CALHOUN COUNTY SCHOOL DISTRICT

RFP for Group Medical Insurance

Proposal Return Date and Time
April 19, 2018 at 1:00 PM (CDT)

Calhoun County School District
20859 Central Avenue East, Room G20
Blountstown, FL 32424

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CALHOUN COUNTY SCHOOL DISTRICT

Section I

Introduction

SECTION I

INTRODUCTION

SCOPE OF REQUEST FOR PROPOSAL

The Calhoun County School District (District) is requesting information for the following coverages/services as further described in this Request for Proposals (RFP):

Section IV:	Fully Insured Group Medical Insurance
Section V:	Medical Claims Administration Services
Section VI:	Stop-Loss Insurance
Section VII:	Agent/Broker Services

Please note that the District will be evaluating and considering fully insured and self-funded options.

PROFILE OF CALHOUN COUNTY SCHOOL DISTRICT

Calhoun County School District is located in northwest Florida in Calhoun County.

CURRENT MEDICAL AND RX PLANS

The current program provides coverage to approximately 270 employees, COBRA participants and retirees (and their additional eligible dependents), who participate in four (4) self-funded Florida Blue plans through the Panhandle Area Education Consortium (PAEC):

1. Florida Blue Plan – BlueChoice 0727
2. Florida Blue Plan – BlueOptions 03359
3. Florida Blue Plan – BlueChoice 0117
4. Florida Blue Plan – BlueOptions 05901

The group medical plans include prescription drugs. This RFP will not request any additional retiree options.

The current FSA administrator is Total Administrative Services Corporation (TASC). The FSA plan includes medical flexible spending and dependent care.

SEPARATION AND DISTRIBUTION

This RFP has been designed for transmittal as a complete document to interested parties. It is recommended that it not be separated; however, it may be reproduced in its entirety as additional distribution might dictate.

The District will utilize its website as a resource for distribution of this RFP for Group Medical Insurance, at:

http://calhounflschools.org/district-news

In addition, vendors may obtain the RFP, Proposal Forms and exhibits by submitting an email request directly to:

Laura Rybka
Siver Insurance Consultants
lrybka@siver.com

with a CC to:

Rhonda O'Bryan, Benefits Coordinator
Calhoun County School District
rhonda.obryan@calhounflschools.org

ROLE OF CONSULTANT

The District retains Siver Insurance Consultants as independent risk and insurance management consultants. Siver acts solely in its capacity as consultant. The consultant does not participate in commissions from any insurance company, agent or broker, nor does it accept any income from other than its clients.

CALHOUN COUNTY SCHOOL DISTRICT

Section II

General Conditions

SECTION II

GENERAL CONDITIONS

PROPOSAL SUBMISSION AND WITHDRAWAL

All proposal sheets and forms must be executed and submitted in a sealed envelope. The completed responses to this RFP include: one (1) paper original and five (5) paper copies (total of six (6) paper proposals) and one (1) electronic copy, either on CD or flash drive (with all documents in their original format: Word, Excel, etc.) which shall be submitted to the Calhoun County School District at the address noted below in sealed envelopes marked "RFP for Group Medical Insurance." Proposals not submitted on the attached forms may be rejected. All proposals are subject to the conditions specified herein. Those which do not comply with these conditions are subject to rejection. It is the sole responsibility of the proposer to deliver the proposal to the address contained herein on, or before, the closing hour and date indicated. The District will not be responsible for the inadvertent opening of a proposal not properly sealed, addressed or identified.

Proposals properly labeled in sealed envelopes will be received at:

Calhoun County School Board
20859 Central Avenue East, Room G20
Blountstown, FL 32424

Proposals are due on Thursday, April 19, 2018 at 1:00 PM (CDT)

Proposals, once received, become the property of the District, cannot be withdrawn, and will not be returned to the Proposers. Upon opening, proposals become subject to public disclosure in accordance with Chapter 119, Florida Statutes.

PROPOSAL OR PUBLIC OPENING

The proposal opening shall be public, at the address indicated on the Request for Proposal document, on the date and at the time specified. It is the proposer's responsibility to assure that the proposal is delivered at the proper time to the place of the opening. Proposals received after the date and time will be rejected and returned unopened to the offeror. Proposals by fax or telephone will not be accepted.

PROPOSER QUESTIONS

Any proposer questions shall be in writing for receipt no later than 2:00 PM on Friday, March 30, 2018. Questions will not be accepted after this time. The District will be closed for Spring Break the week of March 19, 2018; therefore, any questions submitted during Spring Break will not be addressed until the following week when we return to work. Inquiries must reference the date of

RFP opening and RFP number. Failure to comply with this condition will result in proposer waiving his right to dispute the RFP conditions and specifications.

All written questions concerning this RFP must be submitted to:

Laura Rybka
Siver Insurance Consultants
lrybka@siver.com

with a CC to:

Rhonda O'Bryan, Benefits Coordinator
Calhoun County School District
rhonda.obryan@calhounflschools.org

Written responses, in the form of addenda, will be provided via the District's website at:

http://calhounflschools.org/district-news

ADDENDA TO THIS RFP

Prior to submitting the proposal, it will be the sole responsibility of each Proposer to review the District's website to determine if addenda were issued and, if so, to obtain such addenda for attachment to the proposal.

MINIMUM QUALIFICATIONS OF PROPOSER

No proposal will be accepted by the District where insurance coverage is proposed by a person or organization which is not rated by the following rating firm or which has a rating from the following rating firm which is less than the minimum rating specified below.

Rating Firm	Minimum Rating
A. M. Best	B+

INSURANCE REQUIREMENTS

The successful bidder shall furnish the District with proof of:

(1) Statutory Limits of Worker's Compensation in compliance with Chapter 440, Florida Statute.

(2) Employer's Liability Insurance in an amount not less than $1,000,000 per occurrence.

(3) Commercial General Liability Insurance, including Contractual Liability and Products and Completed Operations, in an amount equal to or greater than $1,000,000 per occurrence for any occurrence resulting in bodily injury or death, or personal injury or property damage to any one or group of persons, including any consequential damages that arise therefrom. If policy is on a "CLAIMS MADE" basis, contractor's insurance carrier will identify policy as such and indicate in writing the amount of claims paid by this policy and reserves outstanding. Policy aggregates must equal at least two (2) times the occurrence limit.

(4) Commercial Automobile Liability Insurance in an amount equal to or greater than $1,000,000 per occurrence for bodily injuries and/or death to any person or persons caused by passenger automobiles or commercial vehicles.

(5) Professional (errors and omissions) liability policy in the amount of not less than $2,000,000 covering employees or representatives who provide services to the District.

(6) A fidelity bond in the amount of not less than $1,000,000 covering those employees or representatives who handle or have possession of monies of the Plan. – Self-Insured only

(7) Additional Insured Endorsement: The District shall be named as an additional insured on all policies (except Professional Liability) that are required by these specifications.

(8) Cancellation Notice: All policies in effect shall contain cancellation endorsements providing sixty (60) days written notice of such cancellation, non-renewal and/or reduction in coverage limits prior to the effective date of such cancellation, non-renewal and/or reduction.

(9) Cyber Liability: Such insurance shall be on a form acceptable to the District and shall cover, at a minimum, the following:

- Data Loss and System Damage Liability
- Security Liability
- Privacy Liability
- Privacy/Security Breach Response Coverage, including Notification Expenses

Such Cyber Liability coverage must be provided on an Occurrence Form or, if on a Claims Made Form, the retroactive date must be no later than the first date of this Contract and such claims-made coverage must respond to all claims reported within three years following the period for which coverage is required and which would have been covered had the coverage been on an occurrence basis. The minimum limits (inclusive of any amounts provided by an umbrella or excess policy) shall be: $ 1,000,000 Each Claim/Annual Aggregate.

LATE PROPOSALS, LATE MODIFICATIONS AND LATE WITHDRAWALS

Proposals received after the Proposal Due Date and time are late and will not be considered. Modifications received after the Proposal Due Date are also late and will not be considered. Letters of withdrawal received after the Proposal Due Date or after contract award, whichever is applicable, are late and will not be considered.

COSTS INCURRED BY PROPOSERS

All expenses involved with the preparation and submission of proposals to the District, or any work performed in connection therewith, shall be borne by the proposer(s). No payment will be made for any responses received, nor for any other effort required of or made by the proposer(s) prior to commencement of work as defined by a contract approved by the District.

PROPRIETARY INFORMATION

Please note: Proposers are requested to ensure that boilerplate language in both headers and footers (and any other places) on all proposal pages are accurate and do not assert proprietary and confidential information if not purposefully asserted.

Pursuant to chapter 119, Florida Statutes, 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 Proposers 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 Proposer asserts

any portion of its proposal is confidential or exempt from disclosure under Florida's public records laws, the Proposer must expressly identify all portions of the proposal asserted to be confidential and exempt, along with specific citations of the Florida Statutes establishing the confidentiality or exemption. Failure to identify the portions of the proposal claimed to be exempt or the specific statutory authority establishing the exemption shall be deemed a waiver by the Proposer that any unidentified portion of the proposal is confidential or exempt from disclosure under Chapter 119, Florida Statutes.

Should a public records request for proposal documents or other materials submitted by a Proposer be submitted, Calhoun County School District will notify the contact person identified in the proposal of the request in writing. The notice provided will indicate that requested materials will be produced unless, within ten (10) calendar days of the date of the written notification, the Proposer initiates an action in a court of competent jurisdiction to obtain an injunction or protective order prohibiting the release of the requested materials. The Proposer will name the party requesting the materials as a defendant and will not name the Calhoun County School District as a party to the action. The Proposer agrees to hold Calhoun County School District harmless from any award to a plaintiff for damages, costs, or attorney's fees based on nondisclosure of information asserted to be confidential and exempt. Failure to timely initiate the action will be deemed a waiver by the Proposer that the requested information is confidential and exempt. The Proposer agrees to waive any cause of action it may have against Calhoun County School District for the release of materials pursuant to a public records request except those based on the intentional or grossly negligent conduct of an employee of Calhoun County School District. Any submission by a Proposer in response to this RFP shall be deemed as Proposer's consent to the foregoing conditions.

WAIVER/REJECTION OF PROPOSALS

All reasonably responsive proposals will be considered. However, the District reserves the right to waive formalities or informalities in proposals, to reject, with or without cause, any or all proposals or portions of proposals, or to interview or not interview individual proposers, and to accept any proposal(s) or portions of proposals deemed to be in the best interest(s) of the District.

RULES, REGULATIONS AND LICENSING REQUIREMENT

The proposer shall comply with all laws, ordinances and regulations applicable to the services contemplated herein, including those applicable to conflict of interest and collusion. Proposers are presumed to be familiar with all Federal, State and local laws, ordinances, codes and regulations that may in any way affect the services offered.

RECORDS/AUDIT

Proposer shall maintain records sufficient to document their completion of the scope of services established by this Contract. These records shall be subject at all reasonable time to review, inspect, copy and audit by persons duly authorized by the District. These records shall be kept for a minimum of three (3) years after completion of the Contract. Records which relate to any litigation, appeals or settlements of claims arising from performance under this Order shall be made available until a final disposition has been made of such litigation, appeals, or claims.

The Proposer agrees to maintain books, records, and documents (including electronic storage media) in accordance with generally accepted accounting procedures and practices which sufficiently and properly reflect all revenues and expenditure of funds provided by the District under any contract resulting from the RFP, and agrees to provide a financial and compliance audit to the District or to the Office of the Auditor General and to ensure that all related party transactions are disclosed to the auditor. The contractor agrees to include all record keeping requirements on all subcontracts and assignments related to the contract resulting from this RFP.

INVESTIGATION OF ALLEGED WRONGDOINGS, LITIGATION/SETTLEMENTS/ FINES/PENALTIES

The District specifically requests that responders to this document indicate in writing any investigations of wrongdoings, litigation and/or settlements, and fines or penalties (anywhere in the U.S) involving the Proposer and specific Proposers listed as projected to provide services to the District. You may be required to respond to questions on this subject matter.

CONDUCT OF PROPOSERS

All submitters or individuals acting on behalf of submitters are hereby prohibited from lobbying or otherwise attempting to persuade or influence any member of the Calhoun County School District or any member of the Advisory Committee at any time during the course of the solicitation process. Failure to comply with this procedure will result in rejection/disqualification of said submittal without exception.

All submitters or individuals acting on behalf of submitters are further prohibited from contacting or otherwise attempting to communicate with any member of the Advisory Committee regarding the pending solicitation or its outcome until after the Committee has arrived at a recommendation of the most qualified submitters. Failure to comply with this procedure will result in rejection/disqualification of said submittal without exception.

EVALUATION CRITERIA FOR FULLY INSURED MEDICAL INSURANCE

The Advisory Committee will recommend a firm based upon the evaluation criteria below for the fully-insured medical benefits. If more than one firm is designated qualified enough to be considered as a finalist, the Committee will consider finalist interviews. The District may also conduct simultaneous negotiations with vendors regarding qualifications, quality and price, prior to recommending award of the contract to the vendor believed to provide the most responsive and responsible proposal that is most advantageous to the District.

	Criterion
1.	**Cost –** Although cost will be a major consideration in evaluating proposals, it will not be the only consideration. Cost will include (but not be limited to) disclosure of rates/premiums, service costs (including FSA administrative services), provider discounts, retention and claims cost, pooling costs, any cost guarantees (if applicable) and other cost components.
2.	**Coverage –** The ability to administer the benefits as is, or as close as practical. The amounts and breadth of coverage and extent of deductibles, co-payments, coinsurance, restrictions or exclusions. For prescription benefits, this will also include the formulary list.
3.	**Providers –** The number and types of providers. For medical benefits, the hospitals and number of physicians under contract and the number of contracted physicians who will accept new patients, and the match-up between current top providers and the network

	Criterion
	providers proposed. For pharmacies, the extensiveness of the pharmacy network.
4.	**Service/Customer Service –** The administration capabilities and experience of proposers (including FSA administration). This includes such items as enrollment assistance, service responsiveness, communication with District staff on program administration, quality of billings, Internet website, attendance at District meetings/events, willingness to engage in at-risk performance guarantees, practices dealing with complaints, grievances and satisfaction, etc.
5.	**Wellness and Disease Management Programs –** This includes such items as breadth of wellness and disease management program and predictive modeling capabilities, health risk assessment and self-help tools, health coaching, Internet website, attendance at wellness meetings/events. Experience in developing and administering programs, including use of incentives and other methods to encourage participation.
6.	**Reporting and Data Services –** Monthly and annual reports of paid claims, quality of experience reports, developing adhoc reports, extent and quality of reports on wellness/disease management, etc.
7.	**Stability –** Financial stability of the proposer, A.M. Best rating, the number of years in business, etc.
8.	**References –** The input received from references contacted and the relevant experience such references display (including FSA administration services).
9.	**Interviews –** If interviews are conducted, the Committee will evaluate the quality of the interview, the information provided about the proposal, and the expectations for service to the District.

EVALUATION CRITERIA FOR MEDICAL CLAIMS ADMINISTRATION SERVICES

The Advisory Committee will select and recommend a firm based upon the evaluation criteria below for the medical claims administration services. If more than one firm is designated qualified enough to be considered as a finalist, the Committee will consider finalist interviews. The District may also conduct simultaneous negotiations with vendors regarding qualifications, quality and price prior to recommending award of the contract to the vendor believed to provide the most responsive and responsible proposal that is most advantageous to the District.

Administrative proposals without a coordinating valid stop-loss proposal(s) will not be considered.

	Criterion
1.	**Cost –** Although cost will be a major consideration in evaluating proposals, it will not be the only consideration. Cost will include (but not be limited to) administration fees, service costs (including FSA administrative services), provider discounts, projected claims cost, any cost and discount guarantees (if applicable) and other cost components.
2.	**Coverage –** The ability to administer the benefits as is, or as close as practical. The amounts and breadth of coverage and extent of deductibles, co-payments, coinsurance, restrictions or exclusions. For prescription benefits, this will also include the formulary list.
3.	**Providers –** The number and types of providers. This will include the hospitals and number of physicians under contract and the match-up between current top providers and the network providers proposed. For pharmacies, the extensiveness of the pharmacy network.
4.	**Service/Customer Service –** The administration capabilities and experience of proposers (including FSA administration). This includes such items as staffing, enrollment assistance, service responsiveness, communication with the District staff on program administration, quality of billings, Internet website, attendance at District meetings/events, willingness to

	Criterion
	engage in at-risk performance guarantees, practices dealing with complaints, grievances and satisfaction, etc.
5.	**Reporting and Data Services –** Monthly and annual reports of paid claims, quality of experience reports, developing adhoc reports, extent and quality of reports on wellness/disease management, etc.
6.	**Wellness and Disease Management Programs** – This includes such items as breadth of wellness and disease management program and predictive modeling capabilities, health risk assessment and self-help tools, health coaching, Internet website, attendance at wellness meetings/events. Experience in developing and administering programs, including use of incentives and other methods to encourage participation.
7.	**Stability –** Financial stability of the proposer, A.M. Best rating, the number of years in business, etc.
8.	**References –** The input received from references contacted and the relevant experience such references display (including FSA administration services).
9.	**Interviews –** If interviews are conducted, the Committee will evaluate the quality of the interview, the information provided about the proposal, and the expectations for service to the District.

