirees and dependents may maintain coverage by paying the full amount of the premiums. Eligible employees and their dependents may continue their benefits while on an approved leave of absence by paying the full amount of the premiums. Dependent coverage shall include spouse and eligible dependent children.

In the past, group health insurance has operated under a shared contributor arrangement between the Board and the employee. Currently, the Board contributes 80% of the employee premium and 60% of the dependent premium.

TERMINATION OF INSURANCE

Termination of insurance under the group health policy plan shall not prejudice any claim commencing prior to the effective date of termination. Employees will be covered through the paid to date.

MASTER AGREEMENT

The insurance carrier will be required to provide a group master agreement to the District.

EXPLANATORY LITERATURE

The insurance company shall provide subscriber identification cards and summary plan description for distribution to all covered employees of the Leon County School Board.

CLAIMS PROCESSING

Claims will be processed and paid by the insurance company. Insurance company will be required to maintain eligibility for all covered employees and dependents.

EMPLOYEE CONTRIBUTIONS

The District will make ten (10) employee payroll deductions and pay total premiums to the company selected in twelve (12) payments.

USUAL AND CUSTOMARY CHARGES

Eligible expenses are all usual and customary charges necessarily incurred for medical services and supplies prescribed and/or rendered by a physician.

COORDINATION OF BENEFITS

Coordination of benefits is to be included for all medical care coverages and based upon current NAIC guidelines. When the District coverage is secondary, payment will be the unpaid balance, not exceeding its aggregate coverage or 100% (whichever is greater) of any reasonable and customary expense that is a benefit of the plan.

INITIAL ENROLLMENT

The carrier receiving the award for the health plan must accept current enrollment.

If the District determines a new enrollment is necessary, the insurance carrier must provide materials electronically and personnel to complete this initial re-enrollment prior to July 1st .

CONTRACT PROVISIONS

The District reserves the right to incorporate standard contract provisions into any contract negotiated as a result of a proposal submitted in response to this RFP.

VI. QUESTIONNAIRE AND RESPONSE

A. **PROPOSAL REQUIREMENTS:** Bidders must submit **one (1) original, one electronic (USB drive) and five (5) copies** of their completed proposal. All proposals submitted in response to this RFP shall become the property of the District. Proposals should be sealed and mailed or hand delivered to: Leon County Schools, Purchasing Department, Attn: June Kail, 3397 West Tharpe St., Tallahassee, Florida, 32303.

If any director, officer, employee, agent or other representative of a bidder, including any other parties that may be involved in a joint venture or a consortium with the bidder, makes, from and after the date of issuance of this RFP, any representation or solicitation to any member of the School Board or any official, employee or agent of the District, with the exception of, June Kail, Director of Purchasing with respect to the bidder's response or any other bidder's response, the District shall be entitled to reject that respondent's proposal. A representation for the purposes of this requirement can be considered to be anything said or written to any school board member, official, employee or agent which provides information advancing the interests of a proposal.

1. The undersigned agrees to furnish an EMPLOYEE HEALTH BENEFITS PROGRAM to the Board in compliance with this Request for Proposal, Special Provisions, and Requirements.

2. By submission of this proposal, the proposer certifies:

   A. Prices in this RFP have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition.

   B. Prices in this RFP have not knowingly been disclosed by the proposer and will not be prior to award to any other proposer.

   C. No attempt has been made nor will be by the proposer to induce any other person or firm to submit a proposal for the purpose of restricting competition.

B. The individual signing this proposal certifies that he/she is authorized to represent the company offering and is legally responsible for the decision as to the prices and supporting documentation provided.

C. Check to acknowledge all required submittals are included:

____ One original hard copy and five (5) copies plus one (1) electronic copy (USB drive)
____ Pages 16 through 19
____ Employee and employer requirements for settlement of claims should be included in your quotation.
____ A list of three (3) references of similar size groups.
____ Summary statement detailing the primary advantages of your plan and why the Board should choose your plan over all other plans.
____ A complete list in alphabetical order of the network providers located in Leon County, Florida and surrounding counties.
____ Summary of benefits and cost proposal.

D. Proposal submitted by: **Company/Home Office** with authority for rates, determination of dividends, renewal actions, etc.

Name _____

Mailing Address _____

(Include City/State/Zip)

Phone No. (_____)_____ Fax No. _____ Website: _____

Claims office and representative responsible for payments for this account.

Name _____

Address _____
(include City, State, Zip)

Phone No._____ Fax No. _____ E-Mail: _____

Taxpayer identification.

State of Incorporation _____ Taxpayer identification number _____

What are your current ratings with the various rating companies?

_____

_____

E. PROPOSAL QUESTIONNAIRRE:

1. Do you provide fully insured group health coverage including PPO and HMO? (Circle One) **Yes** **No**

2. Do you provide a network of providers for each plan? (Circle One) **Yes** **No**

3. Does your proposal provide coverages that are as good as or better than current plans? (Circle One) **Yes** **No**
4. Does your proposal include any incentives such as wellness dollars or multi-lines of coverages offer discounts? (Circle One) **Yes** **No** Please explain.
5. Proposer acknowledges that a standard commission to the broker of record HUB/RGVI is included in their proposal. (Circle One) **Yes** **No**
6. Do you accept 834 compliant EDI file feed to the carrier? (Circle One) **Yes** **No**
7. Do you accept self-billing by the Board with monthly variance report between enrolled and what is paid to the carrier? (Circle One) **Yes** **No**
8. Proposer acknowledges that the rates proposed will be made in ten (10) deductions. (Circle One) **Yes** **No**
9. Does your proposal provide retiree benefits same as active employees? (Circle One) **Yes** **No**
10. The Boards open enrollment date is mid July through mid August of each year. Do you agree to provide final annual renewal rates by June 15th of each year? (Circle One) **Yes** **No**

11. Does your company provide compensation to offset the cost of the Boards online enrollment system? (Circle One)

    Yes No

12. Is your company prepared to pay a claim that may have occurred on the job, but is denied by Worker's Compensation, or the individual is not covered by Worker's Compensation? (Circle one) **Yes No**

13. Describe your procedure for claim denials or appeals.

14. Are the network providers required to accept your network fees as payment in full? **(Circle one) Yes No**

15. Are the network providers allowed to balance bill the employee? **(Circle one) Yes No**

16. How are allowable fees calculated for out-of-network providers? Are they paid at the in-network rate or is it based upon a percentage of reasonable and customary? If reasonable and customary, what percentage is used?

17. Do you require precertification on all in-patient hospitalizations**? (Circle one) Yes No** If not, what admissions would require precertification?

18. Do you require the use of a specific transplant network? **(Circle one) Yes No** If yes, please provide a list of the closest transplant facilities.

19. What method does your company use to determine UCR (Percentage of HIAA, MMA, Prevailing Fee, etc.)?

    A. How often do you review the UCR system?

    B. When did you last update/revise the UCR schedule?

20. Did you include the cost of administering Consolidated Omnibus Budget Reconciliation Act (COBRA) in your premium rates? **(Circle one) Yes No** If No, what would be the additional charge?

21. Are additional costs assessed for required reports? **(Circle one) Yes No** Are additional costs assessed for other requested reports? Specify.

22. What is your claim turnaround period? How is this verified? What is your ability to provide an efficient claim turnaround guarantee? Describe.

23. Are your rates guaranteed for 12 months? **(Circle one) Yes No** Can additional expenses be charged to the policyholder in excess of these premiums?

24. How soon after enrollment may the District expect delivery of:

    A. Master Contract?
    B. Employee Certificates?
    C. Initial Premium Billing?
    D. Identification Cards?

25. When may the District expect to review a draft of the Summary Plan Description?

26. What is your charge for providing sign-up forms, contract updates, and discrimination testing for the current Section 125 Plan?

27. We currently have a prescription card and mail order prescription program. Do your premiums include the cost of continuing this program? **(Circle one) Yes No**

28. Confirm your company's agreement to cover intentionally self-inflicted injury, and injuries caused by a person being intoxicated or under the influence of any narcotic. **(Circle one) Yes No** Is there any maximum?

29. Confirm your company's agreement to cover at least a minimum of 60 days of cardiac rehabilitation therapy. **(Circle one) Yes No**

30. Confirm your company's agreement to include coverage for major human organ transplants. Is there any maximum? **(Circle one) Yes No**

31. Does your company provide HIPAA Administration including Certificates of Creditable Coverage? **(Circle one) Yes No** Is there an additional charge for this service? **(Circle one) Yes No** If yes, specify cost.

32. What kind of support will your company provide to the District to comply with The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)? Is there an additional charge for this service? **(Circle one) Yes No** If yes, specify cost.

33. Do you have a disease management program? **(Circle one) Yes No** If yes, is it included in your rates? **(Circle one) Yes No** If no, specify cost to do so? Please provide statistics on how this program will save claims dollars.

EXHIBIT A

LEON COUNTY SCHOOLS

BUILDING THE FUTURE TOGETHER

CONFLICT OF INTEREST CERTIFICATE

Bidder **must** execute either Section I or Section II hereunder relative to Florida Statute 112.313(12). Failure to execute either section may result in rejection of this proposal.

SECTION I

I hereby certify that no official or employee of the School Board requiring the goods or services described in these specifications has a material financial interest in this company.

Signature	*Company Name*
Name of Official (Type or print)	*Business Address*
	City, State, Zip Code

SECTION II

I hereby certify that the following named Leon County School Board official(s) and employee(s) having material financial interest(s) (in excess of 5 %) in this company have filed Conflict of Interest Statements with the Supervisor of Elections, 315 South Calhoun Street, Tallahassee, Leon County, FL prior to bid opening.

Name	**Title or Position**	**Date of Filing**

Signature	*Company Name*
Name of Official (Type or print)	*Business Address*
	City, State, Zip Code

EXHIBIT B

LEON COUNTY SCHOOLS
2757 West Pensacola Street – Tallahassee, FL 32304-2998
FAX FORM TO: (850) 487-7869

APPLICATION FOR VENDOR STATUS

(IRS W-9 Facsimile)

NEW VENDOR ☐
UPDATE ☐

COMPANY NAME: _____

CONTACT PERSON: _____

PHONE NUMBER: (___) _____ **FAX NUMBER:** (___) _____

CORRESPONDENCE ADDRESS: _____

CITY: _____ **STATE:** _____

ZIP + 4: _____ - _____ _____ _____ _____

REMITTANCE: NAME (if different from above): _____

ADDRESS: _____

CITY: _____ **STATE:** _____

ZIP + 4: _____ - _____ _____ _____ _____

EMAIL ADDRESS: _____ **WEBSITE:** _____

PLEASE CHECK APPROPRIATE BOX: ☐ Individual/Sole Proprietor ☐ S Corporation ☐ C Corporation ☐ Partnership
☐ Other_____ ☐ LLC – Type (Check one) ☐ C ☐ D ☐ P

TAX IDENTIFICATION NUMBER: _____ - _____ OR _____ - _____ - _____
Federal Employer Identification Number Social Security Number

Section 6109 of the Internal Revenue Service Code requires you to provide your correct TIN to persons, businesses, or agencies that are required to file information returns with the IRS. Purchase orders will not be issued to vendors who fail to provide a TIN.

PLEASE INDICATE THE FOLLOWING: ***Minority Vendor?** ☐ Yes ☐ No Male ☐ Female ☐

**If yes, certification required – (Please submit with form)*

Race: Caucasian: ☐ Hispanic: ☐ African American: ☐ Asian: ☐
American Indian: ☐ Other: _____

By: _____ _____ _____
Signature Printed Name Date

LCSB site contact requesting vendor: _____ _____
Name Phone/Email

EXHIBIT C

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____
(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number
___ – ___ – ____

or

Employer identification number
__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at www.irs.gov/fw9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding? on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Cat. No. 10231X — Form **W-9** (Rev. 12-2014)

EXHIBIT D

LEON COUNTY SCHOOLS
BUILDING THE FUTURE TOGETHER

CUSTOMER REFERENCE FORM

RFP NO. 431-2018 Group Health Insurance

Please provide all requested information for each reference.

Company Name: _____

Business Type: _____

Contact Person: _____

Telephone: _____

Email: _____

Date Last Supplied Products or Services: _____

Company Name: _____

Business Type: _____

Contact Person: _____

Telephone: _____

Email: _____

Date Last Supplied Products or Services: _____

Company Name: _____

Business Type: _____

Contact Person: _____

Telephone: _____

Email: _____

Date Last Supplied Products or Services: _____

EXHIBIT E

LEON COUNTY SCHOOLS
BUILDING THE FUTURE TOGETHER

VENDOR QUESTIONNAIRE

RFP NO. 431-2018 Group Health Insurance

Please provide written responses to the following questions. If the answer to any of the questions is `Yes`, Vendor shall describe fully the circumstances, reasons therefore, the current status, and ultimate disposition of each matter that is the subject of this inquiry.

1. Has Vendor been declared in default of any contract?
☐ Yes ☐ No

2. Has Vendor forfeited any payment of performance bond issued by a surety company on any contract?
☐ Yes ☐ No

3. Has an uncompleted contract been assigned by Vendor's surety company on any payment of performance bond issued to Vendor arising from its failure to fully discharge all contractual obligations there under?
☐ Yes ☐ No

4. Within the past three years, has Vendor filed for reorganization, protection from creditors, or dissolution under the bankruptcy statutes?
☐ Yes ☐ No

5. Is Vendor now the subject of any litigation in which an adverse decision might result in a material change in the firm's financial position or future viability?
☐ Yes ☐ No

6. Is Vendor currently involved in any state of a fact-finding, negotiations, or resistance to a merger, friendly acquisition, or hostile take-over, either as a target or as a pursuer?
☐ Yes ☐ No

7. Within the next year, does Vendor plan any personnel reductions? If so, explain by attachment.
☐ Yes ☐ No

8. Within the next year, does Vendor plan any divestments? If so, explain by attachment.
☐ Yes ☐ No

EXHIBIT F

LEON COUNTY SCHOOLS

BUILDING THE FUTURE TOGETHER

DRUG FREE WORKPLACE

Preference shall be given to vendors submitting a certification with their bid/proposal certifying they have a drug-free workplace in accordance with Section 287.087, Florida Statutes. Whenever two or more proposals that are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a proposal received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedures for processing tie bids will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

IDENTICAL TIE BIDS – Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids, which are equal with respect to price, quality, and service, are received by the State or any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free workplace program shall be given preference in the award process. Established procedure for processing tie bids shall be followed if none of the tied vendors have a drug-free workplace program.