EVALUATION CRITERIA FOR STOP-LOSS INSURANCE

The Advisory Committee will select and recommend a firm based upon the evaluation criteria below for the stop-loss insurance in situations where the successful administrator of the medical claims administration services is directly proposed with two or more stop-loss proposals. If more than one firm is designated qualified enough to be considered as a finalist, the committee will consider finalist interviews. The District may also conduct simultaneous negotiations with vendors regarding qualifications, quality and price prior to recommending award of the contract to the vendor believed to provide the most responsive and responsible proposal that is most advantageous to the District.

	Criterion
1.	**Cost –** Although cost will be a major consideration in evaluating proposals, it will not be the only consideration. Cost will include (but not be limited to) premium, cost guarantees and other cost components, including claims disclosure requirements and the increased specific deductibles for individuals ("lasers").
2.	**Coverage –** The ability to administer the benefits as is. The amounts and breadth of coverage and extent of restrictions or exclusions.
3.	**Service/Customer Service –** The administration capabilities and experience of proposers. This includes such items as service responsiveness, stop-loss claims filing (if applicable),
4.	**Stability –** Financial stability of the proposer, A.M. Best rating, the number of years in business, etc.
5.	**References –** The input received from references contacted and the relevant experience such references display.
6.	**Interviews –** If interviews are conducted, the Committee will evaluate the quality of the interview, the information provided about the proposal, and the expectations for service to the District.

EVALUATION CRITERIA FOR AGENT/BROKER (IF APPLICABLE)

The Advisory Committee will evaluate proposals for agent/broker services based on the described criteria and points which follow to determine which general insurance agent is the first choice. However, the basic decision to utilize a general agent versus use of a company agent (direct) will be made by simple committee vote independently from the below. An agent may be considered only if the winning and/or shortlisted insurer or administrator names such agent in their RFP response.

	Criterion
1.	**Cost –** Although cost will be a major consideration in evaluating proposals, it will not be the only consideration. Cost will be all remuneration to the agent including (but not be limited to) commission, fees and/or other compensation.
2.	**Background and Experience –** The size of the insurance agency, the experience in providing insurance for public entities and school districts, the personnel and qualifications (particularly of the agent who will serve the District), number of years as an agent/agency, the breadth of experience in medical benefits.
3.	**Service/Customer Service –** Agreement to the Scope of Services included in the RFP. This also includes such items as enrollment assistance, service responsiveness, communication with District staff on program administration, quality of billings and experience reports, Internet website, attendance at District meetings/events, willingness to engage in at-risk performance guarantees, wellness/disease management services, etc.
4.	**References –** The input received from references contacted by the District and/or the relevant experience such references display.
5.	**Interviews –** If interviews are conducted, the Committee will evaluate the quality of the interview, the information provided about the proposal, and the expectations for service to the District.

CONFLICT OF INTEREST

The award hereunder is subject to the provisions of Chapter 112, Florida Statutes. All proposers must disclose with their proposal the name of any officer, director, or agent who is also an employee of the District. Further, all proposers must disclose the name of any employee who owns, directly or indirectly, an interest in the proposer's firm or any of its branches. The proposer shall not compensate, in any manner, directly or indirectly, any officer, agent, or employee of the District for any act or service that he/she may do, or perform for, or on behalf of any officer, agent or employee of the proposer. No officer, agent, or employee of the District shall have any interest, directly or indirectly, in any contract or purchase made, or authorized to be made by anyone for, or on behalf of the District. The proposer shall have no interest and shall not acquire any interest that shall conflict in any manner or degree with the performance of the services required under this RFP.

LEGAL REQUIREMENTS

Applicable provision of all Federal, State, county and local laws, and of all ordinances, rules, and regulations shall govern development, submittal and evaluation of all proposals received in response hereto and shall govern any and all claims and disputes which may arise between person(s) submitting a response to RFP hereto and the District by and through its officers, employees and authorized representatives, or any other person, natural or otherwise; and lack of knowledge by any bidder shall not constitute a cognizable defense against the legal effect thereof.

PUBLIC ENTITY CRIMES STATEMENT

Proposers are hereby notified about Section 287.133(2)(a), Florida Statutes, which requires that:

"A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids 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 s. 287.017 for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list."

ANTI-DISCRIMINATION CLAUSE

The non-discrimination clause contained in Section 202, Executive Order 11246, as amended by Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex or national origin, and the implementing rules and regulations provided by the Secretary of Labor are incorporated herein.

DISCRIMINATORY VENDOR'S LIST

Any entity or affiliate who has been placed on the Discriminatory Vendors List may not submit a proposal to provide goods or services to a public entity, may not be awarded a contract or perform work as a contractor, supplier, subcontractor, or consultant under contract with any public entity and may not transact business with any public entity.

DRUG FREE WORK PLACE

Chapter 287.087, F.S., Procurement of Personal Property and Services. Whenever two or more offers which are equal with respect to price, quality, and service are received by the District for the purchase of commodities or contractual services, an offer received from a business that certifies that it complies fully with the requirements of the Drug-Free Workplace Program shall be given preference in the award process.

USE OF PROPOSAL FORMS

Proposers should complete the appropriate Proposal Form(s) included in Section VIII through Section XI of this RFP. All blanks on the Proposal Forms should be completed. If a question or confirmation is not applicable, it should be answered with an "N/A." Proposal Forms need not be completed for coverages/services not being proposed.

Supplemental information may be attached to the Proposal Forms. Failure to fully complete the appropriate Proposal Forms may result in disqualification of your proposal.

If additional space for a response is required, attach an additional page to the page on which the question is stated. Clearly identify the number of the question to which the response is attached. Further, if additional Proposal Form pages are needed, photocopy or replicate as appropriate, and attach such additional pages to the page on which the question or chart is stated.

The signature on the Proposer's Warranty(ies) must be that of an officer, partner or a sole practitioner of the company making the proposal. The original proposal, and each copy submitted, should contain an original signature on the Proposer's Warranty contained in each Proposal Form.

IRREVOCABILITY OF PROPOSAL

Each Proposer agrees that proposals shall remain open until the effective date of coverage, October 1, 2018, not subject to revocation, and shall be subject to the District's acceptance.

CONTRACT AWARDS

The District anticipates entering into a contract with the Proposer or Proposers who submit the proposals judged by the District to be most advantageous.

The Proposer understands that this RFP does not constitute an agreement or a contract with the Proposer. An official contract or agreement is not binding until proposals are reviewed and accepted by the District and executed by all parties.

The District reserves the right to reject all proposals, to waive any informality, to negotiate with vendors, and to solicit and re-advertise for other proposals.

AGENT/BROKER SERVICES

Proposals are requested, but not required, to be submitted net of any agent or broker commissions.

Agents/Brokers shall recognize that the District will be scrutinizing the amount of remuneration in relation to the expected level of service to be received. The District wants to avoid payment of remuneration that may appear to be excessive. The District may be interested in negotiating such remuneration, especially when two or more agents have similar or identical lowest cost proposals. Proposing agents/brokers shall state if they are willing to negotiate such remuneration.

The Proposal Forms for all proposals must identify any agents or other intermediaries who are not employees of the insurers being proposed, and who will be receiving remuneration for the District's plan(s). The Proposal Forms must disclose the remuneration basis and estimated annual amounts. Any such agents that will be receiving remuneration in connection with proposals submitted in response to this RFP should complete the Proposal Forms contained in Section XI.

Please note that such agents making proposals must be designated by their choice of insurer(s) on the applicable Proposal Form(s). Whether an insurer is proposing with one such agent or multiple agents, all must be shown on the Proposal Form(s) submitted by such insurer, as these are the only agents that will be considered.

The Proposal Forms must include details of the service to be provided by these agents who will be receiving remuneration. See the separate Model Program for Agent Services section.

Also, if an agent who is not an employee of the insurer is chosen, the District reserves the right, based on its evaluation of the value of the service received, to continue such agent upon each renewal or to alternatively consider the direct services of the insurer through its employee agent.

AGENT OF RECORD

The District reserves the right at any time to replace the Agent of Record (if there is one) with another agent of the same company, if, in the opinion of the District, such Agent of Record is not rendering or is incapable or rendering the quality of service and cooperation required.

Please note that agents submitting proposals included or not included with an insurer must be designated on the insurer's applicable Proposal Form(s). If an insurer is proposing with multiple agents, all agents must be shown on the Proposal Form(s), as these are the only agents that will be considered.

DEVIATIONS FROM MODEL PROGRAM

The contract terms and conditions stipulated in this RFP are those desired by the District, and preference will be given to those proposals in full or substantial compliance with them. All deviations from the model program must be clearly stated on the Proposal Forms.

CALHOUN COUNTY SCHOOL DISTRICT

Section III

Common Contract Provisions

SECTION III

COMMON CONTRACT PROVISIONS

PROVISIONS INCORPORATED BY REFERENCE

This Section III contains requirements and endorsements, which are common to more than one coverage or service. The contract requirements and endorsements set forth in this Section III are incorporated by reference in such sections. Those provisions, which are identified as endorsements, are to be included verbatim in the insurance policy or contract.

PROHIBITION OF WARRANTY ENDORSEMENT

The Proposer acknowledges that the District has made a reasonable attempt to provide the Proposer with relevant and appropriate rating exposures and loss data. The Proposer therefore waives any right of denial of coverage or voidance of the contract based upon any expressed or implied warranty or representation (whether written or oral) that the rating exposures and loss data provided disclose all exposures or data known to exist.

SOLE AGENT ENDORSEMENT

It is agreed that the District shall be the Sole Agent with respect to payment, cancellation, and notice with respect to the Contract between the District and the successful proposer(s). Any notice with respect to the foregoing shall be sent in writing to:

Finance Officer
Calhoun County School District
20859 Central Avenue East, Room G20
Blountstown, FL 32424

HOLD HARMLESS/INDEMNIFICATION PROVISION

The successful Proposer shall hold harmless, indemnify and defend the District, its members, officials, officers and employees against any claim, action, loss, damage, injury, liability, cost and expense of whatsoever kind or nature (including, but not by way of limitation, attorneys' fees and court costs) arising out of or incidental to the performance of the contract or work performed thereunder, whether or not due to or caused by negligence of the District, its members, officials, officers or employees, excluding only the sole negligence of the District, its members, officials, officers and employees.

TERMINATION AND NON-RENEWAL ENDORSEMENT

Notwithstanding any provision in this Contract to the contrary, except with respect to cancellation of this Contract for non-payment (for which at least sixty (60) days' written notice shall be provided), the Company may not cancel, non-renew, restrict coverage, or restrict the Company's contractual obligations with respect to this Contract except:

A. as of the end of the *[12]* month anniversary of this Contract; and

B. then only when such action is to be effective at least one hundred and fifty (150) days after receipt by the District of valid written notice from the Company of the Company's

intention with respect to such cancellation, non-renewal, restriction of coverage, or restriction of the Company's contractual obligations.

The Company may not effect cancellation of this Contract for non-payment until at least sixty (60) days after receipt by the District of valid written notice from the Company of the Company's intention with respect to such cancellation.

The written notice of any cancellation, non-renewal or restriction of the Company's contractual obligations shall be delivered by certified mail to:

Finance Officer
Calhoun County School District
20859 Central Avenue East, Room G20
Blountstown, FL 32424

This Contract may be canceled at any time at the request of the District, by written notice to the Company stating when thereafter cancellation is to be effective. In the event of termination of this Contract, for whatever reason, the earned fees or other consideration shall be computed on a pro rata basis without penalty, and the Company shall refund the excess of paid fees or other consideration to the District, within thirty (30) days from the date of termination.

RERATING ENDORSEMENT

Notwithstanding any provision in this Contract to the contrary, the Company may not effect any increase of rates or other consideration applicable to this Contract except:

A. as of the end of the *[12]* month anniversary of this Contract; and

B. then only when such increase is to be effective at least one hundred fifty (150) days after receipt by the District of valid written notice from the Company, stating specifically the amount of change proposed. Mere notice that a change in rates or consideration is proposed, without stating clearly the exact amount and the effect of the proposed change on the overall consideration of this Contract, shall **not** constitute a valid notice.

The written notice of any change in rates or other change in consideration shall be delivered by certified mail to:

Finance Officer
Calhoun County School District
20859 Central Avenue East, Room G20
Blountstown, FL 32424

CALHOUN COUNTY SCHOOL DISTRICT

Section IV

Model Program For Fully Insured Group Medical Insurance

SECTION IV

MODEL PROGRAM FOR FULLY INSURED GROUP MEDICAL INSURANCE

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION IV – MODEL PROGRAM FOR FULLY INSURED GROUP MEDICAL INSURANCE.

SECTION II – GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.

SECTION III – COMMON CONTRACT PROVISIONS – All provisions of Section III are specifically incorporated by reference.

CONTRACT PERIOD

An initial 12-month contract, from October 1, 2018 through and including September 30, 2019, is required, plus the options for four (4) one year extensions are required. Further, it shall be the option of the District to renew the program for additional plan years thereafter.

Renewal guarantees are encouraged and will be considered favorably.

RATE GUARANTEE PERIOD

Regardless of actual enrollment, the initial rates shall be guaranteed for 12 months. Changes after the initial 12 month period shall be subject to the Rerating Endorsement. FSA administrative services shall be guaranteed for 36 months.

REMUNERATION

Any remuneration or other similar compensation included must be shown separately. Remuneration arrangements, if any, will be between the District, the successful Proposer, and any agent, broker or other intermediary representing the successful Proposer.

ACCESS TO CLAIM FILES

The proposer agrees that the District shall have reasonable access to all claim files created as a result of the claims services to be provided by the successful proposer. For the purpose of this provision, reasonable access shall include making available, upon receipt of five (5) days advance written notice, all claim files for review by the District. Further, upon written request of the District, the successful Proposer shall make available to the District at the District's offices and within ten (10) days after the written request, a complete copy of selected files identified by the District.

OWNERSHIP OF CLAIM DATA

The District shall have all right, title, interest and ownership to all loss statistics created as a result of the services to be provided by the successful Proposer. Further, at the sole option of the

District, and upon fourteen (14) calendar days' written notice, the successful Proposer shall provide such data to the District.

At the termination of the contract, the successful Proposer shall provide the District with computer tapes or other computer media containing all of the data required to facilitate a smooth transition. Such data shall be made available within 30 days of written request, in a format generally importable into a commonly recognized database for loss statistics.

AUDIT REQUIREMENT

Proposers shall state to what extent they will allow the District to audit, or to permit designees on behalf of the District, to audit the proposer's files and procedures as they relate to the District.

ELIGIBILITY & ENROLLMENT

Coverage must match the District's current eligibility requirements. Coverage is effective on the 1st of the month following 30 days of full time employment, as outlined in the District's current plan documents.

Proposers should be aware that it is impossible to predict how many employees will elect each plan design and monthly premiums rates for each plan design must be honored as proposed even if there is a substantial change in plan design choices at enrollment.

The District currently contributes the following per employee for employee benefits:

Employee Only Coverage – age 64 and under	$ 432/month
1 Dependent – age 64 and under	$ 432/month
Family	$ 432/month
Family (2 Employees)	$ 865/month
Medicare Supplement – Retired Employee	$ 50/month

Please note census exhibits include a separate sheet showing employees who have waived coverage but are eligible each enrollment to elect coverage.

CONTINUITY OF COVERAGE (NO LOSS/NO GAIN PROVISION)

Notwithstanding any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan to the contrary, if, but for the replacement of the current plan with the proposed plan, an insured would have been covered by the current plan, the insured shall be entitled to the lesser of:

(1) the benefits which would have been payable had the current plan been continued; or

(2) the benefits which would be payable under the proposed plan without the application of any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan.

SCOPE OF COVERAGE

Medical

Currently, the District offers the following four (4) plans:

1. Florida Blue Plan – BlueChoice 0727
2. Florida Blue Plan – BlueOptions 03359
3. Florida Blue Plan – BlueChoice 0117
4. Florida Blue Plan – BlueOptions 05901

All plans offered include in-network and out-of-network coverage. Please review the plan documents in the Exhibits section for more information.

Option 1

Propose the benefits as is: Plans 1 – 4 with the same benefits.

Option 2

For Option 2, the District is asking Proposers to provide innovative ideas to improve member health and control costs, such as alternate plan designs, partnerships with local vendors, etc.

This RFP includes a Benefits Match-Up (a, b, c, d) Exhibit 4, outlining the proposed benefits and asking proposers to respond "Match" or provide details regarding the benefits offered for the plan proposed.

FSA Administration

The District's current FSA administrator is Total Administrative Services Corporation (TASC). The District expects proposers for medical coverage to either provide FSA services or to coordinate these services through another vendor. FSA proposals are only being solicited in conjunction with medical proposals. Stand-alone FSA proposals will not be considered.

The District reserves the right to negotiate with proposer finalist(s) on alternative plan designs.

SCOPE OF SERVICES

The successful Proposer shall perform all services indicated below, including:

- Managed Care Services,
- Administrative Services,
- Healthcare Reform Services,
- Prescription Benefit Services,
- Flexible Spending Account (FSA) Administration Services,
- Reporting and Data Services, and
- Wellness Program and Disease Management Services.

Any sub-contracted services (such as an FSA administrator) to be provided in connection with these requirements must be identified in the proposal.

The District desires to continue a prescription drug plan similar to the current plan design that can deliver cost effective prescription benefits to the District's medical benefits plan participants through an extensive pharmacy network, supplemented by a mail order service and specialty pharmacy services.

All proposals should include copies of any contract which the District will be required to execute. All proposals should include copies of standard communication materials that are sent to members, such as explanation of benefit (EOB) type forms.

MANAGED CARE SERVICES

Proposer should maintain a provider managed care network consisting of hospitals, physicians, allied and ancillary services, and durable medical equipment. This arrangement should:

1. Provide services with reasonable promptness with respect to geographical location, hours of operation, and after hours care; including emergency care available 24 hours a day, 7 days a week.

2. Contract with network physicians that:
   a. Hold appropriate occupational and professional licenses;
   b. Hold active and unrestricted privileges in their specialty;
   c. Have a valid Drug Enforcement and Administration (DEA) number and hold unrestricted prescribing privileges (except chiropractors);
   d. Have hospital privileges at participating hospitals;
   e. Have not been convicted of a felony or greater crime;
   f. Are specialty board certified (80% or greater); and
   g. Have not been suspended, placed on probation or limited from any hospital privileges or restricted from receiving payments from Medicare, Medicaid, or other third party programs during the last five years.

3. Contract with network hospitals that:
   a. Hold current Joint Commission on Accreditation of Hospitals (JCAH) accreditation without conditions and licensure;
   b. Have at least 80% of staff physicians with full admitting privileges board certified;
   c. Are free from disciplinary action for the last five years;
   d. Are Medicare certified; and
   e. Hold current accreditation with one of the following (in lieu of JCAH), if the hospital is primarily of a rehabilitative nature and lacks surgical facilities:
      (1) American Osteopathic Hospital Association; or
      (2) Commission on the Accreditation of Rehabilitative Facilities.

4. Provide a network(s) consisting of providers that have the capacity to provide treatment throughout the State of Florida.

Accordingly, this RFP includes a Most Utilized Providers Exhibit 5 (1 Tab, in Excel), listing the top providers and asking proposers to respond (yes or no) regarding whether the providers are included or not in the network for each plan proposed.

a. Proposers should include a detailed list that includes all participating hospitals in the following Florida counties: Calhoun, Liberty, Jackson, Leon and Bay, and the following Alabama county: Houston.

b. The District desires that the hospitals in the network(s), collectively, should offer the following services:
   (1) Anesthesia
   (2) Audiology
   (3) Day Surgery
   (4) Diagnostic, X-Ray, and Laboratory Services
   (5) Emergency Services
   (6) Medical/Surgical Intensive and Acute Care
   (7) Neo-natal Care
   (8) Neurology Services
   (9) Obstetrical Care and High-Risk Obstetrical Care
   (10) Pediatric Care
   (11) Psychiatric Care
   (12) Respiratory Care
   (13) Social Service & Discharge Planning
   (14) Speech Pathology
   (15) Substance Abuse Treatment
   (16) Therapies - Physical, Respiratory, Occupational
   (17) Trauma Care

c. The District desires that the network(s) include the following providers:

   (1) Primary care physicians who include physicians practicing in the field of General Practice, Family Practice, Internal Medicine, OB/GYN, and Pediatrics.

   (2) Specialty physicians in the network(s), collectively, should provide the following medical practice areas:
   - Allergy/Immunology
   - Anesthesiology
   - Cardiology
   - Chiropractic Medicine
   - Endocrinology
   - Dermatology
   - Gastroenterology
   - Internal Medicine
   - Neurology
   - Obstetrics/Gynecology

- Oncology
- Ophthalmology
- Orthopedic Medicine
- Otolaryngology
- Pediatrics
- Physical and Occupational Therapy
- Podiatry
- Pulmonary Medicine
- Radiology
- Rheumatology
- Speech Pathology and Audiology
- Urology

5. Provide benefits to employees/dependents that are referred to an out-of-network specialist due to the lack of in-network providers in that specialty, at the in-network benefit level.

6. Include ancillary providers in the network(s) that are properly licensed and credentialed, and provide the following services: imaging centers, diagnostic x-ray and laboratory facilities, durable medical goods, home health care, skilled nursing facility, birth centers, and hospices.

7. Provide employees with current directories on an annual basis with quarterly updates, and/or provide on-line access to current directory information.

8. Require that network providers hold the employees/dependents and the District harmless from any fees for services which are rendered that are plan eligible charges (except deductibles, co-payments and coinsurance), regardless of the reason for non-payment.

9. Prohibit network providers from balance billing the patient for any excess of contracted amount, except for deductibles, co-payments and coinsurance.

10. Provide Medical Case Management that:

    a. Uses Florida Registered Nurses and vocational counselors to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.

    b. Performs specific services that coordinate the provision of care and the management of benefits in cases of catastrophic illness or injury. Such a program should strive to ensure that patients receive the most appropriate, cost-effective care and derive maximum advantage from available plan benefits. It may require covering expenses not normally covered by the plan (e.g., air conditioners, wheelchair ramps, etc.) in exceptional situations, to return a patient to a productive life.

c. Follows specific medical/disability criteria to determine which claims may need medical/disability management intervention to include, but not be limited to, the following:
   (1) Spinal cord injury
   (2) Burns (third and fourth degree)
   (3) Amputations
   (4) Traumatic brain injury
   (5) Renal failure
   (6) Neo-natal single or multiple births
   (7) Neoplasm of brain, bone, pancreas, liver
   (8) At risk pregnancy
   (9) Accidents involving multiple family members with multiple injuries
   (10) All claims exceeding a $50,000 threshold
   (11) Organ transplants

d. Coordinates with Utilization Review and claims processing for effectiveness and efficiency.

e. Provides quarterly medical case management reports on all claims expected to exceed $50,000 or otherwise identified as being the type of claim which will benefit from medical case management, in addition to reports that identify current and past case loads, prognoses and savings realized through case management.

11. Provide Utilization Review that:

a. Uses Florida licensed Registered Nurses to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.

b. Includes the following specific services:

   (1) Pre-admission certification for medical admissions, and determination of medical necessity;
   (2) Continued stay review by telephone of all hospitalizations. Certification of the need for additional days beyond the initial pre-certification. Medical necessity of treatment and length of stay to be strictly observed. No benefits are to be payable if the treatment is not medically necessary;
   (3) Concurrent Review of selected hospitalizations via personal visit by a Registered Nurse (RN) where conditions indicate a need for such;
   (4) Retrospective Utilization Review (after delivery of service, but prior to payment) of all unusual claims plus all claims over $50,000; and
   (5) Discharge planning for medical/surgical patients.

c. Provides quarterly statistics on the effectiveness of Utilization Review.

d. Coordinates with Medical Case Management for effectiveness and efficiency.

ADMINISTRATIVE SERVICES

Except for the collection of premium to the successful Proposer and, as except otherwise noted in this RFP, the successful Proposer shall be totally responsible for the administration of the plan. These activities should include, but are not limited to, the following:

1. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported claims.

2. Design, print, and furnish descriptive literature and enrollment material in a sufficient quantity. Additionally, certificates/booklets are to be provided as needed. These certificates must have a readability level acceptable to the District. In addition, furnish an electronic version of the certificates/booklets for the District to use on its website. These documents must be provided at no additional cost to the District.

3. Mail/deliver booklets, ID cards, or certificates directly to the District, after the District has reviewed a draft and approved it. This review and approval by the District is to be completed prior to printing by the successful Proposer.

4. Issue ID cards within three (3) calendar weeks (plus four (4) days' mailing time) after completion of open enrollment periods or after enrollment papers are received for new hires.

5. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

6. Provide enrollment assistance, including educational materials pre-approved by the District in advance of distribution, to the District during open enrollment period on an annual basis. These tasks should include, but not be limited to, providing sufficient and properly trained enrollers employed by successful Proposer, and requiring that they attend all scheduled enrollment meetings.

7. Assign a staff person as the District's account representative in each of the respective areas, including medical claims, medical eligibility and reporting and data services.

8. Meet with the District, at a minimum, quarterly, to discuss the status of the plan, performance, audits, reports, and planning.

9. Attend meetings, if requested by the District.

10. Verify claimant's eligibility for benefits based on eligibility requirements furnished by the District.

11. Maintain covered dependent information by dependent's name, date of birth, gender, and relationship to insured and social security number.

12. Use a fully automated online clinically-oriented claims adjudication and auditing system that analyzes coded claims data to ensure correct identification.

13. Screen for and deny workers' compensation claims.

14. Target (flag) the following types of claims for supervisory review*:

    a. Service required precertification, but certification not obtained;

    b. Actual length of stay or level of service does not match the approved length of stay or level of service;

    c. Dollar amount or diagnoses warrants potential referral to medical case management; or

    d. Any one bill that exceeds $50,000.

    *Supervisory review shall include, as appropriate, at a minimum, a review of itemization of invoices exceeding $50,000 and review of case management notes.

15. Identify and maintain separate COB information for each applicable claimant, as well as distinguish between the various types of COB.

16. Maintain the confidentiality requirements of Federal and Florida law by having adequate systems security features.

17. Turnaround 95% of all "clean" claims within ten (10) working days and 100% of all claims within thirty (30) working days. A "clean" claim is a claim submitted with all needed information for proper processing and adjudication.

18. Issue EOBs to the claimant within five (5) working days of processing claims.

19. Create an EOB that meets the District's approval that uses a format and terminology such that a person not of a medical or insurance background can easily understand the content. This EOB must also comply with Health Care Reform requirements (example: Claims and Appeal procedure requirements).

20. Conduct semi-annual internal audits for claim accuracy and occurrence of mispayments. Report results to the District within ten (10) working days from the end of the reporting period.

21. Provide COBRA and HIPAA administration and pay COBRA beneficiary claims.

22. Establish and maintain a toll-free line for employees. This line should be operational from at least 8 AM to 6 PM (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls.

23. Maintain access to a Medical Director to evaluate appealed claims.

24. Coordinate with the District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the District's eligibility record in Excel format (as described above in the Billing and Eligibility section).

25. Administer the plan on a detail billing remittance basis by division, separated by active employee, retiree and COBRA beneficiary.

26. Conform accounting procedures and practices to generally accepted accounting principles.

27. Maintain proper records for tax reporting purposes; e.g., 1099s.

28. Retain medical claims history online for minimum of twenty-four (24) months.

29. Prepare, maintain, and file with any applicable federal, state or local governmental agencies, any forms or reports as may be required from time to time by law; e.g., New York Public Goods Pool, COBRA, CMS obligations, etc.

30. Provide assistance with regard to: (1) problems arising in connection with insurance laws, (2) tax aspects of the Plan, (3) litigation arising out of the administration of the Plan, and (4) any other legal matters that may arise in the course of the operation of the Plan.

31. Provide assistance with any regulatory employee notifications, both for Healthcare Reform and on an ongoing basis.

32. Establish claim denial and grievance procedures which are clearly communicated to members. Grievance procedures should be consistent with all applicable federal and state laws, rules and regulations, including but not limited to Healthcare Reform.

33. Supply all postage required to service the District's account.

34. Send correspondence using District approved pre-formatted letters to the claimant or provider. The content of these letters must be easily understandable by a person not of a medical or insurance background.

35. The District will have first review and pre-approval of any correspondence that will be sent to claimants or providers that includes changes/amendments to the plan.

HEALTHCARE REFORM SERVICES

1. Assist the District in a timely manner in staying in compliance with the PPACA for their health plans (and if applicable, their prescription plan) by (at a minimum):
    a. Reviewing the language in their plans in regards to the Guaranteed Availability of Coverage.
    b. Providing plan testing, of each plan offered, of the Essential Health Benefits as defined by the PPACA.
    c. Providing plan testing, of each plan offered, of the actuarial value of benefits (minimum value) as defined by the PPACA.
2. To the extent required, provide the District the required Summaries of Benefits and Coverage (SBC) for each offered plan.
3. Assist the District with understanding the fees assessed by the PPACA. In addition, assist the District in the assessment, cost and payment of any PPACA fees, if applicable.
4. Assist the District with other healthcare reform, or subsequent healthcare legislation, reporting.

PRESCRIPTION BENEFIT SERVICES

These activities should include, but are not limited to, the following:

1. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported prescription claims.
2. Provide appropriate literature to describe the benefits offered by the District to its employees and appropriate educational materials regarding use of generics versus brand names, the advantages of mail order service where it is the most efficient for all concerned, and formulary information.
3. Use a fully automated online clinically-oriented claims adjudication/auditing system that analyzes coded claims data to ensure correct identification.
4. Screen for and deny workers' compensation claims.
5. Maintain the confidentiality requirements of Florida and Federal law by having adequate systems security features.
6. Establish and maintain a toll-free customer service line for employees. This line should be operational from at least 8 AM to 6 PM (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls, with call backs to occur within 24 hours of the next business day.

7. Retain claims history online for minimum of 24 months from the last date of any claim activity pertaining to services rendered. All prior claims history incurred during the course of this contract must be captured in such a manner compatible for media storage and delivered to the District at their request. This data must be maintained for the full duration of the contract period, and must also be available for transfer to the subsequent vendor, should the District elect to change vendors in the future.

8. Provide a comprehensive drug utilization review program (DUR).

9. Provide cost effective intervention programs, such as prior authorizations, step therapy, etc.

FLEXIBLE SPENDING ACCOUNT ADMINISTRATION

The administrator is expected to provide the District with at least the following professional services:

1. Assure compliance with applicable law, regulations, etc.
2. Assure proper FSA substantiation procedures.
3. Employee group seminars and individual enrollments.
4. Establish billing procedures that are compatible with the needs and organizational structure of the District.
5. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.
6. Preparation of enrollment communications materials, including a letter explaining the program, FSA question/answers, examples of the benefits of FSAs, a worksheet for employees to determine amounts to place in their FSAs and an enrollment form.
7. A local area telephone number or "800" number that employees may call throughout the year for counseling, information or service regarding the flexible benefit plans.
8. Establishment of all records necessary for maintaining account balances.
9. Forms for reimbursement of claims, change of status, direct deposit, disbursement statements, etc.
10. The administrator shall be responsible for ongoing enrollment and for producing reports to the District as needed and to individual employees.
11. Payment of claims.
12. Quarterly individual account status reports to participants.
13. Bi-weekly participation and account status reports to participants.
14. A summary Annual Report for employees.

15. An annual forfeiture report to the District.

16. Federal report filing requirements, including issuing 1099s to providers.

17. The administrator is required to maintain books, records, documents and any evidence on costs and expenses for services provided. Records must be maintained for three full years after this contract ends and records should be open to the District audit upon request.

18. Debit cards for employees to access their flexible spending accounts is required. Please include details regarding debit card availability.