A business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee s will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of Chapter 893 or of any controlled substance law of the United States or any state, for a violation occur ring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community, by any employee who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

VENDOR'S SIGNATURE: _____

EXHIBIT G

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION -LOWER TIER COVERED TRANSACTIONS

(BEFORE COMPLETING CERTIFICATION, READ INSTRUCTIONS ON THE FOLLOWING PAGE)

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Organization Name	PR/Award Number or Project Name
Name(s) of Authorized Representative(s)	Title(s) of Authorized Representative(s)
Signature(s)	Date

Form AD-1048 (1/92)

INSTRUCTIONS FOR CERTIFICATION OF DEBARMENT

1. By signing and submitting this form, the prospective lower tier participant is providing the certification set out on the reverse side in accordance with these instructions.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this form that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this form that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -Lower Tier Covered Transactions," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

Form AD-IO48 (1/92) U. S. GPO: 1996-757-776/201 07

EXHIBIT H

LEON COUNTY SCHOOLS
BUILDING THE FUTURE TOGETHER

SWORN STATEMENT – NEW CONTRACTS
SWORN STATEMENT PURSUANT TO SECTION 1012.465, FLORIDA STATUTES AS AMENDED BY HB 1877, THE JESSICA LUNSFORD ACT

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to The School Board of Leon County, Florida *(hereinafter "Board" or "School Board")* by _____
(Print individual's name and title)

for _____
(Print name of entity submitting sworn statement)

whose business address is _____

_____

and its Federal Employer Identification Number (FEIN) is _____
If the entity has no FEIN, include the Social Security Number (SSN) of the individual signing this sworn statement and so indicate.

2. I, _____ am duly authorized to make this sworn statement
(Print individual's name and title)

on behalf of: _____

_____

_____
(Print name of entity submitting sworn statement)

3. I understand that during the 2005 Legislative Session, House Bill 1877, The Jessica Lunsford Act (hereinafter "The Act" or "Act") was passed and approved by Governor Bush on May 2, 2005, with an effective date of September 1, 2005.

4. I understand that the Act amends the background screening requirements of section 1012.465, Florida Statutes (2004) for all non-instructional school district employees or **"contractual personnel"** by requiring all non-instructional school district employees or contractual personnel who are permitted access on school grounds when students are present to undergo and pass "level 2 background screening," and further I understand the Act defines **"contractual personnel"** to include any vendor, individual, or entity under contract with the Board.

5. I understand that pursuant to section 1012.465, Florida Statutes as amended by the Act, non-instructional school district employees or contractual personnel who are permitted access on school grounds when students are present, who have direct contact with students or who have access to or control of school funds must meet level 2 screening requirements as described in sections 1012.32 and 435.04, Florida Statutes.

6. I understand that as a _____ *(eg. a charter bus company)*
(Type of entity)
all contractual personnel, as defined in section 1012.465, Florida Statutes, must meet Level 2 screening requirements as outlined in sections 1012.32 and 435.04, Florida Statutes in order to do business with the School Board.

7. I understand that "level 2 screening requirements" as defined in sections 1012.32 and 435.04, Florida Statutes means that fingerprints of all contractual personnel must be obtained and submitted to the Florida Department of Law Enforcement for state processing and to the Federal Bureau of Investigation for federal processing.

8. I understand that the School Board has implemented Board Policy 2.021 to comply with level 2 screening requirements, as defined in sections 1012.32 and 435.04, Florida Statutes. I understand that my company must comply with these local procedures as they are developed or amended from time to time.

9. I understand that any costs and fees associated with the required background screening will be borne by my company.

10. I understand that any personnel of the contractor found through fingerprint processing and subsequent level 2 background screening to have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to any offense outlined in Section 435.04, Florida Statutes (or any similar statute of another jurisdiction), **shall not be permitted** to come onto school grounds or any leased premises where school-sponsored activities are taking place when students are present, shall not be permitted direct contact with students, and shall not be permitted to have access to school district funds.

11. I understand that the failure of any of the company's or my affected personnel to meet level 2 screening standards as required by section 1012.465, Florida Statutes, may disqualify my company from doing business with the School Board.

12. I hereby certify that the foregoing statement is true and correct in relation to the company for which I am submitting this sworn statement. I further certify that this statement is being given knowingly and voluntarily by me on behalf of my company.

The company submitting this sworn statement agrees to be bound by the provisions of SECTIONS 1012.32, 1012.465, AND 435.04 OF THE FLORIDA STATUTES AS AMENDED BY HB 1877, THE JESSICA LUNSFORD ACT 2005.

I CERTIFY THAT THE SUBMISSION OF THIS FORM TO THE SCHOOL BOARD OF LEON COUNTY, FLORIDA ON BEHALF OF THE COMPANY IDENTIFIED IN PARAGRAPH ONE (1) ABOVE BINDS THE COMPANY TO FULLY COMPLY WITH THE BACKGROUND SCREENING REQUIREMENTS OF SECTIONS 1012.32, AND 435.04, FLORIDA STATUTES.

_____
(Signature)

Sworn to and subscribed before me this _____ day of _____ 20_____ .

_____ is personally known to me ☐ OR produced identification ☐

by showing _____
(Type of Identification)

Notary Public – State of _____ My commission expires on: _____

_____ _____
Signature of Notary Public *(Printed, typed or stamped commissioned name of Notary Public)*

EXHIBIT I

AFFIDAVIT FOR CLAIMING LOCAL PURCHASING PREFERENCE

RFP NO. 431-2018 Group Health Insurance

Proposer/Bidder/Quoter/Supplier affirms that it is a local or adjacent county business as defined by Policy #6450 of Leon County Schools and the regulations thereto.

A Leon/adjacent county vendor is a private independent vendor that has been licensed for at least six (6) months preceding the bid or proposal opening, as required by local, State, and Federal law to provide the goods, services, or construction to be purchased. The vendor must have a physical business address, staffed by at least one (1) person, in the geographical boundaries of Leon County or in the adjacent counties of Gadsden, Jefferson, or Wakulla, Florida. The vendor, on a day-to-day basis, should provide to the School Board the needed goods and/or services substantially from the local business address. Post Office boxes are not verifiable and shall not be used for the purpose of establishing said physical address.

Please complete the following in support of the self-certification:

Business Name: _____

Address: _____

_____

_____ _____ _____

Phone *Fax* *Email*

County: _____ Length of time at this location: _____ # of employees at this location ____

Is your business certified as a small business through Leon County Schools? _____

_____

Signature of Authorized Representative *Date*

State of FLORIDA

County of _____

Sworn to and subscribed before me, a Notary Public for the above State and County, on this _____ day of _____, 20 _____.

_____ _____

Notary Public *My Commission Expires*

EXHIBIT J
INDEMNIFICATION AND INSURANCE

In consideration of this Contract, if awarded, the Vendor agrees without reservation to the indemnification and insurance clauses contained herein. These clauses are attached to and form a part of **RFP NO. 431-2018 Group Health Insurance**. The Vendor shall hold harmless, indemnify and defend the indemnities (as hereinafter defined) against any claim, action, loss, damage, injury, liability, cost or expense of whatsoever kind or nature including, but not by way of limitation, attorneys' fees and court costs arising out of bodily injury to persons including death, or damage to tangible property arising out of or incidental to the performance of this Contract (including goods and services provided thereto) by or on behalf of the Vendor, whether or not due to or caused in part by the negligence or other culpability of the indemnities, excluding only the sole negligence or culpability of the indemnities. The following shall be deemed to be indemnities: The School Board of Leon County, Florida and its members, officers and employees.

INSURANCE

Prior to being recommended for award, the Vendor has five business days after notification to submit proof of insurance as required herein. Failure to submit a fully completed certificate of insurance signed by an authorized representative of the insurer providing such insurance coverage's may cause the Vendor to be considered non-responsive and not eligible for award of the Contract. 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 Vendor, 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 Vendor as required by Florida Statutes.
4. The School Board of Leon County, Florida" must be listed as additional insured on all liability coverage's except Workers' Compensation.

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

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

1. The company must be:
   a. authorized by subsisting certificates of authority by the Department of Insurance of the State of Florida or
   b. 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.

or

2. With respect only to the Workers' Compensation insurance, the company must be:
   a. authorized as a group self-insurer pursuant to Florida Statutes or
   b. authorized as a commercial self-insurance fund pursuant to Florida Statutes

Neither approval nor failure to disapprove the insurance furnished by the Vendor to the School Board shall relieve the Vendor of the Vendor's full responsibility to provide insurance as required by this Contract.

The Vendor 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 Vendor. 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 Vendor 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.

Unless otherwise notified, the certificate of insurance must be delivered to the following address:

Leon County School Board
Purchasing Department
Attn: June Kail, Director of Purchasing
3397 W. Tharpe St.
Tallahassee, Florida 32303

The name and address of Leon County Public Schools, as shown directly above, must be listed as Certificate Holder on the Certificate of Insurance as well as clearly noted as "Additional Insured".

The Vendor 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.

Attachment No. 1

Capital Health PLAN

Large Group Employer Application & Renewal Agreement

☐ New Business ☒ Renewal Business ☐ Standalone ☐ Dual Option ☐ Other _____ CHP Group # 00009

I. APPLICANT INFORMATION

A. Name of Group: Leon County School District
Group Tax ID #: 596000709
Nature of Business: Elementary and Secondary Schools SIC Code 611110
Mailing Address: 2757 West Pensacola Street, Tallahassee, FL. 32304
List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application:
Name _____ Address _____

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as Policy) by Capital Health Plan, Inc. (CHP). Upon acceptance of this application by CHP, it will become part of the Policy issued to the applicant named above.

C. Prior Health Carrier: Insurance _____ HMO CHP

D. The Policy excludes expenses for any service or supply to diagnose or treat any condition resulting from or in connection with an insured's job or employment (e.g. any service or supply which is covered by Workers' Compensation insurance), except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers' Compensation carrier is _____.

F. ERISA Classification (Employee Retirement Income Security Act as defined by the U.S. Department of Labor) ☐ ERISA ☒ NON-ERISA

II. EFFECTIVE DATE/ELIGIBILITY INFORMATION

A. Effective Date of this Policy shall be 10/01/1985. The Effective Date of this change to the policy shall be 10/01/2017. This policy may be terminated by the applicant or CHP by giving at least 45 days prior written notice to the other party, except in the case of non-payment of Premium.

B. Only active eligible employees who regularly work a minimum of 20 hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

_____

D. New eligible employees may be covered effective on the Other – See Notes or Comments, so long as the eligible employee submits an application to CHP within 30 days of the date the individual first meets the applicable eligibility requirements.

E. At least 75% of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy.

F. CHP shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage; applicant agrees to furnish any such request.

G. Employer Contribution: Employee 80% Dependents 60% 60% we

III. HEALTH PLAN SUMMARY INFORMATION (select the appropriate box(es))

Mandated Benefit Offerings (Optional): Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

	Included in Product	Accept	Decline
Mental Health Parity	☒	☐	☐
Substance Use Disorder	☒	☐	☐
Enteral Formulas	☒	☐	☐

CHP Health Benefits: Capital Selection w/ $15/30/50 Rx	Employee Only	$583.92	Family	$1693.51	Over-Age Dependent	$642.31
	Employee/Spouse	$1197.12				
Alternate Health Benefits: Value Selection $15/50/100 Rx	Employee Only	$435.90	Family	$1264.22	Over-Age Dependent	$479.49
	Employee/Spouse	$893.66				

Medicare Retiree Advantage Rates:	Medicare Employee Only:	$268.07	Medicare w/Family:	$1377.66
	Medicare w/Med Spouse:	$536.14	Medicare w/Non-Med Dependent:	$851.99

IV. RATE INFORMATION

A. Premiums/Prepayment fees are payable monthly on or before the due date, which will be: 1st of every month.

B. Regular Billing – Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

C. The rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, CHP may change the rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed rates forty-five (45) days prior to their Effective Date.

V. APPLICANT RESPONSIBILITIES

A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the Termination Date of coverage (In this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of CHP for this or any other purpose, nor shall CHP be responsible for such notification to retirees). 2) Notify CHP promptly of any changes in the eligibility of enrollees covered under this Agreement. 3) List any absentees at the time of initial enrollment on the appropriate CHP form. Applications from absentees will be accepted at CHP no later than thirty (30) days from the group's Effective Date. 4) Collect enrollee contribution, if required, and remit Premium payment/pre-payment fees to CHP as specified in this application.

B. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care or benefits in the event of sickness.

VI. FINAL PREMIUMS, BENEFITS AND EFFECTIVE DATES ARE SUBJECT TO APPROVAL BY CHP

Issuance of the Policy by CHP will be deemed acceptance of this application. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. This document alone does not constitute an entire employer contract. The Employer Group Contract consists of the Employer Application, Master Policy, Member Handbook, the Individual Member Enrollment Application and any attachments, amendments, or endorsements to the Member Handbook or Master Policy.

Date	Signature of Applicant	Print/Type Name and Title
6-21-17	Pam Faulkner	Pam Faulkner / Benefits Coordinator

Date	Signature of Agent	Agent License ID	Capital Health Plan Authorized Signature
6/23/2017	Wanda Cuth	A060082	

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Leon County School District

MLR Summary

- P&L -	5-Year Average	10/16-9/17	10/15-9/16	10/14-9/15	10/13-9/14	10/12-9/13
Loss Ratio:	102.3%	93.7%	102.2%	98.5%	107.4%	113.0%
Premiums:	$27,492,335	$31,840,584	$29,220,299	$27,652,831	$25,131,167	$23,616,794
Member Months:	64,742	67,118	65,095	63,217	64,274	64,004
Member Average:	5,395	5,593	5,425	5,268	5,356	5,334

Capital Health Plan
An Independent Licensee of the Blue Cross and Blue Shield Association

Capital Selection 15/30/50 Retiree Advantage (HMO)

Schedule of Copayments

Covered Service	Unit	Your Cost (Copayment)
Physician Services (including maternity care)		
Primary Care: Office visit for services provided by your primary care physician during regular office hours	Per Visit	$15
Specialty Care: Office visit for services provided by a participating provider when authorized by your primary care physician	Per Visit	$40
Urgent Care: Office Visit – Urgent care services provided by your primary care physician, or other Capital Health Plan personnel or participating providers including after regular office hours Telehealth – Urgent care services provided by network physicians through remote access technology including the web and other mobile devices	Per Visit Per Visit	$25 $15
Preventive Services: Preventive services covered under Original Medicare	Per Visit	$0
Chiropractic Care	Per Visit	$20
Mental health and Substance Use Disorder outpatient care when medically necessary and authorized by the primary care physician	Per Visit	$40
Outpatient procedures, surgical services, and other medical care provided by the primary care physician or by a participating provider when authorized by primary care physician	Per Visit	$40
Hospital Services (including maternity care)		
Room and board in a semiprivate room, or private when medically necessary, and all services covered under this agreement	Per Admission	$250
Outpatient procedures performed in a hospital	Per Visit	$250
Mental health inpatient hospital care	Per Admission	$250
Emergency Services		
Emergency room visit	Per Visit	$75 (waived if admitted)
Medically necessary ambulance service	Per Transport	$100

Covered Service	Unit	Your Cost (Copayment)
Other Benefits		
Home health services	Per Occurrence	$0
Hospice care	Per Occurrence	$0
Skilled nursing facility services limited to 100 days of confinement per benefit period	Per Confinement	$0
Outpatient procedures performed in an ambulatory surgical center	Per Visit	$100
Durable medical equipment	Per Device	$0
Orthotic and Prosthetic medical appliances	Per Appliance	$0
Diagnostic Imaging including MRI, PET, CT, and Thallium Scans	Per Visit	$100
Routine eye exams (one every 12 months)	Per Visit	$15
Visits for physical therapy, occupational therapy, and speech language therapy	Per Visit	$40
Visits for cardiac and pulmonary rehabilitation services	Per Visit	$40

Outpatient Prescription Drugs

		30 day supply	60 day supply	90 day supply
Retail	Tier 1	$15	$30	$45
	Tier 2	$15	$30	$45
	Tier 3	$30	$60	$90
	Tier 4	$50	$100	$150
	Tier 5	$50	N/A	N/A
Mail order	Tier 1	$15	$30	$37.50
	Tier 2	$15	$30	$37.50
	Tier 3	$30	$60	$75
	Tier 4	$50	$100	$125
	Tier 5	N/A	N/A	N/A

Exclusions

Services not specifically listed in the Evidence of Coverage; service, which in our opinion was, or is, not medically necessary; hearing aids and devices; cosmetic surgery; nonprescription drugs and vitamins; and custodial care.