MEDICAL AND PRESCRIPTION REPORTING AND DATA SERVICES

1. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

2. Provide the District's designees direct access to claims data and reporting capabilities.

3. Provide the District with aggregated data reporting capabilities.

4. Prepare and furnish the District with monthly exposure and loss data statistics. Exposure data should include census data, such as name of employee, zip code and date of birth and employment status. Loss data reports should include, but not be limited to, the following information: (Data subject to compliance with HIPAA privacy guidelines.)

    a. Claims data should be provided monthly (within 30 days after the end of the month) with cumulative totals for the plan year, separately for participants in each category of plan offered (e.g., PPO and HDHP), preferably in a format that will provide data separately for employees and their dependents, retirees and their dependents and COBRA and their dependents, and total for all participants and all dependents. The desire for separate premium/claims experience for employees, retirees, COBRA and dependents is to permit the District to determine if the rates being charged are equitable. Claim reports should be provided additionally for 12 months after plan termination, or until there are no runout and/or extension of benefits claims.

    b. Claims data should be provided monthly detailing all claims where more than $25,000 has been paid in the current plan year. Data should include amount paid, type of plan participant (employee, dependent, retiree, etc.), diagnosis, prognosis and status of the claim (active, expired, etc.).

5. Provide reports inclusive of data elements specified by the District in mutually agreed upon formats. The required standard reports include, but are not limited to, the following:

    a. Monthly reports are due on the 15th workday following the end of the "report" month. These reports should include paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).

b. Quarterly and Year-to-Date Reports are due on the 15th working day following the "report" quarter. These reports should include: benefit payment summaries, inpatient (utilization) reports, paid claims by coverage and diagnosis types, COB savings, and service inquiries.

6. Provide prescription data reports inclusive of data elements specified by the District in mutually agreed upon formats. The required standard reports will include, but are not limited to monthly reports of claims versus premium are due by the 15th business day following the end of the "report" month. These reports should include paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).

7. Prepare and furnish the District with periodic prescription reports included in the medical benefits reports that provide claims data. Reports on drug benefits costs should include appropriate data on utilization by category (such as retail and mail order, for generic, preferred brand, non-preferred brand, etc.).

8. Provide access to archived data within ten (10) working days of a request by the District.

PERFORMANCE GUARANTEES

Proposers should confirm that they are willing to offer performance guarantees and that they are willing to permit the District access to claims offices, personnel and files to conduct audits necessary to verification of performance standards. Performance may be evaluated on a variety of issues, such as:

- If applicable, timely implementation of the District's account.
- Timely delivery of finalized contracts for the selected program.
- Timely delivery of identification cards, at and subsequent to initial enrollment.
- For provider directories, timely updates either online or if a significant change that will affect a large portion of members, timely communication notices (s) (either verbal or via mail).
- Timely delivery of monthly reporting.
- Timely delivery of plan documents and HCR summaries (as applicable).
- Wellness program health guarantees.
- Claims turnaround time.
- Accuracy of claims coding and payments.
- Telephone response time, and abandonments.
- Quality of service to plan participants, as measured by periodic surveys.
- Quality and timeliness of claims experience reports.
- Network provider participation, with penalties for drops below pre-specified levels.
- Rate of provider turnovers.
- Access to standards of care.
- Collection or other threats to participants by providers not paid by the insurer.

State the extent to which these measurements will be applied specifically to the District's

account (account specific) versus your “book of business”.

Suggestions on criteria for measuring performance and indications of how the organization is set-up to facilitate auditing of performance should be submitted. If the proposer has a performance guarantee agreement, provide a sample for review.

Please confirm your firm’s willingness to enter into such an agreement and to negotiate appropriate terms, and recommend appropriate incentives or disincentives (meaningful penalties) to make the performance guarantee practical.

CALHOUN COUNTY SCHOOL DISTRICT

Section V

Model Program For Medical Claims Administration Services

SECTION V

MODEL PROGRAM FOR MEDICAL CLAIMS ADMINISTRATION SERVICES

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION V – MODEL PROGRAM FOR MEDICAL CLAIMS ADMINISTRATION SERVICES.

SECTION II – GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.

SECTION III – COMMON CONTRACT PROVISIONS – All provisions of Section III are specifically incorporated by reference.

CONTRACT PERIOD

An initial 12-month contract, from October 1, 2018, through and including September 30, 2019, is required, plus the options for four (4) one year extensions are required. Further, it shall be the option of the District to renew the program for additional plan years thereafter.

Renewal guarantees are encouraged and will be considered favorably.

RATE GUARANTEE PERIOD

The medical claims administration services rates shall be guaranteed for 36 months. Changes after the initial 36 month period shall be subject to the Rerating Endorsement. FSA Administration Services shall be guaranteed for 36 months.

REMUNERATION

Any remuneration or other similar compensation included must be shown separately. Remuneration arrangements, if any, will be between the District, the successful Proposer, and any agent, broker or other intermediary representing the successful Proposer.

ACCESS TO CLAIM FILES

The proposer agrees that the District shall have reasonable access to all claim files created as a result of the claims services to be provided by the successful proposer. For the purpose of this provision, reasonable access shall include making available, upon receipt of five (5) days advance written notice, all claim files for review by the District. Further, upon written request of the District, the successful Proposer shall make available to the District at the District's offices and within ten (10) days after the written request, a complete copy of selected files identified by the District.

OWNERSHIP OF CLAIM DATA

The District shall have all right, title, interest and ownership to all loss statistics created as a result of the services to be provided by the successful Proposer. Further, at the sole option of the

District, and upon fourteen (14) calendar days' written notice, the successful Proposer shall provide such data to the District.

At the termination of the contract, the successful Proposer shall provide the District with computer tapes or other computer media containing all of the data required to facilitate a smooth transition. Such data shall be made available within 30 days of written request, in a format generally importable into a commonly recognized database for loss statistics.

AUDIT REQUIREMENT

Proposers shall state to what extent they will allow the District to audit, or to permit designees on behalf of the District, to audit the proposer's files and procedures as they relate to the District.

AUDIT REPORT

Proposers must annually provide the District with a SAS-70 audit, or its equivalent.

ELIGIBILITY & ENROLLMENT

Coverage must match the District's current eligibility requirements. Coverage is effective on the 1st of the month following 30 days of full time employment, as outlined in the District's current plan documents.

Proposers should be aware that it is impossible to predict how many employees will elect each plan design and monthly premiums rates for each plan design must be honored as proposed even if there is a substantial change in plan design choices at enrollment.

The District currently contributes the following per employee for employee benefits:

Employee Only Coverage – age 64 and under	$ 432/month
1 Dependent – age 64 and under	$ 432/month
Family	$ 432/month
Family (2 Employees)	$ 865/month
Medicare Supplement – Retired Employee	$ 50/month

Please note census exhibits include a separate sheet showing employees who have waived coverage but are eligible each enrollment to elect coverage.

CONTINUITY OF COVERAGE (NO LOSS/NO GAIN PROVISION)

Notwithstanding any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan to the contrary, if, but for the replacement of the current plan with the proposed plan, an insured would have been covered by the current plan, the insured shall be entitled to the lesser of:

(1) the benefits which would have been payable had the current plan been continued; or

(2) the benefits which would be payable under the proposed plan without the application of any actively at work, waiting period, pre-existing condition, or other provision or

limitation in the proposed plan.

SCOPE OF COVERAGE

Medical

Currently, the District offers the following four (4) plans:

1. Florida Blue Plan – BlueChoice 0727
2. Florida Blue Plan – BlueOptions 03359
3. Florida Blue Plan – BlueChoice 0117
4. Florida Blue Plan – BlueOptions 05901

All plans offered include in-network and out-of-network coverage. Please review the plan documents in the Exhibits section for more information. Benefits should be proposed as similar as possible and any deviations should be noted.

This RFP includes a Benefits Match-Up (a, b, c, d) Exhibit 4, outlining the proposed benefits and asking proposers to respond "Match" or provide details regarding the benefits offered for the plan proposed.

FSA Administration

The District's current FSA administrator is Total Administrative Services Corporation (TASC). The District expects proposers for medical coverage to either provide FSA services or to coordinate these services through another vendor. FSA proposals are only being solicited in conjunction with medical proposals. Stand-alone FSA proposals will not be considered.

The District reserves the right to negotiate with proposer finalist(s) on alternative plan designs.

SCOPE OF SERVICES

The District is seeking proposals for claims administrative services from a qualified medical claims administrator to support the District 's group plans.

Claims administration for incurred but not reported run out claims following termination of the contract are requested to be outlined in the proposal and proposed fees.

The successful Proposer shall perform all services indicated below, including:

- Managed Care Services,
- Administration Services,
- Healthcare Reform Services,
- Prescription Benefit Services,
- Flexible Spending Account (FSA) Administration Services,
- Reporting and Data Services, and
- Wellness Program and Disease Management Services.

Proposals must include claims administration, network access and utilization review services. Any sub-contracted services to be provided in connection with these requirements must be identified in the proposal.

The District desires to continue a prescription drug plan similar to the current plan design that can deliver cost effective prescription benefits to the District's medical benefits plan participants through an extensive pharmacy network, supplemented by a mail order service and specialty pharmacy services.

All proposals should include copies of any and all contracts which the District will be required to execute. All proposals should include copies of standard communication materials that are sent to members, such as explanation of benefit (EOB) type forms.

MANAGED CARE SERVICES

Network Discounts

The District is interested in a medical claims administrator which has successfully developed a cost-effective provider network allowing the District and its plan participants to access needed medical care with significant discounts. Proposers are requested to provide the network discounts for the current/average percent discounts from billed charges in the following Florida counties: Calhoun, Liberty, Jackson, Leon and Bay, and the following Alabama county: Houston. In addition, proposers will be asked if a guaranteed medical network discount(s) can be provided for the District.

Guaranteed Medical Network Discount
The guaranteed medical network discount will be the discount percent where the administrator is guaranteeing claims in service categories including: inpatient hospital, outpatient hospital, outpatient surgical centers, emergency room facility costs, urgent care facility and professional, to be discounted at a guaranteed percent. Any risk corridor given will be subtracted from the guaranteed network discount percent to come up with a bottom line or "net" guaranteed medical network discount.

Proposer should maintain a provider managed care network consisting of hospitals, physicians, allied and ancillary services, and durable medical equipment. This arrangement should:

1. Provide services with reasonable promptness with respect to geographical location, hours of operation, and after hours care; including emergency care available 24 hours a day, 7 days a week.

2. Contract with network physicians that:
   a. Hold appropriate occupational and professional licenses;
   b. Hold active and unrestricted privileges in their specialty;
   c. Have a valid Drug Enforcement and Administration (DEA) number and hold unrestricted prescribing privileges (except chiropractors);

d. Have hospital privileges at participating hospitals;
e. Have not been convicted of a felony or greater crime;
f. Are specialty board certified (80% or greater); and
g. Have not been suspended, placed on probation or limited from any hospital privileges or restricted from receiving payments from Medicare, Medicaid, or other third party programs during the last five years.

3. Contract with network hospitals that:
   a. Hold current Joint Commission on Accreditation of Hospitals (JCAH) accreditation without conditions and licensure;
   b. Have at least 80% of staff physicians with full admitting privileges board certified;
   c. Are free from disciplinary action for the last five years;
   d. Are Medicare certified; and
   e. Hold current accreditation with one of the following (in lieu of JCAH), if the hospital is primarily of a rehabilitative nature and lacks surgical facilities:
      (1) American Osteopathic Hospital Association; or
      (2) Commission on the Accreditation of Rehabilitative Facilities.

4. Provide a network(s) consisting of providers that have the capacity to provide treatment throughout the State of Florida and for those that are either visiting or reside outside of Florida.

   Accordingly, this RFP includes a Most Utilized Providers Exhibit 5 (1 Tab, in Excel), listing the top providers and asking proposers to respond (yes or no) regarding whether the providers are included or not in the network for each plan proposed.

   a. Proposers should include a detailed list that includes all participating hospitals in the following Florida counties: Calhoun, Liberty, Jackson, Leon and Bay, and the following Alabama county: Houston.

   b. The District desires that the hospitals in the network(s), collectively, should offer the following services:
      (1) Anesthesia
      (2) Audiology
      (3) Day Surgery
      (4) Diagnostic, X-Ray, and Laboratory Services
      (5) Emergency Services
      (6) Medical/Surgical Intensive and Acute Care
      (7) Neo-natal Care
      (8) Neurology Services
      (9) Obstetrical Care and High-Risk Obstetrical Care
      (10) Pediatric Care
      (11) Psychiatric Care
      (12) Respiratory Care

(13) Social Service & Discharge Planning
(14) Speech Pathology
(15) Substance Abuse Treatment
(16) Therapies - Physical, Respiratory, Occupational
(17) Trauma Care

c. The District desires that the network(s) include the following providers:

(1) Primary care physicians who include physicians practicing in the field of General Practice, Family Practice, Internal Medicine, OB/GYN, and Pediatrics.

(2) Specialty physicians in the network(s), collectively, should provide the following medical practice areas:
- Allergy/Immunology
- Anesthesiology
- Cardiology
- Chiropractic Medicine
- Endocrinology
- Dermatology
- Gastroenterology
- Internal Medicine
- Neurology
- Obstetrics/Gynecology
- Oncology
- Ophthalmology
- Orthopedic Medicine
- Otolaryngology
- Pediatrics
- Physical and Occupational Therapy
- Podiatry
- Pulmonary Medicine
- Radiology
- Rheumatology
- Speech Pathology and Audiology
- Urology

5. Provide benefits to employees/dependents that are referred to an out-of-network specialist due to the lack of in-network providers in that specialty, at the in-network benefit level.

6. Include ancillary providers in the network(s) that are properly licensed and credentialed, and provide the following services: imaging centers, diagnostic x-ray and laboratory facilities, durable medical goods, home health care, skilled nursing facility, birth centers, and hospices.

7. Provide employees with current directories on an annual basis with quarterly updates, and/or provide on-line access to current directory information.

8. Require that network providers hold the employees/dependents and the District harmless from any fees for services which are rendered that are plan eligible charges (except deductibles, co-payments and coinsurance), regardless of the reason for non-payment.

9. Prohibit network providers from balance billing the patient for any excess of contracted amount, except for deductibles, co-payments and coinsurance.

10. Provide Medical Case Management that:

    a. Uses Florida Registered Nurses and vocational counselors to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.

       District is looking for proposers to develop a medical case management program that will be effective in controlling high cost claims. Proposers are asked to provide details regarding case management services, including how the services will be evaluated and measured.

    b. Performs specific services that coordinate the provision of care and the management of benefits in cases of catastrophic illness or injury. Such a program should strive to ensure that patients receive the most appropriate, cost-effective care and derive maximum advantage from available plan benefits. It may require covering expenses not normally covered by the plan (e.g., air conditioners, wheelchair ramps, etc.) in exceptional situations, to return a patient to a productive life.

    c. Follows specific medical/disability criteria to determine which claims may need medical/disability management intervention to include, but not be limited to, the following:

       (1) Spinal cord injury
       (2) Burns (third and fourth degree)
       (3) Amputations
       (4) Traumatic brain injury
       (5) Renal failure
       (6) Neo-natal single or multiple births
       (7) Neoplasm of brain, bone, pancreas, liver
       (8) At risk pregnancy

(9) Accidents involving multiple family members with multiple injuries

(10) All claims exceeding a $50,000 threshold

(11) Organ transplants

d. Coordinates with Utilization Review and claims processing for effectiveness and efficiency.

e. Provides quarterly medical case management reports on all claims expected to exceed $50,000 or otherwise identified as being the type of claim which will benefit from medical case management, in addition to reports that identify current and past case loads, prognoses and savings realized through case management.

11. Provide Utilization Review that:

a. Uses Florida licensed Registered Nurses to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.

b. Includes the following specific services:

(1) Pre-admission certification for medical admissions, and determination of medical necessity;

(2) Continued stay review by telephone of all hospitalizations. Certification of the need for additional days beyond the initial pre-certification. Medical necessity of treatment and length of stay to be strictly observed. No benefits are to be payable if the treatment is not medically necessary;

(3) Concurrent Review of selected hospitalizations via personal visit by a Registered Nurse (RN) where conditions indicate a need for such;

(4) Retrospective Utilization Review (after delivery of service, but prior to payment) of all unusual claims plus all claims over $50,000; and

(5) Discharge planning for medical/surgical patients.

c. Provides quarterly statistics on the effectiveness of Utilization Review.

d. Coordinates with Medical Case Management for effectiveness and efficiency.

ADMINISTRATION SERVICES

Except for the collection of premium to the successful Proposer and, as except otherwise noted in this RFP, the successful Proposer shall be totally responsible for the administration of the plan. These activities should include, but are not limited to, the following:

1. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported claims.

2. Design, print, and furnish descriptive literature and enrollment material in a sufficient quantity. Additionally, certificates/booklets are to be provided as needed. These certificates must have a readability level acceptable to the District. In addition, furnish an electronic version of the certificates/booklets for the District to use on their website. These documents must be provided at no additional cost to the District.

3. Mail/deliver booklets, ID cards, or certificates directly to the District, after the District has reviewed a draft and approved it. This review and approval by the District is to be completed prior to printing by the successful Proposer.

4. Issue ID cards within three (3) calendar weeks (plus four (4) days' mailing time) after completion of open enrollment periods or after enrollment papers are received for new hires.

5. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

6. Provide enrollment assistance, including educational materials pre-approved by the District in advance of distribution, to the District during open enrollment period on an annual basis. These tasks should include, but not be limited to, providing sufficient and properly trained enrollers employed by successful Proposer, and requiring that they attend all scheduled enrollment meetings.

7. Assign a staff person as the District's Account Representative.

8. Meet with the District, at a minimum, quarterly, to discuss the status of the plan, performance, audits, reports, and planning.

9. Attend meetings, if requested by the District.

10. Verify claimant's eligibility for benefits based on eligibility requirements furnished by the District.

11. Maintain covered dependent information by dependent's name, date of birth, gender, and relationship to insured and social security number.

12. Use a fully automated online clinically-oriented claims adjudication and auditing system that analyzes coded claims data to ensure correct identification.

13. Screen for and deny workers' compensation claims.

14. Target (flag) the following types of claims for supervisory review*:

    a. Service required precertification, but certification not obtained;

b. Actual length of stay or level of service does not match the approved length of stay or level of service;

c. Dollar amount or diagnoses warrants potential referral to medical case management; or

d. Any one bill that exceeds $50,000.

*Supervisory review shall include, as appropriate, at a minimum, a review of itemization of invoices exceeding $50,000 and review of case management notes.

15. Identify and maintain separate COB information for each applicable claimant, as well as distinguish between the various types of COB, including retirees eligible for Medicare.

16. Coordinate claims with Medicare in accordance with Medicare rules and pay claims where retirees over age 65 and eligible for Medicare Part B and have not elected Medicare Part B as if they had (i.e. secondary).

17. Maintain the confidentiality requirements of Federal and Florida law by having adequate systems security features.

18. Turnaround 95% of all "clean" claims within ten (10) working days and 100% of all claims within thirty (30) working days. A “clean” claim is a claim submitted with all needed information for proper processing and adjudication.

19. Banking arrangements for claims funding will be in accordance with District standards.

20. Issue EOBs to the claimant within five (5) working days of processing claims.

21. Create an EOB that meets the District 's approval that uses a format and terminology such that a person not of a medical or insurance background can easily understand the content. This EOB must also comply with any applicable Health Care Reform requirements (example: Claims and Appeal procedure requirements).

22. Conduct semi-annual internal audits for claim accuracy and occurrence of mispayments. Report results to the District within ten (10) working days from the end of the reporting period.

23. Provide COBRA and HIPAA administration and pay COBRA beneficiary claims.

24. Establish and maintain a toll-free line for employees. This line should be operational from at least 8 AM to 6 PM (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls.

25. Coordinate with the District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the District's eligibility record in Excel format (as described above in the Billing and Eligibility section).

26. Administer the plan on a detail billing remittance basis by division, separated by active employee, retiree and COBRA beneficiary.

27. Conform accounting procedures and practices to generally accepted accounting principles.

28. Maintain proper records for tax reporting purposes; e.g., 1099s.

29. Retain medical claims history online for minimum of twenty-four (24) months.

30. Prepare, maintain, and file with any applicable federal, state or local governmental agencies, any forms or reports as may be required from time to time by law; e.g., New York Public Goods Pool, COBRA, CMS obligations, etc.

31. Provide assistance with regard to: (1) problems arising in connection with insurance laws, (2) tax aspects of the Plan, (3) litigation arising out of the administration of the Plan, and (4) any other legal matters that may arise in the course of the operation of the Plan.

32. Provide claims fiduciary services. Establish claim denial and grievance procedures which are clearly communicated to members. Grievance procedures should be consistent with all applicable federal and state laws, rules and regulations, including but not limited to Healthcare Reform. Maintain access to a Medical Director to evaluate appealed claims.

33. Supply all postage required to service the District's account.

34. Send correspondence using District approved pre-formatted letters to the claimant or provider. The content of these letters must be easily understandable by a person not of a medical or insurance background.

35. The District will have first review and pre-approval of any correspondence that will be sent to claimants or providers that includes changes/amendments to the plan.

HEALTHCARE REFORM SERVICES

1. Assist the District in a timely manner in staying in compliance with the PPACA for their health plans (and if applicable, their prescription plan) by (at a minimum):
    a. Reviewing the language in their plans in regards to the Guaranteed Availability of Coverage.
    b. Providing plan testing, of each plan offered, of the Essential Health Benefits as defined by the PPACA.

c. Providing plan testing, of each plan offered, of the actuarial value of benefits (minimum value) as defined by the PPACA.

2. To the extent required, provide the District the required Summaries of Benefits and Coverage (SBC) for each offered plan.

3. Assist the District with understanding the fees assessed by the PPACA. In addition, assist the District in the assessment, cost and payment of any PPACA fees, if applicable.

4. Assist the District with other healthcare reform, or subsequent healthcare legislation, reporting.

PRESCRIPTION BENEFIT SERVICES

These activities should include, but are not limited to, the following:

1. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported prescription claims.

2. Provide appropriate literature to describe the benefits offered by the District to its employees and appropriate educational materials regarding use of generics versus brand names, the advantages of mail order service where it is the most efficient for all concerned, and formulary information.

3. Use a fully automated online clinically-oriented claims adjudication/auditing system that analyzes coded claims data to ensure correct identification.

4. Screen for and deny workers' compensation claims.

5. Maintain the confidentiality requirements of Florida and Federal law by having adequate systems security features.

6. Establish and maintain a toll-free customer service line for employees. This line should be operational from at least 8 AM to 6 PM (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls, with call backs to occur within 24 hours of the next business day.

7. Retain claims history online for minimum of 24 months from the last date of any claim activity pertaining to services rendered. All prior claims history incurred during the course of this contract must be captured in such a manner compatible for media storage and delivered to the District at their request. This data must be maintained for the full duration of the contract period, and must also be available for transfer to the subsequent vendor, should the District elect to change vendors in the future.

8. Provide a comprehensive drug utilization review program (DUR).

9. Provide cost effective intervention programs, such as prior authorizations, step therapy, etc.

FLEXIBLE SPENDING ACCOUNT ADMINISTRATION

The administrator is expected to provide the District with at least the following professional services:

1. Assure compliance with applicable law, regulations, etc.
2. Assure proper FSA substantiation procedures.
3. Employee group seminars and individual enrollments.
4. Establish billing procedures that are compatible with the needs and organizational structure of the District.
5. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.
6. Preparation of enrollment communications materials, including a letter explaining the program, FSA question/answers, examples of the benefits of FSAs, a worksheet for employees to determine amounts to place in their FSAs and an enrollment form.
7. A local area telephone number or "800" number that employees may call throughout the year for counseling, information or service regarding the flexible benefit plans.
8. Establishment of all records necessary for maintaining account balances.
9. Forms for reimbursement of claims, change of status, direct deposit, disbursement statements, etc.
10. The administrator shall be responsible for ongoing enrollment and for producing reports to the District as needed and to individual employees.
11. Payment of claims.
12. Quarterly individual account status reports to participants.
13. Bi-weekly participation and account status reports to participants.
14. A summary Annual Report for employees.
15. An annual forfeiture report to the District.
16. Federal report filing requirements, including issuing 1099s to providers.
17. The administrator is required to maintain books, records, documents and any evidence on costs and expenses for services provided. Records must be maintained for three full years after this contract ends and records should be open to the District audit upon request.

18. Debit cards for employees to access their flexible spending accounts is required. Please include details regarding debit card availability.

MEDICAL AND PRESCRIPTION REPORTING AND DATA SERVICES

1. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

2. Provide the District's designees direct access to claims data and reporting capabilities.

3. Provide the District with aggregated data reporting capabilities.

4. Prepare and furnish the District with monthly exposure and loss data statistics. Exposure data should include census data, such as name of employee, zip code and date of birth and employment status. Loss data reports should include, but not be limited to, the following information: (Data subject to compliance with HIPAA privacy guidelines.)

    a. Claims data should be provided monthly (within 30 days after the end of the month) with cumulative totals for the plan year, separately for participants in each category of plan offered (e.g., PPO and HDHP), preferably in a format that will provide data separately for employees and their dependents, retirees and their dependents and COBRA and their dependents, and total for all participants and all dependents. The desire for separate premium/claims experience for employees, retirees, COBRA and dependents is to permit the District to determine if the rates being charged are equitable. Claim reports should be provided additionally for 12 months after plan termination, or until there are no runout and/or extension of benefits claims.

    b. Claims data should be provided monthly detailing all claims where more than $25,000 has been paid in the current plan year. Data should include amount paid, type of plan participant (employee, dependent, retiree, etc.), diagnosis, prognosis and status of the claim (active, expired, etc.).

5. Provide reports inclusive of data elements specified by the District in mutually agreed upon formats. The required standard reports include, but are not limited to, the following:

    a. Monthly reports are due on the 15th workday following the end of the "report" month. These reports should include paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).

    b. Quarterly and Year-to-Date Reports are due on the 15th working day following the "report" quarter. These reports should include: benefit payment summaries, inpatient (utilization) reports, paid claims by coverage and diagnosis types, COB savings, and service inquiries.

6. Provide prescription data reports inclusive of data elements specified by the District in mutually agreed upon formats. The required standard reports will include, but are not

limited to monthly reports of claims versus premium are due by the 15th business day following the end of the "report" month. These reports should include paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).

7. Prepare and furnish the District with periodic prescription reports included in the medical benefits reports that provide claims data. Reports on drug benefits costs should include appropriate data on utilization by category (such as retail and mail order, for generic, preferred brand, non-preferred brand, etc.).

8. Provide access to archived data within ten (10) working days of a request by the District.

PERFORMANCE GUARANTEES

Proposers should confirm that they are willing to offer performance guarantees and that they are willing to permit the District access to claims offices, personnel and files to conduct audits necessary to verification of performance standards. Performance may be evaluated on a variety of issues, such as:

- If applicable, timely implementation of the District's account.
- Timely delivery of finalized contracts for the selected program.
- Timely delivery of identification cards, at and subsequent to initial enrollment.
- For provider directories, timely updates either online or if a significant change that will affect a large portion of members, timely communication notices (s) (either verbal or via mail).
- Timely delivery of monthly reporting.
- Timely delivery of plan documents and HCR summaries (as applicable).
- Wellness program health guarantees.
- Claims turnaround time.
- Accuracy of claims coding and payments.
- Telephone response time, and abandonments.
- Quality of service to plan participants, as measured by periodic surveys.
- Quality and timeliness of claims experience reports.
- Network provider participation, with penalties for drops below pre-specified levels.
- Rate of provider turnovers.
- Access to standards of care.
- Collection or other threats to participants by providers not paid by the insurer.

State the extent to which these measurements will be applied specifically to the District's account (account specific) versus your "book of business".

Suggestions on criteria for measuring performance and indications of how the organization is set-up to facilitate auditing of performance should be submitted. If the proposer has a performance guarantee agreement, provide a sample for review.

Please confirm your firm's willingness to enter into such an agreement and to negotiate appropriate terms, and recommend appropriate incentives or disincentives (meaningful penalties)

to make the performance guarantee practical.

CALHOUN COUNTY SCHOOL DISTRICT

Section VI

Model Program for Stop-Loss Insurance

SECTION VI

MODEL PROGRAM FOR STOP-LOSS INSURANCE

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION VI – MODEL PROGRAM FOR STOP-LOSS INSURANCE.

SECTION II – GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.

SECTION III – COMMON CONTRACT PROVISIONS – All provisions of Section III are specifically incorporated by reference.

CONTRACT PERIOD

For Stop-Loss Insurance (specific), an initial contract from October 1, 2018 through and including September 30, 2019 (12 months) is required, with the District having the option of renewing the option of the program for four (4) additional plan years thereafter.

RATE GUARANTEE PERIOD

Regardless of actual enrollment, the initial rates shall be guaranteed for 12 months. Changes after the initial 12 month period shall be subject to the Rerating Endorsement.

REMUNERATION

Any remuneration or other similar compensation to an agent, broker, intermediary or similar must be shown separately. Remuneration arrangements, if any, will be between the District, the successful Proposer, and any agent, broker or other intermediary representing the successful Proposer.

OWNERSHIP OF CLAIM DATA

The District shall have all right, title, interest and ownership to all loss statistics created as a result of the services to be provided by the successful Proposer. Further, at the sole option of the District, and upon fourteen (14) calendar days' written notice, the successful Proposer shall provide such data to the District.

ELIGIBILITY & ENROLLMENT

Proposers must honor the District's current eligibility requirements, as outlined in the District's current plan documents, found in the Exposure Section of this RFP, and applicable employee handbooks and manuals.

Proposers should be aware that it is impossible to predict how many employees will elect each plan design and monthly premiums/rates for each plan design must be honored as proposed even if there is a substantial change in plan design choices at enrollment.

CONTINUITY OF COVERAGE (NO LOSS/NO GAIN PROVISION)

Notwithstanding any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan to the contrary, if, but for the replacement of the current plan with the proposed plan, an insured would have been covered by the current plan, the insured shall be entitled to the lesser of:

1. the benefits which would have been payable had the current plan been continued; or

2. the benefits which would be payable under the proposed plan without the application of any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan.

SCOPE OF COVERAGE

Currently, the District offers the following four (4) plans:

1. Florida Blue Plan – BlueChoice 0727
2. Florida Blue Plan – BlueOptions 03359
3. Florida Blue Plan – BlueChoice 0117
4. Florida Blue Plan – BlueOptions 05901

Proposals for specific and aggregate coverage is being requested and should include both medical and prescription coverage.

Stop-loss proposals should be on a paid contract basis with an unlimited specific limit and a specific retention of $45,000. Additional specific deductible retentions will be considered.

Proposals with enhancements to the contract basis, aggregate coverage, attachment point or others will be considered. In addition, proposals with preferred terms regarding renewal disclosures, timelines and potentials for lasers will also be favored.

If your proposal is contingent upon use of a specific provider network or administrator, please make sure this is clearly stated.

All proposals should include copies of any contract which the District will be required to execute.

The District reserves the right to negotiate with proposer finalist(s) on alternative plan designs, coverage terms and provisions.

ACCOUNT MANAGEMENT

Proposals must be clear on who will be responsible for filing the medical and prescription claims. In addition, specific details regarding the process, accounting of claims and reconciliation of claims is requested.

CALHOUN COUNTY SCHOOL DISTRICT

Section VII

Model Program For Agent/Broker Services

SECTION VII

MODEL PROGRAM FOR AGENT/BROKER SERVICES

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION VII – MODEL PROGRAM FOR AGENT/BROKER SERVICES.

SECTION II – GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.

SECTION III – COMMON CONTRACT PROVISIONS – All the provisions of Section III are specifically incorporated by reference.

APPLICABILITY OF THIS SECTION

If the District chooses to engage an agent who is not an employee of the insurer, rather than choosing a direct proposal by the insurer (utilizing an employee agent), the items in this section are applicable.

The District does not currently have an agent/broker on the medical and prescription benefits plan.

Proposals are requested, but not required, to be submitted net of any agent or broker commissions. The Proposal Forms for all proposals must identify any agents or other intermediaries who are not employees of the insurers being proposed, and who will be receiving remuneration for the District's plan(s). The Proposal Forms must disclose the remuneration basis and estimated annual amounts. Any such agents that will be receiving remuneration in connection with proposals submitted in response to this RFP should complete the Proposal Forms contained in Section XI.

Please note that such agents submitting proposals must be designated by their choice of insurer(s) on the applicable Proposal Form(s). Whether an insurer is proposing with one such agent or multiple agents, all agents must be shown on the Proposal Form(s) submitted by such insurer, as these are the only agents that will be considered.

CONTRACT PERIOD

There will be an initial 12-month contract, from October 1, 2018 through and including September 30, 2019. Renewal of such contract will be at the District's option, based on its evaluation of the value of the service received. The District may opt to continue such agent upon each renewal or to alternatively consider the direct services of the insurer through its employee agent.

Renewal guarantees are encouraged and, depending on the type, may be considered favorably.

SCOPE OF SERVICES

The agent selected should provide the following services. Proposals should clearly state if any additional fees apply to any services.

1. Assist in the coordination of the implementation of the new medical program, including coordination of enrollment materials, planning of enrollment meetings, staffing enrollment meetings.