- You are responsible for the payment of charges for health care services that are not covered and for the payment of charges in excess of any maximum benefit limitation set forth in the Evidence of Coverage or Schedule of Copayments.
- Your maximum out-of-pocket amount for medical services in the calendar year is $3,400 per member, excluding your costs for covered Part D prescription drugs. After reaching your maximum out-of-pocket amount you generally pay nothing for covered Medicare Part A and Part B services for the remainder of the calendar year.
- Covered prescription drugs must be medically necessary, and prescribed by a qualified medical professional acting within the scope of his/her license, and dispensed by a pharmacist. Supplies other than 30, 60, or 90 days are available.
- See the Capital Health Plan Retiree Advantage Evidence of Coverage or the Capital Health Plan Retiree Advantage Summary of Benefits for additional information.

Capital Health PLAN

An Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Program Prescription Drug Endorsement

This Endorsement is to be attached to and made a part of your Capital Health Plan, Inc. (CHP) Member Handbook/Certificate of Coverage. The Member Handbook/Certificate of Coverage hereby is amended by adding to the Covered Services Section a subsection titled "**CHP Prescription Drug Benefit.**"

The Exclusions and Limitations Section of the Member Handbook/Certificate of Coverage is amended by deleting the applicable exclusion for **Prescription Drugs.**

All other provisions of the Member Handbook/Certificate of Coverage shall remain unchanged.

Refer to your Summary of Benefits and Coverage(SBC) document for Cost Share structure and amounts.

CHP PHARMACY PROGRAM

The CHP Prescription Drug Benefit provides covered prescription drugs and supplies. Each covered prescription drug, when purchased from a participating pharmacy, will be subject to a member cost sharing amount. The member cost sharing amount is determined by the tier level or type of the prescription drug dispensed [i.e., Tier 1, Tier 2, Tier 3, or Tier 4 (specialty drug)].

In general, most generic drugs and competitively priced brand drugs are included on Tier 1 and typically represent the lowest cost to plan members. Tier 2 represents the intermediate plan member cost share and generally includes preferred drug products. A Tier 2 preferred prescription drug on the Commercial Formulary may be reclassified as a Tier 3 non-preferred prescription drug on the date the FDA approves a bioequivalent generic prescription drug. Tier 3 represents a higher member cost share than Tier 2 and generally includes most brand name drugs not selected for Tier 1 or 2 and some generic drugs (i.e. non-preferred drug products). Tier 4 prescription drugs are Specialty drugs subject to the highest member cost share (Please see your Summary of Benefits and Coverage document to see if this Tier applies to you).

If a member or the prescriber requests a brand prescription drug not listed as Tier 1, Tier 2 or Tier 3 that has a generic available, the member must pay the non-preferred Tier 3 member cost share plus pay the pharmacy 100% of the additional cost of the more expensive brand prescription drug. Capital Health Plan reserves the right to add, remove or reclassify any prescription drug on the Commercial Formulary at any time.

Covered prescription drugs must be medically necessary, prescribed by a medical professional acting within the scope of his or her license, and dispensed by a pharmacist.

Definitions Specific to the CHP Pharmacy Program

Brand Name Prescription Drug
A prescription drug which is marketed or sold by a manufacturer using a trademark or proprietary name, an original or pioneer drug, or a drug that is licensed to another company by the brand name drug manufacturer for distribution or sale, whether or not the other company markets the drug under a generic or other non-proprietary name [i.e. branded-generic drugs with a multi-source code (MSC) of M or O].

Cost Share
The amount the member pays the participating pharmacy at the time of service for each covered prescription drug, as specifically set forth in your Summary of Benefits and Coverage.

Covered Prescription Drugs
All drugs that

- Require a prescription under federal or state law
- Are covered by this Endorsement when filled at participating pharmacies
- Are prescribed by a participating prescriber
- Are authorized by Capital Health Plan

Drug
Any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical, or chemical compound.

FDA
United States Food and Drug Administration.

Generic Drug
A prescription drug containing the same active ingredients as a brand name prescription drug that either (i) has been approved by the FDA for sale or distribution as the bioequivalent of a brand name prescription drug through an abbreviated new drug application under 21 U.S.C. 355 (j); or (ii) is a prescription drug that is not a brand name prescription drug, is legally marketed in the United States and, in the judgement of CHP, is marketed and sold as a generic competitor to its brand name prescription drug equivalent. All generic drugs are identified by an "established name" under 21 U.S.C. 352 (e), by a generic name assigned by the United States Adopted Names Council, or by an official or non-proprietary name, and may not necessarily have the same inactive ingredients or appearance as the brand name prescription drug. Generic drugs have a Multi-source Code (MSC) of Y.

Medically Necessary
For coverage and payment purposes, that a medical service, drug, or supply is required for the identification, treatment, or management of a condition, and is, in the opinion of CHP:

1. consistent with the symptom, diagnosis, and treatment of the member's condition;
2. widely accepted by the practitioners' peer group as efficacious and reasonably safe based on scientific evidence;
3. universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment;
4. not experimental or investigational;
5. not for cosmetic purposes;
6. not primarily for the convenience of the member, the member's family, or the prescriber; and,
7. the most appropriate level of service, care or supply which can safely be provided to the Member.

Non-participating Pharmacy
A pharmacy that has not signed an agreement with the pharmacy benefit manager (PBM) contracted with CHP to furnish services to members.

Non-preferred Drug
A prescription drug either branded, branded-generic or generic specialty,that is not otherwise listed as preferred on the Commercial Formulary then in effect. **Note:** The Commercial Formulary is subject to change at any time. Please refer to our web site at www.capitalhealth.com for the most current formulary or you may call the member services number on your Identification Card.

Participating Pharmacy
A pharmacy that has signed an agreement with the PBM contracted with CHP to render services to members, as set forth in this Endorsement.

Pharmacist
A person properly licensed to practice the profession of pharmacy under Chapter 465, Florida Statutes, or other states' applicable laws.

Preferred Name Drug
A drug that is noted as preferred on the Commercial Formulary then in effect. A preferred drug on the Commercial Formulary then in effect may be reclassified as a non-preferred prescription drug on the date the FDA approves a bioequivalent generic prescription drug. **Note:** The Commercial Formulary is subject to change at any time. Please refer to our web site at www.capitalhealth.com for the most current formulary or you may call the member services number on your Identification Card.

Preferred Specialty Drug
A medication that meets the definition of a specialty drug and is noted as preferred on the Commercial Formulary. A trial of a preferred specialty drug in treating the indicated disease state may be required before an alternative non-preferred drug will be approved for use. A preferred specialty drug has the same member cost share as a non-preferred specialty drug.

Prescriber
A medical professional (e.g., physician, optometrist, nurse practitioner) whose state license authorizes him or her to prescribe drugs.

Prescription
An order for drugs by a physician authorized by the laws of the state to prescribe such drugs or supplies.

Prescription Drug
Any medicinal substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound that can be dispensed only under a prescription and/or that is required by state law to bear the following statement or similar statement on the label: "Caution: Federal law prohibits dispensing without a Prescription."

Primary Care Physician (PCP)
The physician who is the primary care physician for the member, according to CHP's records, and who provides primary care medical services to members under a primary care physician provider contract with CHP then in effect.

Prior Authorization
Approval in advance to get covered prescription drugs. Some covered prescription drugs require approval in advance from Capital Health Plan.

Provider
"Provider" is the general term that we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by the state to provide health care services.

Specialty Drug
Medications that generally have unique uses, require special dosing, handling or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs or therapies.

Standard Reference Compendium
The United States Pharmacopoeia Drug Information; The American Medical Association Drug Evaluation; and, The American Hospital Formulary Service Hospital Drug Information.

Covered Items

This Endorsement provides benefits for covered drugs.

To be covered, prescriptions must be prescribed by a medical professional acting within the scope of his or her license and dispensed by a participating pharmacy.

Unless otherwise excluded, all prescription drugs are covered under this program.

Insulin and chemstrips are covered if prescribed by a medical professional acting within the scope of his or her license. Insulin needles and syringes will be covered only when prescribed in conjunction with insulin. A separate cost share is required for syringes and needles.

Anaphylactic kits are covered only when self-administered and prescribed by a medical professional acting within the scope of his or her license.

Limitations and Exclusions

The following limitations and exclusions apply to benefits for covered prescription drugs and supplies, in addition to all of the other provisions and exclusions of the Member Handbook/Certificate of Coverage:

Limitations

1. A prescription unit or refill will be covered up to a 90-day supply for generic and brand drugs (at 3 times the member's cost share per 90 day supply) at Retail and Mail Order Pharmacies . Specialty drugs are limited up to a 30-day supply. Refills on prescriptions shall not be covered until at least 75% of the previous prescription has been used by the member based on the dosage schedule prescribed.
2. Refills that are authorized by the prescriber must be filled within six months or one year from the original prescription date, depending on federal law designations.
3. Syringes and needles will be covered only when prescribed and obtained with a prescription for administration of diabetic products.
4. Certain prescription drugs, require prior authorization. For a list of these drugs, refer to www.capitalhealth.com. For instructions about how to get prior authorization, call Member Services at 850-383-3311 (toll-free 1-877-247-6512); TTY 850-383-3534 (1-877-870-8943).
5. If a generic drug is available, and a more expensive brand name prescription drug is dispensed at the request of the member or the prescriber, the member must pay the Tier 3 cost share amount for the non-preferred drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug.
6. CHP retains the right to limit coverage of the quantities of prescribed drugs.

7. CHP retains the right to designate a specific pharmacy or pharmacies that may disperse certain covered drugs.
8. CHP retains the right to limit coverage of some drugs to only when prescribed by specific practitioners.

Exclusions

1. Drugs that can be purchased over the counter without a prescription, even though a prescription was provided by prescriber with the exclusion of Insulin and over the counter medications covered under the Preventive Services as defined by the Patient Protection and Affordable Care Act (ACA).
2. Drugs that are administered or dispensed and billed by a hospital or in a provider's facility with the exclusion drugs covered under the medical benefit.
3. Drugs that are dispensed before the effective date, or after the termination date, of this Endorsement.
4. All syringes and needles except as otherwise covered under this Endorsement.
5. Prescriptions refilled in excess of the amount specified by the prescriber.
6. Drugs in excess of the limitations specified in this Endorsement.
7. Drugs that are obtained by the member without charge.
8. Drugs that are experimental or investigational.
9. Appetite suppressants and other prescription drugs indicated for weight reduction or control.
10. Mineral supplements or vitamins, except for the following: prescription prenatal vitamins, prescription sustained release niacin, prescription folic acid, prescription oral hematinic agents, dihydrotachysterol, fluorinated vitamins, and calcitriol.
11. Certain Immunization agents, biological sera, blood, blood plasma.
12. Fertility drugs or any drugs used for the purpose of enhancing the probability of conception.
13. Drugs used for cosmetic purposes.
14. Drugs used for the topical treatment of Onychomycosis.
15. Drugs prescribed by a pharmacist.
16. Drugs listed in the Homeopathic Pharmacopeia.
17. Drugs prescribed for uses other than the FDA-approved label instructions. (This exclusion does not apply to any drug prescribed for the treatment of cancer that has been approved by the FDA for at least one indication, provided the drug is recognized for treatment of cancer in a Standard Reference Compendium or recommended for treatment in medical literature. Drugs prescribed for the treatment of cancer that have not been approved for any indication are excluded.)
18. Drugs that are not approved by the FDA.
19. Certain generic drugs when competitively priced brand drugs are covered on the formulary.
20. Drugs and supplies that are not medically necessary.
21. Certain prescription drugs approved for sexual dysfunction (Edex, Caverject, papaverine, Yocon, and phentolamine).
22. Drugs purchased from a non-participating pharmacy, except as a result of an emergency medical condition or when authorized by CHP.
23. All new prescription drugs that are approved by the FDA for marketing are excluded during the 12 consecutive months that immediately follow the date of the FDA's approval unless CHP, at its sole discretion, decides to waive this exclusion with respect to a particular prescription drug.
24. Any drug administered by intravenous infusion or injection, regardless of the setting in which it is administered or the type of provider administering the drug, except as specified in the Covered Items section of this Endorsement.
25. All prescription drugs for which prior authorization is required by this Endorsement and for which prior authorization is not obtained before the prescription is filled.
26. Any prescription drug prescribed in excess of the manufacturer's recommended specifications for dosage, frequency of use, or duration of therapy, as set forth in the manufacturer's insert for that prescription drug. This exclusion does not apply if:

- the dosage, frequency of use, or duration of therapy of a prescription drug has been shown to be safe and effective as evidenced in published, peer-reviewed medical or pharmacy literature;
- the dosage, frequency of use, or duration of therapy of a prescription drug is part of an established nationally recognized therapeutic clinical guideline such as those published in the United States by the American Medical Association, National Heart Lung and Blood Institute, American Cancer Society, American Heart Association, National Institutes of Health, American Gastroenterological Association, Agency for Health Care Policy and Research; or,
- CHP, at its sole discretion, waives this exclusion with respect to a particular prescription drug or therapeutic classes of prescription drugs.

Drugs Purchased from a Participating Pharmacy

The member must present the CHP membership card to the participating pharmacy to be identified as a member of this program.

The participating pharmacy will dispense covered prescription drugs to the member. The member will be responsible at the time of purchase for the required member cost share for each covered prescription drug.

The participating pharmacy will obtain the necessary information from the member (e.g., name, contract number, and date of birth) and file the claim. Payment for the covered prescription drugs will be made directly to the participating pharmacy.

Drugs Purchased From a Non-Participating Pharmacy

When covered prescription drugs are purchased from a non-participating pharmacy (because of an emergency medical condition or when authorized by CHP), the member will be required to pay the full cost of the drug at the point of service. To obtain reimbursement, the member must submit an itemized paid receipt to CHP within 90 days of purchase for each covered prescription drug purchased from a non-participating pharmacy. The itemized paid receipt must be submitted to CHP Member Services, P.O. Box 15349, Tallahassee, FL 32317-5349.

Prescription Drug Coverage Prior Authorization Program

Certain drugs need to be approved by CHP before they can be covered for payment; the list of these drugs is available at www.capitalhealth.com. If any of these drugs is prescribed, the person covered by this Endorsement will need to call Member Services (850-383-3311, toll-free 1-877-247-6512; TTY 850-383-3534 (1-877-870-8943)) to obtain prior authorization. Member Services will process the request and the person covered by this Endorsement will be notified if the drug is approved for coverage. **Failure to obtain authorization will result in denial of coverage.**

NOTE: This does not mean that the member cannot obtain the prescription drug from the pharmacy. It only means that CHP will not cover or pay for the prescription. The member may always purchase the prescription drug.

To obtain prior authorization:

1. The member, the prescriber, or the pharmacist must call Member Services and provide the information requested by the Member Services Representative. This information may include, but is not limited to, the member's name, date of birth, name of prescription drug to be covered and prescriber's name and telephone number.

2. CHP will contact the prescriber to get documentation for medical review.
3. Once a decision is made by CHP regarding coverage, the member, the prescriber, and the member's primary care physician will be informed. Denial decisions will be provided to the member in writing together with an explanation of the member's appeal rights.
4. If the decision is made to allow coverage, the member will be able to have the prescription filled at a participating pharmacy for the required member cost share.
5. If the decision is made not to allow the coverage, the member will be able to have the prescription filled, but the member will have to pay the full cost of the drug.

The Prescription Drug Coverage Prior Authorization Program has been established solely to determine whether coverage or benefits for prescription drugs will be provided under the terms of the Member Handbook/Certificate of Coverage. Ultimately, the final decision whether the prescription drug should be prescribed must be made by the member and the prescriber. **Decisions made by CHP in administering the Prescription Drug Coverage Prior Authorization Program are made only to determine whether coverage or benefits are available under the Member Handbook/Certificate of Coverage.**

Any and all decisions that require or pertain to independent professional medical judgments or training, or the need for a prescription drug, must be made solely by the member and the prescriber. It is possible that the member or the prescriber may conclude that a particular prescription drug is needed, appropriate, or desirable, even though that prescription drug may not be authorized for coverage under the Prescription Drug Coverage Prior Authorization Program. In that case, it is the member's right and responsibility to decide whether the prescription drug should be purchased even if CHP has indicated that coverage and payment will not be made under the Member Handbook/Certificate of Coverage.

This Endorsement shall not extend, vary, alter, replace, or waive any of the provisions, benefits, exclusions, limitations, or conditions contained in the Member Handbook/Certificate of Coverage, other than as specifically stated in this Endorsement. In the event of any inconsistencies between the provisions contained in this Endorsement and the provisions contained in the Member Handbook/Certificate of Coverage, the provisions contained in this Endorsement shall control to the extent necessary to accomplish the intent of Capital Health Plan, Inc., as expressed herein.

CAPITAL HEALTH PLAN, INC.

John Hogan
President and Chief Executive Officer

www.capitalhealth.com
P.O. Box 15349 • Tallahassee, Florida 32317-5349 • 850-383-3311

Capital Health Plan — Capital Selection $15/$30/$50 Rx

Coverage Period: Plans beginning on or after 1/1/2017

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Employee or Family | **Plan Type:** HMO

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?	Not Applicable	See the Common Medical Events chart below for your costs for services this plan covers.
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, prescription drug brand additional 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 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	$15 / visit	Not Covered	——————none——————
	Specialist visit	$40 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	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 www.capitalhealth.com/MedCenter	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	If a generic drug is available, and a more expensive brand name drug is dispensed at the request of the member or the prescriber, the member must pay the copayment amount for the brand name drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug. This additional cost does not count towards your out-of-pocket limit. Prior authorization and or quantity limit 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	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	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 limit 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 limit 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	$250 / visit	$250 / visit	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: $25 / visit Telehealth :$15 / visit	Urgent care: $25 / visit Telehealth :$15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
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	————none————
	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	————none————
	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.
	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 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 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.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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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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	**$13,400**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,060**

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	$15

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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,155**

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	**$2,200**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

Nondiscrimination and Accessibility Notice (ACA §1557)

Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Capital Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Capital Health Plan provides 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)
- Provides 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: Member Services 1-850-383-3311 or 1-877-247-6512, TTY/TDD- 850-383-3534 or 1-877-870-8943.

If you believe that Capital Health Plan has 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:

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943, Fax 850-523-7419, Email memberservices@chp.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department 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, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–868–1019, 800–537–7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Have a disability? Speak a language other than English? Call to get help for free.
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

Vous souffrez d'un handicap ? Vous parlez une autre langue que l'anglais ? Appelez pour obtenir une aide gratuite. 850 383 3311, 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

هل تعاني من إعاقة؟ هل تتحدث لغة غير اللغة الإنجليزية؟ اتصل للحصول على المساعدة المجانية.
850-383-3311أو 1-877-247-6512 أو TTY الهاتف النصي/TDD جهاز الاتصال الهاتفي للصم850-383-3534أو 1-877-870-8943

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos

Unterstützung zu erhalten. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

آیا توانایی خاصی دارید؟ به زبانی بجز انگلیسی صحبت می کنید؟ برای دریافت کمک رایگان با این شماره ها تماس بگیرید. 850-383-3311، 1-877-247-6512، TTY/TDD 850-383-3534 یا 1-877-870-8943

અપંગતા છે? ઇંગલિશિ કરતાં અન્ય ભાષા બોલો છો? નશિુલ્ક મદદ મેળવવા કૉલ કરો.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 અથવા 1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis?
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 lub
1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是残障人士吗？您不会说英语吗？请拨打电话以免费获取帮助。电话号码：850-383-3311、 1-877-247-6512；TTY/TDD（听障人士）：850-383-3534 或 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 850-383-3311, 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士? 您是否不會講英語? 請撥打電話以取得免費協助。 850-383-3311、
1-877-247-6512，聽障者請使用 TTY/TDD 850-383-3534 或 1-877-870-8943

พิการหรือเปล่า? พูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษหรือเปล่า? โทรเพื่อขอความช่วยเหลือฟรี
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 หรือ 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 hoặc 1-877-870-8943

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8 am – 5 pm at 850-383-3311 or 1-877-247-6512. State of Florida members can reach Member Services at 1-877-392-1532 from 7 am – 7 pm Monday-Friday. Medicare members please call Capital Health Plan Member Services Department at 850-523-7441 or 1-877-247-6512; October 1 – February 14: 8:00 a.m. – 8:00 p.m., seven days a week; February 15 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday. TTY/TDD (Telecommunication Device for the Deaf) users should call 850-383-3534 or 1-877-870-8943.

Capital Health Plan contact information is located on our website: http://www.capitalhealth.com/Capital-Health-Plan/Contact-Us

Approved by Compliance Committee: 8/23/16

Capital Health Plan — Value Selection HDHP $15/$50/$100 Rx Coverage Period: Plans beginning on or after 1/1/2017
(this plan not an HSA qualifies plan)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Employee or Family | **Plan Type:** HMO

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?	$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. 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, prescription drug brand additional 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 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	$15 / visit	Not Covered	————none————
	Specialist visit	$75 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	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 prescription drug coverage is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	If a generic drug is available, and a more expensive brand name drug is dispensed at the request of the member or the prescriber, the member must pay the copayment amount for the brand name drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug. This additional cost does not count towards your out-of-pocket limit. Prior authorization and or quantity limit may apply. Your benefits/services may be denied.
	Tier 2 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and or quantity limit may apply. Your benefits/services may be denied.

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	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 limit 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 / visit	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: $50 / visit Telehealth :$15 / visit	Urgent care:$50 / visit Telehealth :$15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
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	——none——
	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	——none——
	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.
	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.
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	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————
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- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
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- Private-duty nursing
- Routine foot care
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- Chiropractic care
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Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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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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, □ □ □ □ □ □ □ 850-383-3311, 1-877-247-6512.

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

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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*	$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	**$14,000**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

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*	$75
Hospital (facility) *copayment*	$500
Other *copayment*	$15

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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,455**

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

The plan's overall deductible	$0
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	**$3,200**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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

Nondiscrimination and Accessibility Notice (ACA §1557)

Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Capital Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Capital Health Plan provides 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)
- Provides 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: Member Services 1-850-383-3311 or 1-877-247-6512, TTY/TDD- 850-383-3534 or 1-877-870-8943.

If you believe that Capital Health Plan has 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:

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943, Fax 850-523-7419, Email memberservices@chp.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department 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, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–868–1019, 800–537–7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Have a disability? Speak a language other than English? Call to get help for free.
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

Vous souffrez d'un handicap ? Vous parlez une autre langue que l'anglais ? Appelez pour obtenir une aide gratuite. 850 383 3311, 1 877 247 6512, Téléscripteur/ATME 850 383 3534 ou 1 877 870 8943

Hai una disabilità? Non parli inglese? Chiama uno di questi numeri per chiedere assistenza gratuita: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o 1-877-870-8943

هل تعاني من إعاقة؟ هل تتحدث لغة غير اللغة الإنجليزية؟ اتصل للحصول على المساعدة المجانية.
850-383-3311أو 1-877-247-6512 أو TTY الهاتف النصي/TDD جهاز الاتصال الهاتفي للصم850-383-3534أو 1-877-870-8943

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos

Unterstützung zu erhalten. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

¿Tiene una discapacidad? ¿Habla algún otro idioma que no sea inglés? Llame para obtener ayuda gratis. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 o al 1-877-870-8943

آیا توانایی خاصی دارید؟ به زبانی بجز انگلیسی صحبت می کنید؟ برای دریافت کمک رایگان با این شماره ها تماس بگیرید. 850-383-3311، 1-877-247-6512، TTY/TDD 850-383-3534 یا 1-877-870-8943

અપંગતા છે? ઇંગલિશિ કરતાં અન્ય ભાષા બોલો છો? નશિુલ્ક મદદ મેળવવા કોલ કરો.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 અથવા 1-877-870-8943 પર

Ou gen yon andikap? Ou pale yon lang ki pa Anglè? Rele pou jwenn èd pou gratis?
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 oswa 1-877-870-8943

장애가 있으십니까? 영어가 아닌 다른 언어를 사용하십니까? 전화하십시오. 무료로 도와드립니다. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 또는 1-877-870-8943

Jesteś osobą niepełnosprawną? Mówisz w języku innym niż j. angielski? Zadzwoń, aby uzyskać bezpłatną pomoc. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 lub
1-877-870-8943

Tem algum tipo de incapacidade? Fala outra língua que não o inglês? Ligue para obter ajuda gratuitamente. 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 ou 1-877-870-8943

Ваши возможности ограничены по состоянию здоровья? Вы не говорите по-английски? Обратитесь за бесплатной помощью по телефону: 850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 or 1-877-870-8943

您是残障人士吗？您不会说英语吗？请拨打电话以免费获取帮助。电话号码：850-383-3311、 1-877-247-6512；TTY/TDD（听障人士）：850-383-3534 或 1-877-870-8943

Ikaw ba ay may kapansanan? Ikaw ba ay nakakapagsalita ng ibang wika maliban sa Ingles? Tumawag upang makakuha ng libreng tulong. 850-383-3311, 1-877-247-6512, TTY/TTD 850-383-3534 o sa 1-877-870-8943.

您是否是障礙人士? 您是否不會講英語? 請撥打電話以取得免費協助。 850-383-3311、
1-877-247-6512，聽障者請使用 TTY/TDD 850-383-3534 或 1-877-870-8943

พิการหรือเปล่า? พูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษหรือเปล่า? โทรเพื่อขอความช่วยเหลือฟรี
850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 หรือ 1-877-870-8943

Quý vị có khuyết tật? Quý vị nói ngôn ngữ khác mà không phải tiếng Anh? Vui lòng gọi để được trợ giúp miễn phí.850-383-3311, 1-877-247-6512, TTY/TDD 850-383-3534 hoặc 1-877-870-8943

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8 am – 5 pm at 850-383-3311 or 1-877-247-6512. State of Florida members can reach Member Services at 1-877-392-1532 from 7 am – 7 pm Monday-Friday. Medicare members please call Capital Health Plan Member Services Department at 850-523-7441 or 1-877-247-6512; October 1 – February 14: 8:00 a.m. – 8:00 p.m., seven days a week; February 15 – September 30: 8:00 a.m. – 8:00 p.m., Monday – Friday. TTY/TDD (Telecommunication Device for the Deaf) users should call 850-383-3534 or 1-877-870-8943.

Capital Health Plan contact information is located on our website: http://www.capitalhealth.com/Capital-Health-Plan/Contact-Us

Approved by Compliance Committee: 8/23/16

Attachment No. 2

BLUEMEDICARE GROUP MASTER AGREEMENT

SECTION 1: INTRODUCTION

This BlueMedicare Group Master Agreement (this "Agreement") describes the rights and obligations which you and Blue Cross and Blue Shield of Florida, Inc. ("Florida Blue") have with respect to the group Medicare Advantage, Medicare Advantage Prescription Drug Plan, and/or standalone Medicare Prescription Drug Plan (hereinafter, "Medicare Plan(s)") coverage to be provided by us to your Covered Retirees and Covered Dependents.

References to "we", "us", "our," and Florida Blue throughout this Agreement refer to Blue Cross and Blue Shield of Florida, Inc. In exchange for your payment of the Premium, we agree to provide the coverage and/or benefits specified in the Evidence of Coverage for the Medicare Plan(s) ("Evidence of Coverage"), a copy of which is attached to this Agreement. The coverage to be provided by us under the Group Plan which you have established is described in the Evidence of Coverage.

SECTION 2: DEFINITIONS

Certain terms defined in the Agreement are also used and defined (for the convenience of Covered Persons) in the Evidence of Coverage. If a word or phrase starts with a capital letter, it is either the first word in a sentence, a proper name, a title, or a defined term. The following defined terms apply to this Agreement:

Anniversary Date means the date one year after the Effective Date of coverage and subsequent annual anniversaries or such other date as mutually agreed to in writing by the parties.

Appeal means a request submitted by or on behalf of a Covered Person for a review of our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs.

CMS means the Centers for Medicare and Medicaid Services.

CMS Requirements means the provisions of Parts C and D of Title XVIII of the Social Security Act, CMS Medicare Part C and D regulations at 42 C.F.R. Parts 422 and 423, the CMS Managed Care and Prescription Drug Benefit Manuals, other CMS instructions and guidance and the provisions of Florida Blue's contracts with CMS to offer the Medicare Plans.

Covered Dependent means an Eligible Dependent who continues to meet all applicable eligibility requirements described in the Evidence of Coverage and who is enrolled, and actually covered, under the Agreement other than as a Covered Retiree.

Covered Person means a Covered Retiree or a Covered Dependent.

Covered Retiree means an Eligible Retiree, who continues to meet all applicable eligibility requirements described in the Evidence of Coverage and who is enrolled, and actually covered, under the Agreement other than as a Covered Dependent.

Effective Date for the Group means 12:01 a.m. on the date specified on the last page of this Agreement and for Covered Persons means 12:01 a.m. on the date coverage will begin as specified in the Evidence of Coverage.

Eligible Dependent means an individual who meets and continues to meet all of the eligibility requirements described in the Evidence of Coverage.

Eligible Retiree means an individual who meets and continues to meet all of the eligibility requirements set forth in the Evidence of Coverage and is eligible to enroll as a Covered Retiree. An Eligible Retiree is not a Covered Retiree until actually enrolled and accepted for coverage as a Covered Retiree by us.

Enrollment Forms means those forms, electronic or paper, which are approved by us and used to maintain accurate enrollment files under the Agreement.