2. For the stop-loss insurance, be responsible for filing the medical and prescription claims. Specific details regarding the process, accounting of claims and reconciliation of claims is requested.

3. Assist in planning and staffing each annual enrollment process.

4. Assist with any Healthcare Reform items/issues.

5. Assist with the implementation of changes, including preparation of communication materials, as needed.

6. Respond to questions regarding the medical plan as submitted by the District and by employees.

7. Be available on-site, as needed, for meetings. At the District's request, attend scheduled employee benefit meetings. Meet with the District at least quarterly to review and discuss plan performance, premium/claims history, market trends, medical insurance trends, and provide observations. Agent representation will not preclude the District from gaining centralized electronic access to open enrollment services, claims administration, reporting, billing and customer service.

8. Provide, or coordinate with the medical insurer, or medical and prescription administrator, to provide an estimated renewal projection in May of each year based upon standard underwriting formulas.

9. Present, or coordinate with other vendors to present, final renewal pricing on a schedule agreed upon with District Human Resources staff.

10. If the District conducts a procurement process for medical coverage, promptly assist in coordination of necessary documentation, background and rating data, premiums/claims history as needed.

11. Compare and contrast the District's plan and performance with other similar plans, as requested by the District.

12. Provide, and/or coordinate with the District and other vendors to provide annual benefit statements for employees.

13. Other services, as agreed between proposer and District.

All proposals should include copies of any contract which the District will be required to execute. Please indicate if the contract terms are negotiable.

REMUNERATION

If the services of the chosen insurer will be supplemented by an agent who is not an employee of the insurer, remuneration of such agent in the form or commissions or other compensation must be shown separately by the proposing agent.

Insurance agents should recognize that the District will be scrutinizing the amount of remuneration in relation to the expected level of service to be received. The District is desirous of avoiding payment of remuneration that may appear to be excessive. The District may be interested in negotiating such remuneration, especially when two or more agents have similar or identical lowest cost proposals. Proposing agents should state if they are willing to negotiate such remuneration.

Remuneration for the contract year October 1, 2018 through September 30, 2019 shall be specifically described by the submitting agent. If offering subsequent year remuneration guarantees that may be selected prior to future renewals, such guarantees shall be specifically described.

Remuneration arrangements, if any, will be between the District, the successful insurance proposer and any agent or other intermediary representing the successful proposer.

CALHOUN COUNTY SCHOOL DISTRICT

Section VIII

Proposal Forms for Fully Insured Group Medical Insurance

SECTION VIII

CALHOUN COUNTY SCHOOL DISTRICT

FULLY INSURED GROUP MEDICAL INSURANCE

PROPOSAL FORMS

A. PROPOSER'S IDENTIFICATION

Name of Insurer: _____

FEIN/SS#: _____

Address: _____

_____

_____

Insurer Proposal Contact: _____

Telephone Numbers Daytime/After Hours: _____

E-mail: _____

B. IF APPLICABLE – INSURANCE AGENCY(IES)/AGENT(S)

NOTE: If one or more agencies/agents are acceptable to the proposing insurer, please list those firms and representatives which you approve, if the District should decide on a proposal other than directly through the proposing insurer's employee agent:

	Agency	**Agent**
1.	_____	_____
2.	_____	_____
3.	_____	_____

NOTE: If an agent(s) is/are listed, the Agents proposal forms at the end of this document, Section XI - Agent/Broker Services must be completed by each of such agent(s).

FULLY INSURED MEDICAL INSURANCE COST INFORMATION

Please read this section carefully. The District is requesting two (2) different plan options:

Option 1
Propose the benefits as is: Plans 1 – 4 with the same benefits.

Option 2
For Option 2, the District is asking Proposers to provide innovative ideas to improve member health and control costs, such as alternate plan designs, partnerships with local vendors, etc.

OPTION 1 – Four (4) Plan Options. Propose Benefits As-Is.

Please complete the charts below for the requested plans including all four (4) Florida Blue Plans. Please propose your benefit plans as described below and shown in **Exhibit 4 (a,b,c,d) Benefits Match-up.**

All deviations from the requested plan design(s) must be listed on a separate page.

PPO Medical Plan – PLAN 1
Rates/Annualized Premium

Same as or reasonably similar to current Florida Blue Plan – BlueChoice 0727
(No changes)

PPO – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name, Number, Type _____							
For 10/1/2018:	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees Only	65	X	$	X	12	=	$
Employee/Retiree + 1 Dependent	0	X	$	X	12	=	$
Family	0	X	$	X	12	=	$
Family (2 Employees)	11	X	$	X	12	=	$
Retiree over 65	0	X	$	X	12	=	$
plus Dependent	0	X	$	X	12	=	$
Total Plan 1 Premium							$

PPO Medical Plan – PLAN 2
Rates/Annualized Premium

Same as or reasonably similar to current Florida Blue Plan – BlueChoice 03559
(No changes)

PPO – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name and Number _____							
For 10/1/2018:	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees Only	60	X	$	X	12	=	$
Employee/Retiree + 1 Dependent	0	X	$	X	12	=	$
Family	0	X	$	X	12	=	$
Family (2 Employees)	23	X	$	X	12	=	$
Retiree over 65	0	X	$	X	12	=	$
plus Dependent	0	X	$	X	12	=	$
Total Plan 2 Premium							$

PPO Medical Plan – PLAN 3
Rates/Annualized Premium

Same as or reasonably similar to current Florida Blue Plan – BlueChoice 0117
(No changes)

PPO – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name and Number _____							
For 10/1/2018:	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees Only	15	X	$	X	12	=	$
Employee/Retiree + 1 Dependent	0	X	$	X	12	=	$
Family	0	X	$	X	12	=	$
Family (2 Employees)	4	X	$	X	12	=	$
Retiree over 65	0	X	$	X	12	=	$
plus Dependent	0	X	$	X	12	=	$
Total Plan 3 Premium							$

PPO Medical Plan – PLAN 4
Rates/Annualized Premium

Same as or reasonably similar to current Florida Blue Plan – BlueChoice 05901
(No changes)

PPO – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name and Number _____							
For 10/1/2018:	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees Only	74	X	$	X	12	=	$
Employee/Retiree + 1 Dependent	0	X	$	X	12	=	$
Family	0	X	$	X	12	=	$
Family (2 Employees)	30	X	$	X	12	=	$
Retiree over 65	0	X	$	X	12	=	$
plus Dependent	0	X	$	X	12	=	$
Total Plan 4 Premium							$

Total Annual Premium for all four (4) plans	**$**

For Medical & Rx Services:

1. Is agent/broker remuneration included in your fees or rates?
   Yes ____ No ____

2. Please indicate the manner in which remuneration is calculated:
   Percentage of premiums: Indicate percentage _____%
   Other amount: Indicate annual amount $_____

3. Regardless of the remuneration method utilized, provide an estimate of the annual remuneration payable. $_____

4. If pooling is used, please state amount: _____

OPTION 2 – Innovative Ideas to Improve Member Health and Control Costs

For Option 2, the District is asking Proposers to provide innovative ideas to improve member health and control costs, such as alternate plan designs, partnerships with local vendors, etc.

For any plans proposed for Option 2, please use the format from the chart below for each proposed plan. Please include details, such as if the plan is PPO, HMO, HDHP, etc. Please include a Total Annual Premium for all proposed plans. Please attach plan designs and any other descriptions.

If multiple plans are being offered, please describe your assumptions regarding how many employees will choose each plan.

_____ – MEDICAL AND RX BENEFITS Unlimited Lifetime Maximum Your Plan Name and Number _____							
For 10/1/2018:	#	X	$Rate	X	12	=	Annual Premium
Employees/Retirees Only		X	$	X	12	=	$
Employee/Retiree + 1 Dependent		X	$	X	12	=	$
Family		X	$	X	12	=	$
Family (2 Employees)		X	$	X	12	=	$
Retiree over 65		X	$	X	12	=	$
plus Dependent		X	$	X	12	=	$
Total Plan Premium							$

Total Annual Premium for all plans	**$**

For Medical & Rx Services:

1. Is agent/broker remuneration included in your fees or rates?
   Yes ____ No ____

2. Please indicate the manner in which remuneration is calculated:
   Percentage of premiums: Indicate percentage _____%
   Other amount: Indicate annual amount $_____

3. Regardless of the remuneration method utilized, provide an estimate of the annual remuneration payable. $_____

4. If pooling is used, please state amount: _____

RETENTION

OPTION 1 – Four (4) Plan Options. Propose Benefits As-Is.

Retention for all four (4) fully insured plans based on per employee per month cost

Show these monthly rates and annual cost in the table below if the rates are the same for all four (4) plans being offered. However, if the rates are different for two or more of the plans, create an additional table(s) for each plan(s) that are different. Make sure that if you add one or more tables to account for different rates that the total of all tables equals total annual cost for all plans.

	RETENTION COST FOR 10/1/2018-9/30/2019	#	X	$Rate	X	12	=	Annual Cost
1.	Claims service cost	282	X	$	X	12	=	$
2.	Network access fees, if any	282	X	$	X	12	=	$
3.	Wellness Program (attach explanation)	282	X	$	X	12	=	$
4.	COBRA administration cost *	282	X	$	X	12	=	$
5.	HIPAA administration cost	282	X	$	X	12	=	$
6.	PPACA Insurer Fee	282	X	$	X	12	=	$
7.	PCOR Fee	282	X	$	X	12	=	$
8.	Transitional Reinsurance Fee	282	X	$	X	12	=	$
9.	Additional PPACA items (please list and explain)	282	X	$	X	12	=	$
10.	Premium taxes	282	X	$	X	12	=	$
11.	Commissions, finders fees or other remuneration to insurance agent **	282	X	$	X	12	=	$
12.	Enrollment meetings and materials	282	X	$	X	12	=	$
13.	Printing of booklets, plan documents	282	X	$	X	12	=	$
14.	Other charges (explain)	282	X	$	X	12	=	$
15.	Profit	282	X	$	X	12	=	$
	TOTAL RETENTION COST							**$**

* Proposers should clearly state if COBRA services are to be provided by an outside firm, charging extra.

** Proposers offering proposals through insurance agencies should propose net of any remuneration, which should be left up to the proposing agencies/agents to separately indicate later herein. If such a proposal is accepted, such remuneration will be added to the rates proposed to determine total rates to be charged.

1. Are these costs flat charges, minimum or maximum charges or variable based on claims?

2. Are any of your administration fees not guaranteed and/or subject to final retroactive accounting at the end of each plan year?

3. List any assumptions, limitations, or exclusions that are conditions of the retention costs your company is proposing. Indicate any impact to your proposed premiums/fees if any of these conditions are not met.

4. Confirm that your cost includes payment of run-out claims and extension of benefits claims of disabled persons (the District is obligated to pay claims as required by Florida Statute 627.667(3)(a) for up to 12 months after plan termination). If your cost is not included, provide the additional cost for such coverage.

5. Confirm that your costs include compliance for Health Care reform. If not, please describe what additional costs may be applicable.

MEDICAL AND RX CLAIMS PROJECTIONS – OPTION 1

PPO PLAN 1_____(state plan name/#) CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	

PPO PLAN 2_____(state plan name/#) CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	

PPO PLAN 3_____(state plan name/#) CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	

PPO PLAN 4_____(state plan name/#) CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	

All 4 Plans CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$

Pooling of Claims

POOLING point - State the annual premium for pooling, if any:	**Annual Premium**
Pooling point	$

Medical Cost Sharing/Cost Control, Renewal Caps/Guarantees, etc.

1. What rate/cost guarantees/caps/ceilings are you providing beyond the first 12 months, e.g., renewal retention, renewal trend, profit or other? Provide details and number of years.

2. Are you offering the District a profit/risk sharing option? Explain, and provide complete details if there are requirements or contingencies involved.

    a. If the program generates a surplus, will dividends or other return moneys be payable? When?

b. Does your contract provide for a deficit carry-forward? If yes, explain the method of recouping deficits in future years.

c. If upon termination of the plan excess moneys remain after payment of all claims and expenses, will such excess moneys be refunded to the District? When?

d. If upon termination of the plan there is a deficit at the termination date or thereafter, will the deficit be forgiven? If not, explain.

RETENTION

OPTION 2 – Innovative Ideas to Improve Member Health and Control Costs

Retention for both fully insured plans based on per employee per month cost

Show these monthly rates and annual cost in the table below if the rates are the same for both plans being offered. However, if the rates are different for either of the plans, create an additional table(s) for each plan(s) that are different. Make sure that if you add one or more tables to account for different rates that the total of all tables equals total annual cost for all plans.

	RETENTION COST FOR 10/1/2018-9/30/2019	#	X	$Rate	X	12	=	Annual Cost
1.	Claims service cost	282	X	$	X	12	=	$
2.	Network access fees, if any	282	X	$	X	12	=	$
3.	Wellness Program (attach explanation)	282	X	$	X	12	=	$
4.	COBRA administration cost *	282	X	$	X	12	=	$
5.	HIPAA administration cost	282	X	$	X	12	=	$
6.	PPACA Insurer Fee	282	X	$	X	12	=	$
7.	PCOR Fee	282	X	$	X	12	=	$
8.	Transitional Reinsurance Fee	282	X	$	X	12	=	$
9.	Additional PPACA items (please list and explain)	282	X	$	X	12	=	$
10.	Premium taxes	282	X	$	X	12	=	$
11.	Commissions, finders fees or other remuneration to insurance agent **	282	X	$	X	12	=	$
12.	Enrollment meetings and materials	282	X	$	X	12	=	$
13.	Printing of booklets, plan documents	282	X	$	X	12	=	$
14.	Other charges (explain)	282	X	$	X	12	=	$
15.	Profit	282	X	$	X	12	=	$

	RETENTION COST FOR 10/1/2018-9/30/2019	#	X	$Rate	X	12	=	Annual Cost
	TOTAL RETENTION COST							$

* Proposers should clearly state if COBRA services are to be provided by an outside firm, charging extra.

** Proposers offering proposals through insurance agencies should propose net of any remuneration, which should be left up to the proposing agencies/agents to separately indicate later herein. If such a proposal is accepted, such remuneration will be added to the rates proposed to determine total rates to be charged.

1. Are these costs flat charges, minimum or maximum charges or variable based on claims?

2. Are any of your administration fees not guaranteed and/or subject to final retroactive accounting at the end of each plan year?

3. List any assumptions, limitations, or exclusions that are conditions of the retention costs your company is proposing. Indicate any impact to your proposed premiums/fees if any of these conditions are not met.

4. Confirm that your cost includes payment of run-out claims and extension of benefits claims of disabled persons (the District is obligated to pay claims as required by Florida Statute 627.667(3)(a) for up to 12 months after plan termination). If your cost is not included, provide the additional cost for such coverage.

5. Confirm that your costs include compliance for Health Care reform. If not, please describe what additional costs may be applicable.

CLAIMS PROJECTIONS – OPTION 2

PPO PLAN 1_____(state plan name/#) CLAIMS PROJECTIONS	Next 12 Months
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	

All Plans CLAIMS PROJECTIONS	Next 12 Months
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$

Pooling of Claims

POOLING point - State the annual premium for pooling, if any:	Annual Premium
Pooling point	$

FULLY INSURED MEDICAL INSURANCE COST QUESTIONS

Attach necessary explanations and/or deviations.

1. What is the range of required enrollment for each option offered? State here if there are any required minimums.

2. For what range of employees and retirees are the proposed costs applicable (e.g., within 5%, 10%, etc. of the census)

3. If the number of enrollees is less than the plan members in the census data, but the age and sex mix are not materially different, will you honor your proposal as proposed?

4. Will you agree to negotiate changes in proposed benefits and/or premiums, administration and other costs, if the District should desire to do so?

5. Are you agreeable to negotiate variations in the rates proposed, if the District wishes to increase or decrease the rate distribution between employees and dependents, or between plans offered?

6. Are you able to provide a telemedicine benefit with your proposal offering? If the company providing the service is a third party, that is acceptable. Please describe the details of what the offering is, the company who can provide it and any additional costs, if applicable.

7. Is there any additional cost for HIPAA administration? Who is providing HIPAA administration? Explain and provide details.

8. Are there any additional costs for COBRA? Who is providing the COBRA administration? Explain and provide details.

9. For the COBRA administration, the District would prefer a COBRA administrator that can also administer all COBRA required coverages that are offered by the District. Are you able to administer coverages other than medical? Explain.

10. To what extent do you coordinate benefits and subrogate with other insurance sources of participants? What savings do you typically generate from each source?