Grace Period means the sixty (60) calendar day period beginning on the date the Premium is due.

Grievance means a type of complaint submitted by a Covered Person (or other person eligible under CMS Requirements to submit a Grievance) about us or one of our network providers or pharmacies, including a complaint concerning the quality of care. This type of complaint does not involve coverage or payment disputes.

Group means the employer, labor union, association, partnership, corporation, department, other organization or entity through which coverage and benefits are issued by us.

Note: References to "you" or "your" throughout the first part of this Agreement also refer to the Group. References to "you" or "your" in the Evidence of Coverage refer to Eligible Retirees, Eligible Dependents, Covered Retirees and/or Covered Dependents depending on the context and intent of the specific provision.

Group Master Agreement or Agreement means the written document which is evidence of the entire agreement between the Group and Florida Blue whereby coverage and benefits are provided to Covered Persons.

Late Enrollment Penalty ("LEP") means an amount added to the Part D Premium of an individual who did not have Part D coverage or other creditable prescription drug plan when the individual first became eligible for Part D or who had a break in Part D or other creditable prescription drug coverage for at least 63 days.

Low Income Subsidy ("LIS") means the premium subsidy amount paid to us by CMS for qualifying Covered Persons with Medicare Part D coverage.

Medicare Plan means the group Medicare Advantage Plan, Medicare Advantage Prescription Drug Plan, and/or standalone Medicare Prescription Drug Plan that you select.

Premium means the amount required to be paid by the Group to us for coverage under this Agreement.

Service Area means a geographic area where a Medicare Plan accepts members.

SECTION 3: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

A. Eligibility Determination

Determination of whether an individual is an Eligible Retiree or Eligible Dependent will be a two-step process:

1. You will determine whether the individual is eligible to participate in the retiree group health benefit plan that you sponsor. For individuals meeting your eligibility criteria, you will promptly forward completed applications to us. You are responsible for complying with all applicable laws and regulations, including but not limited to the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, in making this eligibility determination. You must also comply with all eligibility guidelines included in the benefit administrative guide and Evidence of Coverage.

2. After receiving a complete application, we will process the application in accordance with CMS Requirements. An application must be approved by us and accepted by CMS for an individual to be enrolled in a Medicare Plan.

B. Distribution of Enrollment Materials

You may only distribute materials describing the Medicare Plan that we have provided to you or that we have approved in writing. You will distribute any pre-enrollment materials that we provide to you to each potential enrollee before collecting enrollment applications. Nothing in this Section will preclude you from making additional disclosures about your group health benefit plan as applicable to comply with ERISA, such as a wrap-around summary plan description or other plan document. If applicable, you are solely responsible for compliance with ERISA disclosure requirements in connection with the Medicare Plan(s).

C. Group Disenrollment

If you decide to disenroll all Covered Persons from a Medicare Plan, you must:

1. Notify all beneficiaries that you intend to disenroll them from the Medicare Plan. You will provide this notice at least twenty one (21) calendar days before the disenrollment. This notice will explain how to contact Medicare for information about other plan options that may be available. You will include language provided by Florida Blue in this notice to meet specific CMS Requirements for notice contents.

2. Provide us with all information necessary to submit a complete disenrollment request transaction to CMS in accordance with CMS Requirements.

3. In the event of termination of this Agreement, provide advanced notice in accordance with Section 4 of this Agreement.

D. Individual Covered Person Disenrollment

Covered Persons may be disenrolled from a Medicare Plan by Florida Blue if they become ineligible for continued enrollment. Covered Persons may also be disenrolled if this Agreement terminates or if you

inform us that they are no longer eligible to participate in your retiree group health plan. If Florida Blue determines that a Covered Person is ineligible for continued enrollment or if you instruct us to disenroll an individual, you must:

1. Provide us with at least thirty (30) calendar days advanced notice of the ineligibility or disenrollment election of an individual; and

2. Provide the Covered Person(s) who will be disenrolled with at least twenty one (21) calendar days advanced notice of the termination and of other insurance options that are available to them. You will include language provided by Florida Blue in this notice to meet specific CMS Requirements for notice contents.

The Covered Person will have the opportunity to elect another plan offered by us or by you, join Original Medicare, or join another carrier's Medicare Plan (by submitting an enrollment request to that organization).

SECTION 4: TERM AND TERMINATION

A. Term of Agreement and Renewal Process

This Agreement shall become effective as of the Effective Date provided: (1) that we accept your Group Application; and (2) that you pay the required initial Premium specified by us.

This Agreement shall continue in effect until the first Anniversary Date following the Effective Date unless terminated earlier as permitted by its terms. After the initial term, this Agreement shall automatically renew each succeeding year on the Anniversary Date for an additional one-year period unless:

1. At least sixty (60) calendar days prior to such Anniversary Date, you notify us that you do not want the Agreement to automatically renew; or

2. It is terminated as permitted by its terms.

At least ninety (90) calendar days before each Anniversary Date, we will provide you with notice of changes in Premium and benefits under the Medicare Plan for the upcoming year (the "Renewal Notice").

If this Agreement renews as specified above, all of its terms and provisions (including the Premium due) shall be amended to include the terms of the Renewal Notice, and the amended Agreement shall govern coverage as of the Anniversary Date. Payment of the new charges shall constitute acceptance of the change in Premium rates. This Agreement is conditionally renewable. This means that it automatically renews each year on your Anniversary Date unless terminated earlier in accordance with its terms.

B. Termination by Group

The Group may cancel this Agreement on its Anniversary Date by giving written notice to us at least sixty (60) calendar days in advance, unless we have initiated a termination for any of the reasons stated below.

C. Termination by Florida Blue

We may terminate this Agreement or refuse to renew for the following reasons:

1. **Failure to Pay Premiums**. You do not pay Premiums in accordance with its terms or we have not received timely Premium payments prior to the end of the Grace Period. Termination of this Agreement for failure to pay premiums shall be effective as of the end of the Grace Period. In the event of such termination, you are obligated to pay the following:

    a. Any portion of the Premium due for coverage provided by us prior to termination; and

    b. Any amounts otherwise due us.

2. **Fraud or Intentional Misrepresentation of Material Fact.** You perform an act, or engage in any practice, that constitutes fraud or make an intentional misrepresentation of material fact.

3. **Group Contribution and Participation and CMS Rules.** You do not comply with: (1) a material provision which relates to rules for Group contributions or Covered Person participation; or (2) any provision in this Agreement which relates to LIS or other CMS Requirements.

4. **Service Area**. There is no longer any Covered Person who lives, resides, or works in the Service Area.

5. **Termination or Non-renewal of the CMS Contract**. We will provide you with at least ninety (90) calendar days' notice upon termination or non-renewal of our contract with CMS.

Except as specifically provided in this Subsection 4.C, if we decide to terminate or not renew the Agreement based on one or more of the circumstances mentioned above, we will give you at least forty-five (45) calendar days advance written notice.

D. Notification of Termination to Covered Retirees

It is your obligation to immediately notify each Covered Person of any such termination of this Agreement for any reason, consistent with the requirements of Section 3 of this Agreement.

E. Representations Made By, and Obligations of, the Group

In agreeing to provide coverage in accordance with the terms of this Agreement, we rely on the representations you made when you applied for coverage with us and your representation that you have authority to act on behalf of all Covered Persons with respect to this Agreement. Consequently, every act by, agreement with, or notice given to, you will be binding on all Covered Persons. You agree that you shall offer to all Eligible Retirees the opportunity to become a Covered Person under this Agreement. You agree that, if requested by us, you will distribute the Evidence of Coverage and other coverage materials to Covered Persons.

SECTION 5: PAYMENT PROVISIONS

A. Monthly Invoice

We will prepare a monthly invoice of the Premium due on or before the due date. This monthly invoice will also reflect any prorated charges and credits resulting from changes in the number of Covered Persons and changes in the types of coverage that took place in the previous or current month.

If you become aware that a Covered Person will become ineligible, you must provide us with written notice of such ineligibility as described in Section 3 of this Agreement. You shall be liable to us for the Premium due for each individual enrolled in a Medicare Plan under this Agreement until the effective date of disenrollment, which is set by CMS Requirements.

You must pay the total amount of the invoice. Do not add names to an invoice, change coverage or pay for a retiree or dependent whose name does not appear on the invoice. No changes can be made to a Group invoice unless a signed application form is on file and submitted to Florida Blue. Payment shall be for the total amount of the Group invoice.

B. Payment Due Date

The first Premium payment is due before the Effective Date of the Agreement. Each following payment is due monthly unless you agree with us in writing on some other method and/or frequency of payment. The Premium is due and payable on or before the first day of each succeeding calendar month to which such payments apply.

C. Grace Period

This Agreement has a sixty (60) calendar day Premium payment Grace Period, which begins on the date the Premium payment is due. If we do not receive the required Premium payment on or before the date it is due, it may be paid during this Grace Period. Coverage will stay in force during the Grace Period. If Premium payments are not received by the end of the Grace Period, we will terminate this Agreement and proceed with the disenrollment of Covered Persons as described in Section 3 of this Agreement.

D. Changes in Premium

Premium rates may be changed on your Anniversary Date as described in Section 4.A above regarding renewal.

E. Other Rules Regarding the Payment of Premiums

1. CMS rules govern the effective date of any disenrollment of a Covered Person under this Agreement, and we are not required to retroactively terminate this Agreement or coverage for any Covered Person.

2. If full payment of the Premium is not paid when due, this Agreement may be terminated as described in Section 4 of this Agreement.

F. Premium Subsidization

You may subsidize Premium amounts charged to Eligible Retirees. You are responsible for compliance with all applicable laws and regulations relating to your subsidy of Premiums, including ERISA and CMS Requirements, as applicable. You acknowledge and agree that Premium subsidization may vary for different classes of Eligible Retirees only if such classes are reasonable and based on objective business criteria. You represent and warrant that you will not vary Premium subsidization based on any Covered Person's eligibility for LIS. Further, you will not vary Premium subsidization for individuals within a given class of Eligible Retirees. In no case will you charge an Eligible Retiree more than the sum of the monthly Premium that we charge you for the Medicare Plan benefits.

G. Low Income Subsidy

You will comply with the following requirements in connection with LIS:

1. You are required to pass through any LIS payments received from CMS to reduce the Premium amount that the Covered Retiree pays. You will first apply any LIS amounts to a Covered Person's share of Premium. You may not benefit from any LIS amount until the Premium for a Covered Person (including amounts for the non-drug benefits in a combined Medicare Advantage Prescription Drug Plan) paid by a Covered Retiree is reduced to zero ($0.00).

2. You are responsible for reducing up-front Premium contributions that you collect from Covered Retirees for any Covered Persons eligible for LIS. In limited situations where you are unable to reduce the up-front Premium contribution (*e.g.* if LIS is awarded retroactively), you will directly refund the LIS amount to the Eligible Retiree within fifteen (15) calendar days of the date you receive the LIS amount from Florida Blue.

H. Late Enrollment Penalty (LEP)

The Premium for an individual Covered Person may be higher if the Covered Person is assessed an LEP for not enrolling in Part B in a timely manner. This higher Premium will be reflected on the bill you receive from us.

I. Premium Billing

You will be responsible for the payment of the "Total Monthly Premium per Covered Retiree" of all Group members. The Total Monthly Premium may be less for Covered Persons who qualify for LIS as defined by CMS. You will also be responsible for any LEP charges that Group members have been assessed by CMS. The first Premium charge is payable before the Effective Date of this Agreement. Monthly charges are payable on the first day of each following month during the time this Agreement is in effect.

J. Retroactive Premium Adjustment

The monthly charge will be determined from our records by the number of Covered Retirees who have been confirmed through the CMS enrollment transaction process. Retroactive adjustments will be made for additions and terminations of Covered Retirees and for Covered Retirees who have been confirmed through the CMS enrollment transaction process after the initial billing statement. Any refund that is owed to a Covered Retiree must come from the Group, unless the Covered Retiree is billed directly by us. Florida Blue will only adjust the amount due of a Group and will not refund Premium(s) paid to a Covered Retiree, unless we mutually agree that a Covered Retiree is to be directly billed by Florida Blue. You must refund to Covered Retirees any amounts received from us that are due to Covered Retirees in a timely manner.

SECTION 6: HOST BLUE PLANS

A. Out of Area Services

We have relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") referred to generally as the "Medicare Advantage Program." When Covered Persons access healthcare services outside of Florida, the claim for those services will be processed through the Medicare Advantage Program

and presented to us for payment in accordance with the rules of the Medicare Advantage Program policies then in effect. The Medicare Advantage Program available to Covered Persons under this Agreement is described generally below.

B. Covered Persons Liability Calculation

The cost of the service on which the Covered Person's liability is based, will be either:

1. The Medicare allowable amount for covered services; or

2. The amount we negotiate with the provider of the Host Blue negotiates with its provider on behalf of our Covered Persons, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

SECTION 7: GENERAL PROVISIONS

A. Administration and Record Retention

You must provide us with any information we need to administer the coverage and/or benefits to be provided or needed to compute the Premium due. While this coverage is in force, we have the right, at any reasonable time, to examine your records on any issues necessary to verify information provided by you. You must retain all records relating to this Agreement, including but not limited to those relating to LIS administration, for the current calendar year plus an additional ten (10) years.

B. Assignment and Delegation

You may not assign, delegate or otherwise transfer this Agreement and the obligations hereunder without our written consent. Any assignment, delegation, or transfer made in violation of this provision shall be void. We may assign, delegate, or otherwise transfer this Agreement to our successor in interest or an affiliated entity without your consent at any time.

C. Authorization

Where this Agreement requires that an act involving the administration of coverage and/or benefits be authorized or approved by us, such authorization or approval shall be considered given when provided in writing by a duly authorized officer of Florida Blue or his or her designee.

D. Evidence of Coverage

We will provide an Evidence of Coverage and ID Card for each Covered Retiree. The Evidence of Coverage will describe the coverage and benefits to be provided to Covered Persons by us.

You agree that, if requested by us, you will distribute the Evidence of Coverage (and any Endorsements to it) and other coverage materials to Covered Persons.

E. Grievance and Appeals Process

We have established and will maintain a process for hearing and resolving Grievances and Appeals raised by Covered Persons in accordance with CMS requirements. Details regarding this process are provided in the Evidence of Coverage.

F. Changes to the Agreement

Florida Blue may make any changes to this Agreement that are necessary to meet CMS Requirements ("CMS Mandated Amendments") with sixty (60) calendar days advanced written notice to you. Such changes shall become effective as amendments to this Agreement upon expiration of this sixty (60) calendar day notice period.

Except in the case of (a) CMS Mandated Amendments or (b) Renewal Notices as described in Section 4.A., no person may change, modify, or revise the written terms or provisions of this Agreement unless such change is made by a written amendment signed by one of our duly authorized officers. For example, no Eligible Retiree or agent of Florida Blue or the Group can change or waive the written terms or provisions of this Agreement except as stated in the first sentence of this paragraph.

G. Furnishing and Maintaining Enrollment Records

You must provide any information required by us for the purpose of creating and maintaining enrollment records, processing terminations, and recording changes in family status. In addition, you and each Eligible Retiree must submit accurate and complete Enrollment Forms on a timely basis. You are responsible for collecting the Enrollment Forms, reviewing them for accuracy and completeness, and forwarding them to us, along with the applicable Premium payment. All enrollment record information which is relevant to the eligibility or coverage status of any individual must be made available to us for inspection and copying upon request.