11. Identify approximate medical network provider discounts in the following counties for the plans you are proposing:

Calhoun County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Liberty County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Jackson County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Leon County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Bay County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Houston County, Alabama

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

12. Is a specific lab company required to be used by members? Describe your contracted arrangements for laboratory work. Is the lab arrangement capitated? Describe the discounts and terms.

PRESCRIPTION COST QUESTIONS

Attach necessary explanations and/or deviations.

1. For the District's size and medical and prescription experience, what would you recommend to the District to control escalating prescription costs?

2. Please describe any generic prescriptions available to members at a reduced or zero cost share. Are you able to match the current "Free Preventative Medications" and "Free Preventative Generic Medications" lists?

3. What additional programs can the District consider for prescriptions? I.e., 90-day retail option, generic usage program, step therapy, etc. Please note the current programs they are participating in and also describe the options available and if there are any additional costs.

4. Provide your recommendations on how to improve generic utilization. Explain.

5. Is the mail order pharmacy owned by the proposing company or is it outsourced? If outsourced, to which mail order pharmacy company and why? Explain the benefits of this mail order service.

6. What incentives do you recommend to encourage participants to use the mail order service?

7. What controls do you recommend to minimize over-utilization and/or fraud in connection with the mail order service?

8. Is the specialty pharmacy owned by the proposing company or is it outsourced? If outsourced, to which specialty pharmacy company and why? Explain the benefits of this specialty pharmacy.

9. What initiatives do you employ against other types of claims fraud and are there any additional costs for these initiatives?

10. Describe the extent to which you perform any screening to detect possible multiple drug interactions/reactions and your procedure for notifying participants.

FSA COST INFORMATION

Complete the table below based on coverages outlined in the RFP Scope of Services section:

Item	**Basis**		**Rate**	**Month**	**Annual Cost**
Per Employee Per Month*	282	X	$	X 12	$
Debit Card	282	X	$	X 12	$
FSA Plan Documents	Flat Rate	Not Applicable			$
Generic Communication Materials	282	X	$	X 12	$
Custom Communication Materials	If Any	X	$	X 12	$
Check Writing	Per Check	X	$	X 12	$
Other Charges (list/describe below)					
		X	$	X 12	$
		X	$	X 12	$
TOTAL ESTIMATED FSA ANNUAL COST					**$**

*If the Per Employee Per Month option is proposed, indicate "Included" for the annual cost of services above, and indicate the costs for services not included in the PEPM fee.

For FSA Services:

1. Is agent/broker remuneration included in your fees or rates? Yes ____ No ____

2. Is agent/broker remuneration left up to the agent/broker to declare in the Agents section at the end of this document?
   Yes ____ No ____

3. Please indicate the manner in which agent/broker remuneration is calculated:
   Percentage of premiums: Indicate percentage _____%
   Other amount: Indicate annual amount $_____

4. Regardless of the remuneration method utilized, provide an estimate of the annual remuneration payable. $_____

FSA COST QUESTIONS

Attach necessary explanations and/or deviations.

1. Have you stated the range of required enrollment for each option offered or if there are no minimum requirements for any/all options offered? Are there any required minimums?

2. What rate/cost guarantees will you provide beyond the first 36 months?

3. Are rates subject to change based on any enrollment changes?

4. Describe how your firm expects to be remunerated in any way that differs from above. State your total remuneration and be specific if there are any minimum and/or maximum fees.

MEDICAL AND PRESCRIPTION COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Have you provided the Benefits Match-up a,b,c,d (Exhibit 4 in Word format)?

2. Are the plans proposed file and approved with the State of Florida for 10/1/2018? If not, explain.

3. Have you provided descriptive material on all medical benefits provided and all limitations and exclusions?

4. Will you provide ongoing PPACA (Healthcare Reform) guidance, updates and resources? Explain.

5. How will you assist the District in remaining in compliance with the PPACA, specifically with:

a. Guaranteed Availability of Coverage
b. Essential Health Benefits
c. Actuarial Value of Benefits (Minimum value)
d. Others – please list.

6. Will you provide a Summary of Benefits and Coverage?

7. How will you assist the District in understanding the fees associated with the PPACA?

8. If applicable, how you will assess the fees, specifically, the Insurer fee, the PCOR fee and Transitional Reinsurance Program fee? Will these fees be assessed back to the District?

9. What reporting will you provide or assist the District with for the PPACA fees?

10. Are sample summary plan documents and other benefits plan descriptions and riders provided for analysis?

11. Will you assure that your takeover of administration of the plan from the current insurer will be on a no loss/no gain basis to participants and the District?

12. Do you agree that coverage is to be provided to those that meet the District's eligibility requirements?

13. Do you agree to cover all presently insured employees, retirees and dependents whether at work, disabled or otherwise on approved absence on the effective date of coverage?

14. Will you be responsible for takeover of the current plan's extension of benefits? Explain.

15. With regard to transition of care, how will employees under the care of a physician or specialist for a serious health condition be notified?

16. What steps will be taken to assure continuation of quality care that transition of care patients require?

17. Please explain how you will assure that a key member of your service team will participate in any transition of care situation. Describe the team member's role and responsibilities.

18. How is lab work covered if performed in a physician's office? Is a specific lab company required to be used by members?

19. How is lab work covered if performed in an outside lab? Is a specific lab company required to be used by members?

20. **RAP BENEFITS:** The District's plan offers both in-network and out-of-network benefits. For provider services for Radiologists, Anesthesiologists and Pathologists, please describe how you handle providers at an in-network facility that are out-of-network.

21. **PRE-AUTHORIZATION:** Explain how any pre-authorization program (medical and prescription) works for members and their dependents. What services need to have a pre-authorization? Who is responsible for pre-authorizations? How do members ensure that their services will be covered prior to a pre-authorized required service?

22. Explain the full claims decision appeals process for members and their dependents.

23. Briefly describe to what extent benefits are provided out of the local service area, e.g. if a participant (employee, retiree, COBRA or dependent) needs medical care elsewhere in the U.S. or abroad.

24. How are non-emergency services covered for participants who must travel for extended periods of time outside of their home location?

25. How do you propose to cover retirees whether they remain in the local area or move out of the area or out of state?

26. How do you cover dependents living out of the local service area for whom a participant has a legal responsibility (e.g. divorced spouse and/or child support) to provide medical coverage?

27. How do you cover dependent students living out of the local area?

28. What specific services or programs targeted at quality health care that are not addressed in the RFP do you offer that set you apart from your competitors? What do you do that is especially innovative?

PRESCRIPTION COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Are you proposing to manage/administer prescription drug benefit equivalents to those currently offered?

2. Are you offering a generic listing of medications at no cost as currently provided to District members? Are you able to offer any other programs that members can take advantage of? If there are any additional costs, explain.

3. Is your prescription drug formulary an open, closed or restricted formulary? Explain and give your definition of these terms.

4. How often are formulary changes allowed? What controls are there on balancing District convenience with the frequency that formulary changes are made? How are members notified?

5. Have you enclosed a list of the prescription drugs your formulary includes?

6. In regards to mail order, are there any requirements for specific drugs to be filled only at mail order? If so, please explain and provide a list. The District is concerned about mandatory

mail order on specific drugs due to the cost for employees. Are there options that the District can consider?

7. How do you report prior authorizations and pharmacy DUR overrides entered in your claims system?

8. How are physicians directed or otherwise influenced to write prescriptions from the formulary?

9. What is your expectation of the pharmacist, the physician, and the participant when a non-formulary prescription is written?

10. Describe any cost effective interventions that you recommend, e.g., prior authorizations, step therapies and quantity limits, and your rationale for adopting them. State which programs are mandatory and which ones are optional.

11. Explain in detail how you can assist the District in identifying if any members are potential drug abusers and the tactics you provide to contact members and prescribing physicians to alter purchase behavior and prescribing patterns. Be certain to highlight any caveats or plan parameters you require, and if there are any additional costs for such service.

FSA COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Are you agreeable to take over FSA administration?

2. Have you provided details of all your costs for such administration?

3. How is the payment claims process completed? Please outline the claims payment process.

4. Please describe your specific process to achieve compliance for reimbursement of only eligible FSA Healthcare receipts with respect to FSA debit card usage (substantiation process). Include a copy of your sample FSA substantiation letter and educational brochure.

5. How and to whom will the funding be transmitted?

6. Have you provided detailed recommendations, and your plan to promote participation in the District's flexible spending account?

7. What information will you need from the District initially and on an ongoing basis? How often? In what format?

8. Will you, prior to solicitation of enrollment, provide communications materials to participants regarding options they may choose and the effect on their taxable income, especially for child/elder care deductions and for those that may have FSA accounts?

9. Will you, with regard to child/elder care, individually prepare and explain to employees their options, to allow them to knowledgeably choose between flexible spending accounts and itemizing the expense for federal income tax purposes?

10. What is your most realistic estimate of the least number of calendar days required for the education phase and the enrollment of the District's group?

11. State whether your service fees and/or other cost factors will be affected by the number of enrolled participants including any minimum costs and/or requirements.

12. List the optional methods you can offer participants for paying for services from their FSA account. Debit card is required. e.g., ID card, Check, ATM, etc.

13. Explain the full range of services available to the District and your experience, expertise and data processing capability relative to the solicited services.

14. What hours will your service be available to employees by telephone?

15. Will participants have on-line access to information about their accounts?

16. Have you provided information with your proposal on specific personnel to be assigned to the District?

17. Do you acknowledge that you shall be strictly prohibited from any sales or marketing efforts regarding insurance or other products? Do you agree that your involvement in marketing or sales activities of unauthorized (by the District) products or services will result in termination of the FSA contract and forfeiture of any fees payable by the District?

18. Will you be utilizing the services of subcontractors in rendering this service? If so, it is required that you provide the details on whom and what services they perform.

MEDICAL PROVIDER/MANAGED CARE INFORMATION

1. Identify the name and address of the organization(s) providing the following services and their characteristics:

    a. Provider Network(s)
    Please list all provider networks that you are proposing.

    Organization: _____
    Contact: _____
    Phone: _____
    Address: _____

    b. Medical Case Management

    Organization: _____
    Contact: _____
    Phone: _____
    Address: _____

    c. Utilization Review

Organization: _____
Contact: _____
Phone: _____
Address: _____

d. Pharmacy Benefit Manager

Organization: _____
Contact: _____
Phone: _____
Address: _____

2. Have you compared your network with the District's network providers (Exhibit 5, 1 tab, in Excel format) and submitted a network match-up for the top providers?

3. Have you provided descriptive materials of the plan offered, including a directory of network hospitals, physicians and specialists, locations and office hours of facilities and staff and arrangements for after hours or emergency services?

4. State the duration of your provider contracts. For example, if most are "evergreen" state so and define what you mean by "evergreen". For major providers, indicate which contracts are for one year only (and the anniversary date), and which contracts are for longer than one year (and the expiration date of such longer term contracts).

5. Are there any major hospital or provider care systems whose contracts are expiring within the plan year? How does your company handle the increasing instances of insurer and provider contract conflicts? What assurances can you provide the District?

6. Will District employees have access to network providers on a statewide basis?
If No, explain why not.

7. Is provider network information available on the Internet? Yes__ No___

If Yes, indicate website address _____
What is the date of the current directory? _____
How often is the directory updated? _____

8. What is your procedure to address the need for a primary care provider or specialist who may not be in your network?

9. How do you achieve cost effectiveness through negotiations when plan participants utilize providers not in the network, and the charges are very substantial?

10. The following questions are about primary care physicians (PCPs).
    a. Do any of your proposed plans require the use of a primary care physician, with referrals required to see a specialist? Which plans?

b. Describe in detail how the referral process works and when a referral is required.

c. Do you allow patients to select their PCP?

d. What percentage of your PCPs and other physicians are not accepting new patients? (Please specify by County)

e. Are your PCPs and specialists subject to quality assurance and utilization reviews?

f. If your company has a sub network of select physicians, summarize your company's selection criteria, e.g., board designations, efficiency of care, statistical evaluation.

g. If your company has a sub network of select hospitals, summarize your company's selection criteria, e.g., board designations, efficiency of care, statistical evaluation.

11. Respond appropriately for any additional hospitals.

a. Calhoun:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

b. Liberty:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

c. Jackson:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

d. Leon:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

e. Bay:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

f. Houston County, Alabama:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

12. Indicate the number of hospitals with the following services, by county.

Network Provider	Calhoun	Liberty
Hospital with Trauma Unit		
Hospital with Obstetrical Services		
Hospital with Cardiac Unit		
Hospital with Ambulatory Surgical Unit		
Hospital with Psychiatric Services		
Hospital with Chemical Dependency Service		

Network Provider	Jackson	Leon
Hospital with Trauma Unit		
Hospital with Obstetrical Services		
Hospital with Cardiac Unit		
Hospital with Ambulatory Surgical Unit		
Hospital with Psychiatric Services		
Hospital with Chemical Dependency Service		

Network Provider	Bay	Houston County, Alabama
Hospital with Trauma Unit		
Hospital with Obstetrical Services		
Hospital with Cardiac Unit		
Hospital with Ambulatory Surgical Unit		
Hospital with Psychiatric Services		
Hospital with Chemical Dependency Service		

13. PPO and High Deductible Options – Attach a listing of current network providers, including pharmacies and hospitals in the following Florida counties: Calhoun, Liberty, Jackson, Leon and Bay, and in the following Alabama county: Houston. Additionally, indicate on these listings those providers who are not accepting new patients. *These listings should include provider's address (street and city) and category of practice.*

14. Please provide the number of physicians in each of the following counties in the following specialties: (Count each physician once based on their primary practice.)

	Calhoun – For each plan			Liberty – For each plan		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Jackson – For each plan			Leon – For each plan		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Bay – For each plan			Houston County, Alabama – For each plan		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

PRESCRIPTION PROVIDER INFORMATION

Attach necessary explanations and/or deviations.

1. Have you provided a directory of network and other pharmacies, mail order services, etc.

2. Is your directory on the Internet?

3. How often is the directory updated?

4. Have you provided a list of participating pharmacies that include major retailers and local pharmacies in the District's local area?

5. What major national or regional chains that are common sources of retail prescription drugs are not on your pharmacy list?

6. In regards to local pharmacies within the District's immediate area, there is a concern that these pharmacies are not included in the participating pharmacy listing. Please provide a specific listing of the pharmacies in Calhoun County (specifically within a 25 mile radius of zip code 32424). It is important that District members be able to fill their prescriptions at the local pharmacies (non-national chain brand pharmacies).

7. Are there any major areas in Florida or nationally where there are few or no participating pharmacies?

MEDICAL SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Where is the administration and claims payment facility located?

   _____

   a. If not local, can the District contact the claims and/or administration departments by a toll-free number? Yes____ No_____

3. Please list (by person and title) of all personnel who will implement and manage all services of the account. Please provide copies of any implementation tools, such as an "Implementation Log" or "Implementation Schedule Timeline."

4. Will you require a new enrollment?

5. If so, what is your most realistic estimate of the least number of calendar days required to enroll the District's group, to include the FSA setup?

6. Will you provide representation for enrollment at each work location in sufficient numbers, as requested by the District?

7. Do you agree to participate in the re-enrollment process, as needed, possibly by conducting employee orientation meetings, including explanation of the plan(s) offered, and key differences between current plans and those to be implemented?

8. Will you prepare literature describing the new plan in layman's terms and make such literature available for the employee meetings?

9. Will you provide an insurance policy/certificate/booklet, plan document, I.D. cards (coordinating with others to include pharmacy benefit information on a single card), and other appropriate literature to describe benefits to employees?

10. In addition, will you furnish an electronic version of the certificates/booklets for the District to use on their website? Confirm these documents will be provided at no additional cost to the District.

11. How will you coordinate with the District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the District's eligibility record in Excel format?

12. Will you offer online access for employees and dependents to review their medical claims, plan information, etc.? Explain.

13. To what extent do you recommend electronic enrollment? At what cost? Attach details.

14. What is your procedure and assistance for enrollment of employees who become eligible after plan inception?

15. Do you provide a 24-hour nurse "hot line" via a toll free number?

16. What service hours will you provide for the District that will include time before and after the District's normal work hours, and what access to service representatives will be available nights, weekends and holidays, if needed (describe your accommodations other than weekdays)?

17. Will you perform the following claims functions requested by the District?

    a. Verify coverage and eligibility for benefits.

    b. Verify/confirm dependent eligibility.

    c. Make any necessary investigations or consultations with plan participants, medical care providers or others necessary to assure claim validity.

    d. Establish and maintain complete claims files on each claim.

    e. Coordinate with preferred providers, utilization review services and others who have an effect on claims activity.

    f. Properly review, process and pay claims.

    g. Provide direct payment to medical providers on assignment by participants.

    h. Coordinate benefits with all available sources, if not prohibited by law.

    i. Provide explanations of benefits (EOBs) to plan participants.

    j. Continuously advise with regard to actions, procedures, etc. which will result in control of claims and cost containment.