H. Errors or Delays

Clerical errors or delays by us in maintaining enrollment records regarding Covered Persons will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise be validly terminated, provided you have furnished us with timely and accurate enrollment information. Errors or delays by you in furnishing accurate enrollment information to us will not affect our right to strictly enforce any and all eligibility requirements.

I. Entire Agreement

This Agreement sets forth the exclusive and entire understanding and agreement between the parties and shall be binding upon the Covered Persons, the parties, and any of their subsidiaries, affiliates, successors, heirs, and permitted assigns. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of this Agreement, which includes the terms of coverage and/or benefits set forth in the Evidence of Coverage, the Schedule of Benefits, and any other attachments, amendments or riders.

J. Financial Responsibilities of the Group

We reserve the right to recover any benefit payments made to or on behalf of any individual whose coverage has been terminated. Our recovery efforts may relate to benefit payments made for health care services rendered subsequent to the Covered Person's termination date and prior to the date notice of coverage termination is required to be made by you. Your cooperation with and support such recovery efforts is required.

In the event that you do not comply with the notice requirements set forth in Subsection 5.A (Monthly Invoice), you shall be solely liable to us for Premium due until the effective date established by CMS for a Covered Person's disenrollment.

K. Indemnification

You shall hold harmless and indemnify Florida Blue, against all claims, demands, liabilities, or expenses (including reasonable attorney fees and court costs), which are related to, arise out of, or are in connection with any of your acts or omissions, or acts or omissions of any of your employees, retirees or agents, in the performance of your obligations under this Agreement. We are not your agent, nor are you our agent, for any purpose. This paragraph shall only apply to the extent allowed under Florida Statutes § 768.28.

L. Representations on the Group Application and the Enrollment Forms

We rely on the information you and your Eligible Retirees provide to determine whether to issue coverage; the appropriate Premium and financing method; and eligibility for coverage. All such information must be accurate, truthful, and complete. Statements made on the Enrollment Forms are representations and not warranties.

We may cancel, terminate, or void this Agreement if the information which you provide is fraudulent, or if you make an intentional misrepresentation.

M. Reservation of Right to Contract

We reserve the right to contract with any individuals, corporations, associations, partnerships, or other entities for assistance with the servicing of coverage and benefits to be provided by us or obligations due, under this Agreement.

N. Service Mark

You, on behalf of the Group and its Covered Retirees, hereby expressly acknowledge your understanding that this Agreement constitutes a contract solely between you and Florida Blue. We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting us to use the Blue Cross and Blue Shield Service Mark in the state of Florida and that we are not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this contract based upon representations by any person other than us and that no person, entity, or organization other than us shall be held accountable or liable to you for any of our obligations created under this Agreement. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this Agreement.

O. Third Party Beneficiary

This Agreement was entered into solely and specifically for the benefit of Florida Blue and the Group. The terms and provisions of the Agreement shall be binding solely upon, and inure solely to the benefit of, Florida Blue and the Group, and no other person shall have any rights, interest or claims under this Agreement, including the Evidence of Coverage, or be entitled to sue for a breach thereof as a third-party beneficiary or otherwise. Florida Blue and the Group hereby specifically express their intent that health care providers that have not entered into contracts with Florida Blue to participate in Florida Blue's

provider networks shall not be third-party beneficiaries under this Agreement, including the Evidence of Coverage.

P. Inspection and Audit

You shall permit CMS, The U.S. Department of Health and Human Services, the Comptroller General, or their designees, to inspect, evaluate, and audit any of your books, contracts, medical records, patient care documentation, documents, papers, and other records pertaining to coverage by providing records to Florida Blue, which will submit the records to CMS. This right to inspect, evaluate, and audit shall extend ten (10) years from the expiration or termination of the Agreement or completion of final audit, whichever is later, unless otherwise required by applicable law.

Q. Benefit Administrator Guide

We will provide you with a Benefit Administrator Guide, which provides details related to how your plan is administered and your responsibilities as a benefit administrator.

R. Member Communications and Campaigns

We may send CMS required or Florida Blue member communications without your consent. Samples of all required materials are available upon request for informational purposes.

We may also contact Covered Persons by telephone regarding any Florida Blue campaign and any campaign approved by the Florida Office of Insurance Regulation and/or CMS, as applicable. We will notify you of the campaign prior to making contact with members.

S. COBRA

You are solely responsible for determining when individuals are eligible for coverage under a Medicare Plan pursuant to the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). You will notify us promptly of any COBRA elections. For more information on your COBRA responsibilities refer to the Benefit Administrator Guide.

* * * * * * *

In consideration of the payment of Premiums when due and subject to all of the terms of this Agreement, Blue Cross Blue Shield of Florida, Inc. hereby agrees to provide each enrollee of **<GROUP NAME>** the benefits of this Agreement as set forth in the attached Evidence of Coverage beginning on each enrollee's effective date.

The Group has selected the following plan and premium: **<PLAN NAME(S) AND PREMIUM(S)>**

The Group's Agreement is effective as of <Effective Date>.

IN WITNESS WHEREOF, the parties have executed this Agreement as of <Date of Signature>.

Blue Cross Blue Shield of Florida, Inc.
(DBA Florida Blue)

<GROUP NAME>

By: _____ (Signature)	By: _____ (Signature)
Name: Lynn Esposito (Please Print or Type)	Name: _____ (Please Print or Type)
Title: Vice President, Sales Operations	Title: _____

Monitoring by Utilization and Enrollment

Company: COUNTY OF LEON BOARD
Group: 78116
Current Service Period: From 10/2014 to 09/2017
Current Paid Period: From 10/2014 to 12/2017

	Enrollment		Premium	Capitation			Fee for Service Claims							
Service Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201410	369	560	$233,298.62	$0.00	$349.06	$349.06	$19,764.27	$67,820.78	$47,777.96	$15,351.09	$150,714.10	$35,173.72	$186,238.88	79.83%
201411	376	567	$250,307.90	$0.00	$352.16	$352.16	$215,675.85	$32,501.60	$66,199.50	$17,094.45	$331,471.40	$28,795.44	$360,819.00	144.07%
201412	372	562	$250,100.75	$0.00	$348.44	$348.44	$58,426.90	$41,949.70	$46,965.57	$14,126.81	$161,468.98	$35,976.19	$197,793.61	79.09%
201501	370	560	$246,212.83	$0.00	$347.82	$347.82	$85,821.96	$84,736.91	$61,049.94	$16,549.24	$248,158.05	$38,635.86	$287,141.73	116.62%
201502	369	583	$250,053.32	$0.00	$350.92	$350.92	$0.00	$55,063.34	$40,948.17	$11,235.19	$107,246.70	$30,590.69	$138,188.31	55.26%
201503	371	567	$245,481.14	$0.00	$352.78	$352.78	$93,557.79	$40,666.36	$52,903.05	$24,131.24	$211,260.44	$34,537.89	$246,151.11	100.27%
201504	370	569	$246,915.69	$0.00	$775.20	$775.20	$3,604.71	$15,748.55	$41,228.90	$15,647.67	$78,227.83	$31,663.28	$108,666.31	44.01%
201505	370	571	$248,594.81	$0.00	$775.20	$775.20	$0.00	$22,885.35	$38,877.99	$17,198.63	$78,961.97	$33,534.60	$113,271.77	45.56%
201506	373	577	$249,711.07	$0.00	$783.36	$783.36	$9,857.11	$35,674.96	$52,436.20	$21,898.96	$119,867.23	$36,072.62	$156,723.21	62.76%
201507	379	588	$251,018.44	$0.00	$796.96	$796.96	$39,728.48	$33,412.87	$63,953.22	$14,871.09	$151,763.64	$50,670.51	$203,231.11	80.96%
201508	379	588	$263,663.57	$0.00	$805.56	$805.56	$17,010.78	$14,682.34	$45,714.61	$19,709.12	$97,116.85	$35,207.97	$133,130.38	50.49%
201509	381	590	$262,481.46	$0.00	$802.08	$802.08	$0.00	$48,470.68	$42,493.20	$13,876.92	$102,840.80	$45,102.12	$148,745.00	56.67%
201510	214	296	$299,459.98	$0.00	$405.52	$405.52	$0.00	$7,530.12	$18,766.10	$5,987.74	$32,283.96	$26,856.27	$59,525.75	19.88%
201511	216	293	$118,125.26	$0.00	$401.41	$401.41	$65,840.23	$45,806.66	$27,809.05	$7,268.81	$146,724.75	$20,119.48	$167,245.64	141.58%
201512	218	299	$14,275.42	$0.00	$408.63	$408.63	$44,788.57	$22,762.47	$33,854.78	$7,287.22	$108,691.04	$28,147.67	$137,247.34	981.42%
201601	219	301	$150,272.08	$0.00	$338.24	$338.24	$27,199.00	$13,682.90	$22,693.79	$9,328.92	$72,904.61	$25,267.14	$98,509.99	65.55%
201602	218	297	$149,378.12	$0.00	$333.76	$333.76	$5,438.40	$16,963.00	$21,275.31	$5,253.72	$48,930.43	$24,554.50	$73,818.69	49.42%
201603	218	297	$145,302.01	$0.00	$310.24	$310.24	$108,100.09	$22,610.82	$55,324.19	$9,287.81	$195,322.91	$24,527.13	$220,160.28	151.52%
201604	215	291	$146,726.37	$0.00	$300.16	$300.16	$4,247.18	$9,222.05	$18,461.10	$5,548.04	$37,478.37	$24,373.91	$62,152.44	42.36%
201605	211	285	$135,780.45	$0.00	$292.32	$292.32	$8,840.34	$73,097.61	$24,857.01	$10,694.51	$117,489.67	$23,677.17	$141,459.16	104.18%
201606	213	290	$141,038.15	$0.00	$301.28	$301.28	$82,433.29	$108,820.75	$39,133.25	$11,042.00	$239,429.29	$25,744.86	$265,475.43	188.23%
201607	212	289	$141,199.75	$0.00	$290.52	$290.52	$28,695.69	$29,850.85	$24,857.05	$8,027.68	$91,231.27	$26,551.01	$118,072.80	83.62%
201608	216	293	$141,805.73	$0.00	$297.57	$297.57	$0.00	$21,782.37	$22,806.69	$5,468.78	$50,055.84	$25,045.98	$75,399.39	53.17%
201609	212	289	$142,132.68	$0.00	$295.39	$295.39	$0.00	$64,833.49	$15,184.77	$9,012.31	$89,030.57	$24,563.01	$113,888.97	80.13%
201610	97	128	$93,069.40	$0.00	$119.90	$119.90	$0.00	$7,352.00	$11,998.87	$1,448.10	$20,798.97	$21,302.17	$42,221.04	45.37%

	Enrollment		Premium	Capitation			Fee for Service Claims							
Service Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201611	95	124	$91,244.39	$0.00	$117.72	$117.72	$11,471.41	$20,507.73	$11,146.77	$3,549.56	$46,675.47	$18,767.11	$65,560.30	71.85%
201612	94	123	$85,789.09	$0.00	$116.63	$116.63	$7,751.99	$9,808.31	$12,317.56	$3,665.93	$33,543.79	$11,900.53	$45,560.95	53.11%
201701	88	116	$82,792.08	$0.00	$112.27	$112.27	$2,000.00	$11,284.19	$11,016.39	$2,784.15	$27,084.73	$21,764.02	$48,981.02	59.14%
201702	85	113	$84,591.30	$0.00	$111.18	$111.18	$0.00	$17,830.75	$12,700.62	$3,366.00	$33,697.37	$20,547.95	$54,556.50	64.49%
201703	85	113	$79,045.83	$0.00	$111.18	$111.18	$0.00	$9,049.03	$7,675.57	$4,606.13	$21,330.73	$21,747.71	$43,189.62	54.64%
201704	85	113	$80,544.33	$0.00	$111.18	$111.18	$0.00	$18,749.31	$8,875.91	$3,635.44	$31,260.66	$24,958.52	$56,330.36	69.94%
201705	85	113	$81,293.59	$0.00	$111.16	$111.16	$0.00	$23,696.15	$14,246.37	$2,908.77	$40,851.29	$22,286.30	$63,250.77	77.81%
201706	84	112	$76,798.06	$0.00	$107.91	$107.91	$45,518.26	$11,602.57	$16,838.68	$4,752.71	$78,712.22	$35,003.72	$113,823.85	148.21%
201707	83	110	$77,547.34	$0.00	$107.91	$107.91	$1,316.00	$23,471.19	$9,324.41	$3,509.77	$37,621.37	$17,393.85	$55,123.13	71.08%
201708	80	107	$74,550.33	$0.00	$106.82	$106.82	$0.00	$28,820.04	$15,484.55	$2,980.12	$47,264.71	$16,790.68	$64,162.21	86.07%
201709	80	107	$75,813.38	$0.00	$106.18	$106.18	$656.00	$9,971.73	$10,729.76	$2,395.28	$23,754.77	$22,820.65	$46,681.60	61.57%
Total	**8,102**	**11,757**	**$5,706,414.74**	**$0.00**	**$12,154.64**	**$12,154.64**	**$987,742.28**	**$1,118,521.73**	**$1,067,924.86**	**$335,257.91**	**$3,509,446.78**	**$990,674.23**	**$4,512,275.65**	**79.07%**
Grouping Avg	**225**	**327**	**$158,511.52**	**$0.00**	**$337.63**	**$337.63**	**$27,437.29**	**$31,070.05**	**$29,664.58**	**$9,312.72**	**$97,484.63**	**$27,518.73**	**$125,340.99**	**79.07%**
Monthly Avg	**225**	**327**	**$158,511.52**	**$0.00**	**$337.63**	**$337.63**	**$27,437.29**	**$31,070.05**	**$29,664.68**	**$9,312.72**	**$97,484.63**	**$27,518.73**	**$125,340.99**	**79.07%**

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

Monitoring by Utilization and Enrollment

Service Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201410	270	51	0	45	2	1	0	369	560
201411	277	47	0	47	4	1	0	376	567
201412	274	47	0	47	3	1	0	372	562
201501	274	45	0	48	2	1	0	370	560
201502	273	44	0	49	2	1	0	369	563
201503	276	43	0	50	1	1	0	371	567

Service Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201709	67	4	0	7	2	0	0	80	107
Total	6,317	787	0	931	59	8	0	8,102	11,757
Grouping Avg	175	22	0	26	2	0	0	225	327
Monthly Avg	175	22	0	26	2	0	0	225	327

Notes:
- Enrollment is recast to reflect retroactive adjustments.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.

BlueOptions

Florida Blue

For Large Groups
Health Benefit Plans 05172 and 05173

Summary of Benefits for Covered Services

	Amount Member Pays			
	HSA-Compatible			
	Plan 05172 (Single)	Plan 05173 (Family)	Plan 05172 (Single)	Plan 05173 (Family)
Financial Features	In-Network		Out-of-Network	
Deductible (EM DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue pays)	$3,000 per person	$3,000 per person $6,000 per family[1]	$10,000 per person	$10,000 per person $20,000 per family
Coinsurance (Coinsurance is the percentage the member pays for services)	10% of the allowed amount		20% of the allowed amount	
Out-of-Pocket Maximum (EM OOP[3]) (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$6,550 per person	$6,850 per person $13,100 per family[3]	$10,000 per person	$20,000 per person $20,000 per family
Office Services				
Physician Office Services				
Primary Care Physician	10% after Deductible		20% after Deductible	
Specialist	10% after Deductible		20% after Deductible	
Convenient Care	10% after Deductible		20% after Deductible	
e-Office Visit	10% after Deductible		20% after Deductible	
Maternity (Cost Share for initial visit only)				
Primary Care Physician	10% after Deductible		20% after Deductible	
Specialist	10% after Deductible		20% after Deductible	
Allergy Injections (per visit)				
Primary Care Physician	10% after Deductible		20% after Deductible	
Specialist	10% after Deductible		20% after Deductible	
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	10% after Deductible		20% after Deductible	
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)				
In-Network Monthly Out-of-Pocket (OOP) Maximum[4]	$200			
Provider	10% after Deductible		50% after Deductible	
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under the *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**				
Preventive Care				
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	$0		20%	
Mammograms	$0		$0	

[1] EM DED = Deductible is Embedded: A covered member's family deductible costs are capped at the individual deductible amount on the family plan.

[2] PBP = Per Benefit Period

[3] EM OOP = Out-of-Pocket Maximum is Embedded: A covered family member's out-of-pocket costs are capped at the individual out-of-pocket maximum amount on the family plan.

[4] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

Note: Out-of-Network services may be subject to balance billing.

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BlueOptions

For Large Groups
Health Benefit Plans 05172 and 05173

Summary of Benefits for Covered Services	Amount Member Pays			
	HSA-Compatible			
	Plan 05172 (Single)	Plan 05173 (Family)	Plan 05172 (Single)	Plan 05173 (Family)
Preventive Care (continued)	In-Network		Out-of-Network	
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0		$0	
Emergency Medical Care				
Urgent Care Centers	10% after Deductible		20% after Deductible	
Emergency Room Facility Services (per visit)	10% after Deductible		10% after Deductible[5]	
Ambulance Services	10% after Deductible		10% after In-Network Deductible	
Outpatient Diagnostic Services				
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) Diagnostic Services (except AIS) Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	 10% after Deductible 10% after Deductible		 20% after Deductible 20% after Deductible	
Independent Clinical Lab (e.g., Blood Work)	Deductible		20% after Deductible	
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays) Option 1 and Option 2	10% after Deductible		20% after Deductible	
Hospital / Surgical				
Ambulatory Surgical Center Facility (ASC)	10% after Deductible		20% after Deductible	
Outpatient Hospital Facility Services (per visit) Therapy Services (Option 1 and Option 2) All other Services (Option 1 and Option 2)	 10% after Deductible 10% after Deductible		 20% after Deductible 20% after Deductible	
Inpatient Hospital Facility and Rehabilitation Services (per admit) Option 1 and Option 2	10% after Deductible		20% after Deductible[5]	
Mental Health / Substance Dependency				
Inpatient Hospitalization Facility Services (per admit) Option 1 and Option 2	10% after Deductible		20% after Deductible[5]	
Outpatient Hospitalization Facility Service (per visit) Option 1 and Option 2	10% after Deductible		20% after Deductible	
Emergency Room Facility Services (per visit)	10% after Deductible		10% after In-Network Deductible	
Provider Services at Hospital and ER Primary Care Physician / Specialist	10% after Deductible		10% after In-Network Deductible	
Provider Services at Locations other than Office, Hospital and ER Primary Care Physician / Specialist	10% after Deductible		20% after Deductible	
Outpatient Office Visit Primary Care Physician / Specialist	10% after Deductible		20% after Deductible	
Other Provider Services				
Provider Services at Hospital and ER	10% after Deductible		10% after In-Network Deductible	
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	10% after Deductible		10% after In-Network Deductible	

[5] If admitted as an Inpatient from the Emergency Room member pays Out-of-Network DED and In-Network Emergency Room Coinsurance.

BlueOptions

For Large Groups
Health Benefit Plans 05172 and 05173

Summary of Benefits for Covered Services

	Amount Member Pays			
			HSA-Compatible	
	Plan 05172 (Single)	Plan 05173 (Family)	Plan 05172 (Single)	Plan 05173 (Family)
Other Provider Services (continued)	**In-Network**		**Out-of-Network**	
Provider Services at Locations other than Office, Hospital and ER				
Primary Care Physician	10% after Deductible		20% after Deductible	
Specialist	10% after Deductible		20% after Deductible	
Other Special Services				
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations				
Outpatient Rehabilitation Therapy Center	10% after Deductible		20% after Deductible	
Outpatient Hospital Facility Services (per visit)				
Option 1 and Option 2	10% after Deductible		20% after Deductible	
Durable Medical Equipment, Prosthetics and Orthotics	10% after Deductible		20% after Deductible	
Home Health Care	10% after Deductible		20% after Deductible	
Skilled Nursing Facility	10% after Deductible		20% after Deductible	
Hospice	10% after Deductible		20% after Deductible	

Important: To ensure quality care and to help you get the most value from your plan benefits, for certain medical services you need to get an approval from Florida Blue before your service or you'll have to pay the entire cost for the service. Before an appointment, visit floridablue.com/Authorization or call the toll-free number on your member ID card to see if a prior approval is needed and your next steps.

Benefit Maximums	
Home Health Care	20 Visits PBP
Inpatient Rehabilitation Therapy	30 Days PBP
Outpatient Therapy	35 Visits PBP
Spinal Manipulations	26 PBP (accumulates towards the Outpatient Therapy maximum)
Skilled Nursing Facility	60 Days PBP

Additional Benefits and Features

- We encourage you to call the care consultants team at 1-888-476-2227 to find out more about your benefits and/or treatment options. This can help you save time and money.
- You have online access to everything about your health benefit plan as well as all of our self-service tools at floridablue.com.
- Go to floridablue.com, click on **Find a Doctor** and follow the on-screen directions to easily find a doctor in your plan's network and you don't need a referral to see a participating provider.

BlueScript Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them. Important Note: Your health plan may include prescription drug coverage that only provides coverage at Exclusive Pharmacies except for emergency situations.

Access to Our Strong Networks

NetworkBlue℠ is the Preferred Provider Network designated as "In-Network" for BlueOptions. While In-Network providers remain the best value, members are still protected from balance billing if they go Out-of-Network to someone who is part of our Traditional Provider Network. You may also receive out-of-state coverage through the BlueCard® Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are not Covered Services under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, Florida Blue does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician before you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at floridablue.com.

Florida Blue
In the pursuit of health

Leon County School District #78116
2017 BlueMedicare Group PPO (Employer PPO) Health Benefits

Benefits	BlueMedicare Group PPO Plan 1
Premium (per member, per month)	$339.10 for PPO1Rx1
Annual Deductible	$0 In-Network / $1,000 Out-of-Network
Out-of Pocket Maximum (based on plan year)	$1,000 In-Network / $3,000 Out-of-Network In-Network out-of-pocket maximum accumulates toward Out-of-Network out-of-pocket maximum
Physician Office	
Primary Care (per visit)	In-Network $10 Copayment Out-of-Network Deductible & 20% Coinsurance
Specialist Care (per visit)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance
e-Visit	In-Network $5 Copayment Out-of-Network Deductible & 20% Coinsurance
Convenient Care Center	In-Network / Out-of-Network $30 Copayment
Podiatry Services (per visit) (routine foot care up to 6 visits per year)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance
Chiropractic Services (per visit) For each Medicare-covered visit (manual manipulation of the spine to correct subluxation)	In-Network $20 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Mental Health Care (per visit) For individual or group therapy (including partial hospitalization)	In-Network $35 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Substance Abuse Care (per visit)	In-Network $35 Copayment Out-of-Network Deductible & 20% Coinsurance
Part B Drugs (including chemotherapy)	In-Network 20% Coinsurance Out-of-Network Deductible & 20% Coinsurance
Allergy Injections	In-Network $5 Copayment Out-of-Network Deductible & 20% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Other Services	
Outpatient Surgery	In-Network • $150 Copayment for each outpatient hospital facility visit • $100 Copayment for each visit to an ambulatory surgical center Out-of-Network Deductible & 20% Coinsurance In-Network / Out-of-Network • $0 Copayment for physician services
Diagnostic Tests, X-Rays Office	In-Network • PCP $10 Copayment • Specialist $30 Copayment Out-of-Network Deductible & 20% Coinsurance
IDTF	In-Network $50 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Hospital	In-Network $150 Copayment Out-of-Network Deductible & 20% Coinsurance
Lab Services Independent Clinical Lab Outpatient Hospital All Locations	In-Network $0 Copayment In-Network $15 Copayment Out-of-Network Deductible & 20% Coinsurance
Advanced Imaging (MRI, MRA, CT Scan, PET Scan and Nuclear Medicine): Office	In-Network $125 Copayment Out-of-Network Deductible & 20% Coinsurance
IDTF	In-Network $125 Copayment Out-of-Network Deductible & 20% Coinsurance
Outpatient Hospital	In-Network $150 Copayment Out-of-Network Deductible & 20% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Outpatient Hospital Services (per visit): Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac and Pulmonary Rehab (including intensive cardiac rehab)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance $1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Radiation Therapy	In-Network $50 Copayment Out-of-Network Deductible & 20% Coinsurance
Dialysis	In-Network / Out-of-Network 20% Coinsurance
Lab Only	In-Network $15 Copayment Out-of-Network Deductible & 20% Coinsurance
All Other Diagnostic Tests, X-Rays, Advanced Imaging, etc.	In-Network $150 Copayment Out-of-Network Deductible & 20% Coinsurance
Urgently Needed Care (This is not emergency care, and in most cases is out-of-the-service area.)	In-Network / Out-of-Network $30 Copayment
Emergency Services (Including Worldwide Coverage)	In-Network / Out-of-Network $75 Copayment
Dental, Hearing and Vision (Medicare-Covered)	In-Network $30 Copayment Out-of-Network Deductible & 20% Coinsurance
Home Health	In-Network / Out-of-Network $0 Copayment
Ambulance	In-Network / Out-of-Network $150 Copayment for Medicare-covered ambulance services

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Outpatient Medical Services and Supplies	
Durable Medical Equipment/Diabetic Supplies Diabetic Supplies (glucose meters, test strips and lancets) *Note: needles, syringes and insulin for self-injection are covered under your Part D benefit*	In-Network $0 Copayment Out-of-Network Deductible & 20% Coinsurance
Equipment: Plan-Approved Electric Customized Wheelchairs, Electric Scooters	In-Network 20% Coinsurance Out-of-Network Deductible & 20% Coinsurance
All Other Medicare-Covered Durable Medical Equipment	In-Network $0 Copayment Out-of-Network Deductible & 20% Coinsurance
Prosthetic Devices	In-Network $0 Copayment for Medicare-covered items Out-of-Network Deductible & 20% Coinsurance
Outpatient Rehabilitation Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac and Pulmonary Rehab (including intensive cardiac rehab)	$1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Office or Freestanding Facility Services	In-Network $30 Copayment for each visit Out-of-Network Deductible & 20% Coinsurance
Outpatient Hospital Services	In-Network $30 Copayment for each visit Out-of-Network Deductible & 20% Coinsurance
Dialysis	In-Network/Out-of-Network 20% Coinsurance
Inpatient Care	
Inpatient Hospital Care (including substance abuse treatment)	In-Network • $150 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • After the 7th day, the plan pays 100% of covered expenses per stay Out-of-Network Deductible & 20% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Inpatient Mental Health Care	In-Network • $200 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • $0 Copayment each day for day(s) 8-90 for a Medicare-covered stay in a network hospital • 190-day lifetime limit in a psychiatric hospital Out-of-Network Deductible & 20% Coinsurance
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In-Network • $0 Copayment each day for days 1-20 per benefit period • $75 Copayment each day for days 21-100 per benefit period • There is a limit of 100 days for each benefit period • 3-day prior hospital stay is not required Out-of-Network Deductible & 20% Coinsurance
Hospice	Member must receive care from a Medicare-certified hospice
Preventive Services	
Annual Screening Mammograms (for women with Medicare, age 40 and older)	In-Network $0 Copayment for Medicare-covered screening mammograms Out-of-Network 20% Coinsurance
Pap Smears and Pelvic Exams (for women with Medicare)	In-Network • $0 Copayment per pap smear • $0 Copayment per pelvic exam Out-of-Network 20% Coinsurance
Bone Mass Measurement (for people with Medicare who are at risk)	In-Network $0 Copayment for each Medicare-covered bone mass measurement Out-of-Network 20% Coinsurance
Colorectal Screening Exams (for people with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered colorectal screening exams Out-of-Network 20% Coinsurance
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered prostate cancer screening exams Out-of-Network 20% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 1
Vaccines (Medicare-covered)	In-Network • $0 Copayment for influenza vaccine • $0 Copayment for pneumococcal vaccine • $0 Copayment for hepatitis B vaccine Out-of-Network 20% Coinsurance
Health & Wellness Benefit	
Fitness	Free membership through SilverSneakers

BlueMedicare Group PPO out-of-pocket maximum includes all covered health services member cost share rendered in/out of network on a Plan Year basis. Supplemental services and Part D costs are not applied to out-of-pocket maximum.

Medicare Part B - the premium provided under this plan excludes the Medicare Part B premium payments. (Members must continue to pay the Medicare Part B premium unless paid by Medicaid or another third party.)

Florida Blue is a PPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Florida Blue
In the pursuit of health

Leon County School District #78116
2017 BlueMedicare Group Rx (Employer PDP)

Benefits	BlueMedicare Group Rx Option 1
Premium	Included in PPO1Rx1
Annual Deductible	$0
Retail	**31-day Supply**
Tier 1 - Preferred Generics	$10 Copayment
Tier 2 - Generics	$10 Copayment
Tier 3 - Preferred Brand	$40 Copayment
Tier 4 - Non-Preferred Brand	$70 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Mail Order	**90-day Supply with PRIME Mail Order**
Tier 1 - Preferred Generics	$0 Copayment
Tier 2 - Generics	$0 Copayment
Tier 3 - Preferred Brand	$80 Copayment
Tier 4 - Non-Preferred Brand	$140 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance (31-day supply only)
Gap	**31-day Supply**
Tier 1 - Preferred Generics	$10 Copayment
Tier 2 - Generics	$10 Copayment
Tier 3 - Preferred Brand	$40 Copayment
Tier 4 - Non-Preferred Brand	$70 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Catastrophic	$3.30 Copayment for generic drugs $8.25 Copayment for brand drugs

Florida Blue is an Rx (PDP) Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Prescription drug copayments do not accumulate towards the health Plan Year out-of-pocket maximum.

Part D Creditable Coverage – The enrolling member may incur late enrollment penalties as defined and set by CMS in accordance with Part D guidelines if prior creditable coverage cannot be proven.

Florida Blue
In the pursuit of health

Leon County School District #78116
2017 BlueMedicare Group PPO (Employer PPO) Health Benefits

Benefits	BlueMedicare Group PPO Plan 2
Premium (per member, per month)	$289.26 for PPO2Rx2
Annual Deductible	$0 In-Network / $2,000 Out-of-Network
Out-of Pocket Maximum (based on plan year)	$2,000 In-Network / $4,000 Out-of-Network In-Network out-of-pocket maximum accumulates toward Out-of-Network out-of-pocket maximum
Physician Office	
Primary Care (per visit)	In-Network $35 Copayment Out-of-Network Deductible & 40% Coinsurance
Specialist Care (per visit)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
e-Visit	In-Network $5 Copayment Out-of-Network Deductible & 40% Coinsurance
Convenient Care Center	In-Network / Out-of-Network $50 Copayment
Podiatry Services (per visit) (routine foot care up to 6 visits per year)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Chiropractic Services (per visit) For each Medicare-covered visit (manual manipulation of the spine to correct subluxation)	In-Network $20 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Mental Health Care (per visit) For individual or group therapy (including partial hospitalization)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Substance Abuse Care (per visit)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance
Part B drugs (including chemotherapy)	In-Network 20% coinsurance Out-of-Network Deductible & 40% Coinsurance
Allergy Injections	In-Network $10 Copayment Out-of-Network Deductible & 40% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 2
Other Services	
Outpatient Surgery	In-Network • $250 Copayment for each outpatient hospital facility visit • $175 Copayment for each visit to an ambulatory surgical center Out-of-Network Deductible & 40% Coinsurance In-Network / Out-of-Network • $0 Copayment for physician services
Diagnostic Tests, X-Rays	
Office	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
IDTF	In-Network $100 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance
Lab Services	
Independent Clinical Lab	In-Network $0 Copayment
Outpatient Hospital	In-Network $30 Copayment
All Locations	Out-of-Network Deductible & 40% Coinsurance
Advanced Imaging (MRI, MRA, CT Scan, PET Scan and Nuclear Medicine):	
Office	In-Network $175 Copayment Out-of-Network Deductible & 40% Coinsurance
IDTF	In-Network $175 Copayment Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 2
Outpatient Hospital Services (per visit): Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac Rehab (including intensive cardiac rehab)	In-Network $40 Copayment Out-of-Network Deductible & 40% Coinsurance $1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Pulmonary Rehab	In-Network $30 Copayment Out-of-Network Deductible & 40% Coinsurance
Radiation Therapy	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Dialysis	In-Network / Out-of-Network 20% Coinsurance
Lab Only	In-Network $30 Copayment Out-of-Network Deductible & 40% Coinsurance
All Other Diagnostic Tests, X-Rays, Advanced Imaging, etc.	In-Network $250 Copayment Out-of-Network Deductible & 40% Coinsurance
Urgently Needed Care (This is not emergency care, and in most cases is out-of-the-service area.)	In-Network / Out-of-Network $50 Copayment
Emergency Services (Including Worldwide Coverage)	In-Network / Out-of-Network $75 Copayment
Dental, Hearing and Vision (Medicare-Covered)	In-Network $50 Copayment Out-of-Network Deductible & 40% Coinsurance
Home Health	In-Network / Out-of-Network $0 Copayment
Ambulance	In-Network / Out-of-Network $150 Copayment for Medicare-covered ambulance services

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 2
Outpatient Medical Services and Supplies	
Durable Medical Equipment/Diabetic Supplies Diabetic Supplies (glucose meters, test strips and lancets) *Note: needles, syringes and insulin for self-injection are covered under your Part D benefit*	In-Network $0 Copayment Out-of-Network Deductible & 40% Coinsurance
Equipment: Plan-Approved Electric Customized Wheelchairs, Electric Scooters	In-Network 20% Coinsurance Out-of-Network Deductible & 40% Coinsurance
All Other Medicare-Covered Durable Medical Equipment	In-Network $0 Copayment Out-of-Network Deductible & 40% Coinsurance
Prosthetic Devices	In-Network $0 Copayment for Medicare-covered items Out-of-Network Deductible & 40% Coinsurance
Outpatient Rehabilitation Occupational Therapy, Physical Therapy, Speech & Language Therapy, Cardiac Rehab (including intensive cardiac rehab)	$1,980 Physical and Speech Therapy Annual Benefit Maximum $1,980 Occupational Therapy Annual Benefit Maximum
Office or Freestanding Facility Services	In-Network $40 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Outpatient Hospital Services	In-Network $40 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Pulmonary Rehab	In-Network $30 Copayment for each visit Out-of-Network Deductible & 40% Coinsurance
Dialysis	In-Network/Out-of-Network 20% Coinsurance
Inpatient Care	
Inpatient Hospital Care (including substance abuse treatment)	In-Network • $250 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • After the 7th day, the plan pays 100% of covered expenses per stay Out-of-Network Deductible & 40% Coinsurance

Florida Blue
In the pursuit of health

Benefits	BlueMedicare Group PPO Plan 2
Inpatient Mental Health Care	In-Network • $250 Copayment each day for day(s) 1-7 for a Medicare-covered stay in a network hospital • $0 Copayment each day for day(s) 8-90 for a Medicare-covered stay in a network hospital • 190-day lifetime limit in a psychiatric hospital Out-of-Network Deductible & 40% Coinsurance
Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	In-Network • $0 Copayment each day for days 1-20 per benefit period • $100 Copayment each day for days 21-100 per benefit period • There is a limit of 100 days for each benefit period • 3-day prior hospital stay is not required Out-of-Network Deductible & 40% Coinsurance
Hospice	Member must receive care from a Medicare-certified hospice
Preventive Services	
Annual Screening Mammograms (for women with Medicare, age 40 and older)	In-Network $0 Copayment for Medicare-covered screening mammograms Out-of-Network 40% Coinsurance
Pap Smears and Pelvic Exams (for women with Medicare)	In-Network • $0 Copayment per pap smear • $0 Copayment per pelvic exam Out-of-Network 40% Coinsurance
Bone Mass Measurement (for people with Medicare who are at risk)	In-Network $0 Copayment for each Medicare-covered bone mass measurement Out-of-Network 40% Coinsurance
Colorectal Screening Exams (for people with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered colorectal screening exams Out-of-Network 40% Coinsurance
Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	In-Network $0 Copayment for Medicare-covered prostate cancer screening exams Out-of-Network 40% Coinsurance

Benefits	BlueMedicare Group PPO Plan 2
Vaccines (Medicare-covered)	In-Network • $0 Copayment for influenza vaccine • $0 Copayment for pneumococcal vaccine • $0 Copayment for hepatitis B vaccine Out-of-Network 40% Coinsurance
Supplemental Benefit	
Fitness	Free membership through SilverSneakers

BlueMedicare Group PPO out-of-pocket maximum includes all covered health services member cost share rendered in/out of network on a Plan Year basis. Supplemental services and Part D costs are not applied to out-of-pocket maximum.

Medicare Part B - the premium provided under this plan excludes the Medicare Part B premium payments. (Members must continue to pay the Medicare Part B premium unless paid by Medicaid or another third party.)

Florida Blue is a PPO Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Florida Blue
In the pursuit of health

Leon County School District #78116
2017 BlueMedicare Group Rx (Employer PDP)

Benefits	BlueMedicare Group Rx Option 2
Premium	Included in PPO2Rx2
Annual Deductible	$75 for Brand Drugs Only
Retail	**31-day Supply**
Tier 1 - Preferred Generics	$15 Copayment
Tier 2 - Generics	$15 Copayment
Tier 3 - Preferred Brand	$45 Copayment
Tier 4 - Non-Preferred Brand	$85 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Mail Order	**90-day Supply with PRIME Mail Order**
Tier 1 - Preferred Generics	$8 Copayment
Tier 2 - Generics	$8 Copayment
Tier 3 - Preferred Brand	$135 Copayment
Tier 4 - Non-Preferred Brand	$255 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance (31-day supply only)
Gap	**31-day Supply**
Tier 1 - Preferred Generics	$15 Copayment
Tier 2 - Generics	$15 Copayment
Tier 3 - Preferred Brand	$45 Copayment
Tier 4 - Non-Preferred Brand	$85 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Catastrophic	$3.30 Copayment for generic drugs $8.25 Copayment for brand drugs

Florida Blue is an Rx (PDP) Plan with a Medicare contract. Enrollment in Florida Blue depends on contract renewal.

Prescription drug copayments do not accumulate towards the health Plan Year out-of-pocket maximum.

Part D Creditable Coverage – The enrolling member may incur late enrollment penalties as defined and set by CMS in accordance with Part D guidelines if prior creditable coverage cannot be proven.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual and/or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.floridablue.com/plancontracts/group or by calling **1-800-352-2583**. In the event there is a conflict between this summary and your Florida Blue coverage documents the terms and conditions of the coverage documents will control.

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.** Does not apply to In-Network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	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 during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of **network providers.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-352-2583 or visit us at www.floridablue.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call **1-800-352-2583** to request a copy.

- **Copays** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copays** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copay	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Specialist visit	$30 Copay	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Other practitioner office visit	$30 Copay	Deductible + 40% Coinsurance	Physician administered drugs may have higher cost shares.
	Preventive care/ screening/immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost shares.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $75 Copay	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Physician Office: $30 Copay/ Independent Diagnostic Testing Center: $75 Copay	Deductible + 40% Coinsurance	Prior authorization may be required. Tests performed in hospitals may have higher cost share.
If you need drugs to treat your illness or condition	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.

Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide.	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. (retail)	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/ Outpatient Hospital Option 1: $100 Copay	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Outpatient Hospital: $300 Copay	Option 2 hospitals may have higher cost shares.
	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 services	$100 Copay + 10% Coinsurance	$100 Copay + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Urgent care	$30 Copay	Deductible + $30 Copay	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Option 1: $400 Copay	Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have higher cost shares.
	Physician/surgeon fee	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
If you have mental health, behavioral health, or substance	Mental/Behavioral health outpatient services	No Charge	Physician Office: 40% Coinsurance/ Hospital: $300 Copay	————none————

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
abuse needs	Mental/Behavioral health inpatient services	No Charge	Physician Services: No Charge/ Hospital: 40% Coinsurance	————none————
	Substance use disorder outpatient services	No Charge	Physician Office: 40% Coinsurance/ Outpatient Hospital: $300 Copay	Option 2 hospitals may have higher cost shares.
	Substance use disorder inpatient services	No Charge	Physician Services: No Charge/ Hospital: 40% Coinsurance	————none————
If you are pregnant	Prenatal and postnatal care	$30 Copay	Deductible + 40% Coinsurance	————none————
	Delivery and all inpatient services	Physician Services: Deductible + 10% Coinsurance/ Hospital Option 1: $400 Copay	Physician Services: In-Network Deductible + 10% Coinsurance/ Hospital: Deductible + 40% Coinsurance	Option 2 hospitals may have higher cost shares.
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.
	Rehab services	$30 Copay	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
	Hospice service	Deductible + 10% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered
	Glasses	Not Covered	Not Covered	Not Covered
	Dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-352-2583**. You may also contact your state insurance department at **1-877-693-5236**, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

For more information on your rights to a grievance or appeal, contact the insurer at **1-800-352-2583**. You may also contact the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or **www.dol.gov/ebsa/healthreform** , or your state insurance department at **1-877-693-5236**.

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**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-352-2583**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-352-2583**.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-800-352-2583**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-352-2583**.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,840
- **Patient pays** $700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Lab tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,050
- **Patient pays** $1,350

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Lab tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$70
Copays	$1,200
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,350**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- If the SBC includes both individual and family coverage tiers, the coverage examples were completed using the per-person deductible and out-of-pocket limit on page 1.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copays**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copays**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-352-2583** or visit us at www.floridablue.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call **1-800-352-2583** to request a copy.

Nondiscrimination and Accessibility Notice (ACA §1557)

Florida Blue and Florida Blue HMO comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Blue and Florida Blue HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Blue and Florida Blue HMO:

- Provides 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)
  - Provides 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 1-800-352-2583.

If you believe that Florida Blue and Florida Blue HMO has 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: Senior Manager of Business Ethics at 4800 Deerwood Campus Parkway, DC1-7, Jacksonville, FL 32246, by phone at 1-800-477-3736 X56300 (TTY:1-800-955-8770), by fax at 904-357-8203, or email compass@floridablue.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Senior Manager of Business Ethics 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,* or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1–800–868–1019, 800–537–7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html.*

Have a disability? Speak a language other than English? Call to get help for free. [1-800-352-2583] (TTY: 1-800-955-8770)

¿Habla español? ¿Tiene alguna discapacidad? Llame para obtener ayuda de forma gratuita al [1-800-352-2583] (TTY: 1-800-955-8773)

Èske w pale kreyòl ayisyen? Èske w andikape? Rele nou pou w jwenn èd graris. [1-800-352-2583] (pou moun ki tande di: 1-800-955-8770)

Quý vị nói tiếng Việt? Quý vị bị khuyết tật? Hãy gọi trợ giúp miễn phí. [1-800-352-2583] (TTY: 1-800-955-8770)

Você fala potuguês? Tem alguma deficiência? Telefone para obter assistência. [1-800-352-2583] (TTY: 1-800-955-8770)

您会讲中文吗？是否为伤残人士？如需帮助，请拨打我们的免费电话：[1-800-352-2583]（TTY：1-800-955-8770）

Vous parlez français ? Vous avez une incapacité ? Appelez pour recevoir une assistance gratuite. [1-800-352-2583] (TTY: 1-800-955-8770)

Nagsasalita ng Tagalog o Filipino? May kapansanan? Tumawag para sa libreng tulong. [1-800-352-2583] (TTY: 1-800-955-8770)

Вы говорите по-русски? Вы являетесь инвалидом? Свяжитесь с нами для получения бесплатной помощи по телефону [1-800-352-2583] (телетайп: 1-800-955-8770)

هل تتحدث (العربية)؟ هل لديك إعاقة؟ اتصل للحصول على مساعدة مجانية. [1-800-352-2583] (التواصل للذين يعانون من مشاكل في السمع: 1-800-955-8770)

Parli italiano? Hai una disabilità? Chiama per un'assistenza gratuita. [1-800-352-2583]
(TTY: 1-800-955-8770)

Sprechen Sie deutsch? Haben Sie eine Behinderung? Rufen Sie an, um kostenlos Hilfe zu erhalten. [1-800-352-2583] (TTY: 1-800-955-8770)

한국어 통역이 필요하세요? 장애가 있나요? 전화하시면 무료로 도와드립니다. [1-800-352-2583] (TTY: 1-800-955-8770)

Mówi po polsku? Czy ma niepełnosprawność? Zadzwoń po bezpłatną pomoc. [1-800-352-2583] (TTY: 1-800-955-8770)

ગુજરાતી બોલો છો? અક્ષમતા ધરાવો છો? મફત સહાયતા મેળવવા ફોન કરો. [1-800-352-2583] (TTY: 1-800-955-8770)

พูดภาษาไทยได้? เป็นผู้พิการใช่หรือไม่? โทรศัพท์ขอรับคำปรึกษาได้ฟรีที่ [1-800-352-2583] (หมายเลขโทรศัพท์สำหรับผู้พิการทางการได้ยิน: 1-800-955-8770)