18. Do your provider contracts include a "hold harmless" clause to protect employees from any fees for provider services rendered that are eligible charges according to the plan (except deductible and coinsurance), regardless of the reason for non-payment? If yes, describe.

19. Do you assume fiduciary liability for administration of the plan? If yes, explain the process for settlement of a claim dispute. If not, explain both the financial and legal support that will be available to the District.

20. What percentage of claims do you audit each month? Describe the audit process. Will you supply routine audit findings to the District? Please provide a sample of this report.

21. Will your contract include a provision reserving the District the right to audit claims at its expense, as the District deems necessary?

22. Will you make all necessary records available for audit for up to three (3) years after the final year of your contract, and assist the District regarding reconciliation of reports, if so requested?

23. Describe the instances in which an explanation of benefits (EOB) will be generated and forwarded to participants. Are EOBs in paper or electronic format, or both?

24. Will you perform all COBRA services needed by the District? Explain if there are any COBRA related services you will not provide.

25. Will you administer HIPAA and assure compliance with HIPAA law?

26. Will any costs incurred at installation of your plan, be expected to be incurred by the District? What costs and what amounts?

27. Are you providing any sort of installation allowance to financially aid the District in getting through the installation?

28. Explain how your organization will coordinate with managed care network(s).

29. Describe your organization's method of data exchange and controls used to insure accurate transfer of data from utilization review and medical case management firm.

30. Have you provided an attachment of your performance guarantees? Are they specific to the District? If not, why? What is your total/maximum at-risk amount?

31. Are you willing to negotiate alternative terms, and to recommend incentives and/or disincentives to make the performance guarantee(s) practical?

32. Will you permit the District to perform audits regarding the performance guarantees?

33. Explain how your system identifies claims with medical case management potential.

34. Please confirm that you will provide the insurance coverage as described in Section II of the RFP. If there are any deviations, please state them here.

35. Identify below any additional information about your proposal that the District should consider (*attach and identify additional pages as necessary*).

PRESCRIPTION SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Can the District contact the administration department by a toll free number? What is the number?

3. Have you provided details of the administration services proposed, and a description of experience, staffing, locations, computer capability, etc.?

4. State and define your expected mail order turnaround time for a prescription drug the first time it is requested as mail order.

5. State and define your expected specialty drug turnaround time and any other special instructions that have to be followed with specialty drug ordering.

FSA SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Can the District contact the administration department by a toll free number? What is the number?

3. How does the account team representing the FSA administration coordinate with the medical and prescription insurer? Explain the process of coordination. Is it seamless to the District and what is the expected involvement of the District?

4. Have you provided details of the FSA services proposed, and a description of experience, staffing, etc.?

MEDICAL AND PRESCRIPTION REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide monthly summaries of enrollment, rates, premiums and claims, (within 30 days of the end of the month) with cumulative totals for the plan year? Explain any differences between what is requested and what you will provide.

2. Will you provide such information separately for employees and their dependents, retirees (Medicare and non-Medicare eligible) and their dependents, COBRA and their dependents, and total for all participants and all dependents?

3. Will you provide such claims reports additionally for 12 months after plan termination, or until there are no run-out claims? State the cost, if any.

4. Will you provide and update monthly information on claims over $50,000? State the cost, if any.

5. State specifically which of the following are automatically included in your proposed costs, and which are not. For reports not automatically provided, separately state the additional cost.
    a) Total charges by provider and for all physicians collectively, total charges by hospital and for all hospitals collectively, total charges for all prescriptions by pharmacy and for all pharmacies collectively. State the cost, if any.

    b) Number of hospital admissions, number of hospital days, and number of hospital days per admission by hospital and for all hospitals collectively. State the cost, if any.

    c) Total charges in network versus out-of-network, separately for physicians and for hospitals. State the cost, if any.

d) Frequency and severity by diagnosis (provide the top 20). State the cost, if any.

e) Estimated cost reductions produced by pre-certification/utilization review or other cost containment method. State the cost, if any.

f) Total dollar recoveries from subrogation and coordination of benefits. State the cost, if any.

6. Please describe other claims reports formats and management reporting systems available to the District. If there are any additional costs, please state.

7. Are you capable of modifying existing report formats to provide the premium/claims experience information desired by the District?

8. Describe how the District can have access to its data to produce reports on its own, and the support to be provided to assist the District in doing so.

PRESCRIPTION REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide the District with more detailed reports at least quarterly, and an annual report of claims for the policy year, within 30 days of the end of the quarter and policy year?

2. Describe the information and reports that the District has access to via the web interface.

3. Describe the District's participants' ability to access online information via web interface.

4. Will your reports provide details of brand (and preferred brand, where applicable) versus generic utilization, and will you proactively assist the District in promoting increased use of generics if there is less utilization than should be expected?

5. Will your reports provide details of retail versus mail order utilization?

6. Please list the types of reports you can provide and provide examples.

7. Provide sample communication materials you have concerning:
   a) Formulary
   b) Medical conditions for which generic medications are available
   c) Merits of generic substitution
   d) Advantages of mail order service
   e) Step Therapy programs for specific drugs
   f) Any additional drug programs available

FSA SERVICES REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you prepare and mail quarterly individual account status reports to participants?

2. Will you provide a biweekly participation and account status reports to the District?

3. Will you provide a summary Annual Report for employees?

4. Will you prepare an annual forfeiture report to the District?

5. Will you fulfill federal report filing requirements, including issuing 1099s to providers?

6. Do you agree to the District retaining property rights, for the District's own use, to all materials, reports, produced by the administrator specifically for the District?

7. What information do you need from the District initially and on an ongoing basis? How often? In what format and media?

8. Will you maintain books, records, documents, and evidence on costs and expenses for services provided?

9. Will such records be presented to the District for audit, if desired by the District?

10. Will you establish records necessary for maintaining account balances?

WELLNESS/DISEASE MANAGEMENT

Attach necessary explanations and/or deviations.

1. Are you able to offer a wellness/disease management program?

2. Does your proposal include any additional wellness benefits such as health screenings (i.e., skin cancer screening, vision screening, etc.), flu shot program and/or mini health fairs?

3. Does you proposal include an annual wellness incentive fund or similar program fund for the District?

4. What incentives do you provide for complying with wellness initiatives? E.g., prevention screenings, reduction in premium for compliance, etc.

5. What type of return on investment should be expected from the wellness program you are proposing? How are you able to measure and demonstrate such a return?

6. What other services or programs do you offer that set you apart from your competitors? What do you do that is especially innovative?

7. Do you have experience either administering or participating in a health fair?

8. Does your proposal include any online and/or telephonic coaching services?

9. What extent of health coaching do you expect to provide, for what conditions?

10. Will an employee being health coached for a condition be able to talk to the same health coach each time, or will the employee have to take whatever health coach is available at the time?

11. Do you have any programs specifically designed for diabetes? Explain.

12. Do you have any programs specifically designed for allergies? Explain.

13. Do you have any programs specifically designed for high blood pressure? Explain.

14. Do you have any programs specifically designed for high cholesterol? Explain.

15. Do you have any programs specifically designed for weight loss? Explain.

16. Do you have ready-made programs for implementation, such as smoking cessation and nutrition?

17. What is your approach to the following items regarding disease management programs?
    a. Identifying persons at risk (i.e., Health Risk Assessment).
    b. Intervention and your basis for such.
    c. Educating targeted persons to take an active role in disease prevention/ management.
    d. Conduct of on-going (e.g., monthly) activities and programs to encourage continuous commitment by participants
    e. Coordination of providers and cost-efficiently maximizing their involvement.
    f. Management of chronic diseases.
    g. Measuring the results.

18. Which of the following diseases/conditions/procedures are targeted in your disease management program? Check in the column left of each item, if you are involved.

	Acid Related Disorders		High Cholesterol
	Allergies		Hypertension
	ALS (Amyotrophic Lateral Sclerosis)		Inflammatory Bowel Disease
	Arthritis (Rheumatoid)		Irritable Bowel Syndrome
	Asthma		Joint Pain
	Atrial Fibrillation		Kidney Disease (Chronic)
	Back pain		Lung disease (chronic obstructive)
	Cancer, incl breast, colon, prostate, skin		Lupus Erythematosis (Systemic)
	COPD		Maternity

	Congestive heart failure		Migraine
	Coronary artery disease		Multiple Sclerosis
	Crohn's Disease		Musculoskeletal (excluding low back)
	Cystic Fibrosis		Myasthenia Gravis
	Depression		Osteoarthritis
	Dermatomyositis		Osteoporosis
	Diabetes		Parkinson's Disease
	Fibromyalgia		Prostatic Hyperlasia (Benign)
	Gastroesophageal reflux		Renal Disease (End Stage)
	Gaucher Disease		Scleroderma
	Hemophilia		Seizure Disorders
	Hepatitus		Sickle Cell Anemia
	HIV		Transplants
	High Blood Pressure		Uterine Conditions (Benign)

19. Which of these diseases/conditions/procedures are prime targets in your involvement?

20. How do you plan to coordinate medical claims, pharmacy and other sources of data to maximize the effectiveness of the wellness program?

21. Do your disease management programs take into consideration care for males versus females, age differences, etc.?

22. What specific services or programs do you offer towards age-recommended testing (i.e., PSA tests, mammograms, etc.)?

23. What kind of credentials are held by the persons who are going to provide the basic wellness/disease management services you are proposing; e.g., will they include nurses, doctors, etc.?

24. What supplemental support for non-covered services can you make available? Do you have wellness items/services that are automatically included as part of your program, such as fitness club memberships, Nutri-System, discount bicycle helmets, Jenny Craig, Weight Watchers, etc.

25. What local partnerships can you help develop, e.g., discounts at local gyms, YMCA, YWCA, etc.

MEDICAL & PRESCRIPTION INSURER STABILITY

Attach necessary explanations and/or deviations.

1. Provide your current financial rating from A.M. Best and your current Financial Outlook.

Rating Firm	Rating
A.M. Best	_____
Financial Outlook	_____

2. Are you rated by NCQA? What is your rating?

3. Is the insurer authorized to do business in Florida?

4. Does your proposed program comply with all applicable Federal and Florida Statutes regarding group insurance/self-insurance and PPOs and will you assure future compliance?

5. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

6. What year did the insurer begin business in Florida?

7. How many employees does your company have?

8. How many employees does your company have in Florida?

9. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to District and surrounding counties?

FSA ADMINISTRATOR STABILITY

Attach necessary explanations and/or deviations.

1. Is the administrator authorized to do business in Florida?

2. Does your proposed program comply with all applicable Federal and Florida Statutes regarding FSAs, and will you assure future compliance?

3. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

4. What year did the administrator begin business in Florida?

5. How many employees does your company have?

6. How many employees does your company have in Florida?

7. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to District and surrounding Counties?

MEDICAL & PRESCRIPTION CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Insurance Services Provided
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form. The absence of any notation will be presumed to indicate full compliance.

Section	RFP Provisions	Will	Will Not
II	Minimum Qualifications of Proposer		
II	Insurance Requirements		
II	Late Proposals, Late Modifications and Late Withdrawals		
II	Costs Incurred by Proposers		
II	Proprietary Information		
II	Waiver/Rejection of Proposals		
II	Rules, Regulations and Licensing Requirement		
II	Records/Audit		
II	Investigation of Alleged Wrongdoings, Litigation/Settlement/Fines/Penalties		
II	Conduct of Proposers		
II	Conflict of Interest		
II	Legal Requirements		
II	Public Entity Crimes Statement		
II	Anti-Discrimination Clause		
II	Discriminatory Vendor's List		
II	Drug Free Workplace		
II	Use of Proposal Forms		
II	Irrevocability of Proposal		
II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		

III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
IV	Contract Period		
IV	Rate Guarantee Period		
IV	Remuneration		
IV	Access to Claim Files		
IV	Ownership of Claim Data		
IV	Audit Requirement		
IV	Eligibility & Enrollment		
IV	Continuity of Coverage (No Loss/No Gain)		
IV	Scope of Coverage		
IV	Scope of Services		
IV	Managed Care Services		
IV	Administrative Services		
IV	Healthcare Reform Services		
IV	Prescription Benefit Services		
IV	Flexible Spending Account Administration		
IV	Medical & Prescription Reporting & Data Services		
IV	Performance Guarantees		

ADDITIONAL COMMENTS/DEVIATIONS FROM MODEL PROGRAM

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

ACKNOWLEDGMENT OF RECEIPT OF ADDENDA

The Proposer hereby acknowledges receipt of the following addenda:

1. _____ 2. _____ 3. _____ 4. _____

CHECKLIST OF MATERIAL TO BE INCLUDED

The following material should be included as part of each of the completed responses to this RFP including: one (1) paper original and five (5) paper copies (total of six (6) paper proposals) and an electronic copy, either on CD or flash drive (with all documents in their original format: Word, Excel, etc.):

1. Completed Proposal Forms, and specimen contracts or policies as described in this RFP.

2. Acknowledgment of any addenda.

3. Specimen copy or samples of the following:

    a. Benefit booklets

b. Benefits Match-Up a,b,c,d Exhibit 4– In Word format
c. Network provider (and pharmacy directories)
d. Most Utilized Providers Exhibit 5– In Excel format
e. Explanation of Benefits Statement
f. ID cards and claim forms
g. Claims and exposure report samples

4. Descriptive literature on Utilization Management Services Program, Medical Case Management and Prescription Drug Program and FSA System/Capabilities.

5. Completion of financial ratings as outlined under "Medical and Prescription Insurer Stability" and "FSA Administrator Stability."

6. Information on experience and references as requested on Proposal Forms.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (insurer) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided on the insurer's proposal on behalf of the insurer, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the insurer is in full compliance with the Minimum Qualifications of Proposer set forth in Section II of this RFP;

4. The insurer authorizes the District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the insurer offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

_____

Name of Firm/Insurer

_____

Signature of Authorized Representative

_____

Printed Name of Authorized Representative

_____

Title of Authorized Representative

_____

Date Signed by Authorized Representative

CALHOUN COUNTY SCHOOL DISTRICT

Section IX

Proposal Forms for Medical Claims Administration Services

SECTION IX

CALHOUN COUNTY SCHOOL DISTRICT

MEDICAL CLAIMS ADMINISTRATION

PROPOSAL FORMS

A. PROPOSER'S IDENTIFICATION

Name of Insurer: _____

FEIN/SS#: _____

Address: _____

_____

_____

Insurer Proposal Contact: _____

Telephone Numbers Daytime/After Hours: _____

E-mail: _____

B. IF APPLICABLE – INSURANCE AGENCY(IES)/AGENT(S)

NOTE: If one or more agencies/agents are acceptable to the proposing insurer, please list those firms and representatives which you approve, if the District should decide on a proposal other than directly through the proposing insurer's employee agent:

	Agency	**Agent**
1.	_____	_____
2.	_____	_____
3.	_____	_____

NOTE: If an agent(s) is/are listed, the Agents proposal forms at the end of this document, Section XI - Agent/Broker Services must be completed by each of such agent(s).

MEDICAL CLAIMS ADMINISTRATION COST INFORMATION

Administration costs for the four (4) self-insured plans based on per employee per month (PEPM) cost

Provide the monthly rates and annual cost in the table below if the rates are the same for the four (4) plans being offered. However, if the rates are different for the plans, create an additional table for each plan. Make sure that if you add one (1) or more tables to account for different rates that the total of all tables equals total annual cost for all plans.

	ADMINISTRATION COST FOR 10/1/2018-9/30/2019	#	X	$Rate	X	12	=	Annual Cost
1.	Claims service cost	282	X	$	X	12	=	$
2.	Network access fees, if any	282	X	$	X	12	=	$
3.	Wellness Program (attach explanation)	282	X	$	X	12	=	$
4.	COBRA administration cost *	282	X	$	X	12	=	$
5.	HIPAA administration cost	282	X	$	X	12	=	$
6.	Premium taxes	282	X	$	X	12	=	$
7.	Commissions, finders fees or other remuneration to insurance agent	282	X	$	X	12	=	$
8.	Enrollment meetings and materials	282	X	$	X	12	=	$
9.	Printing of booklets, plan documents	282	X	$	X	12	=	$
10.	Other charges (explain)	282	X	$	X	12	=	$
	TOTAL ADMINISTRATION COST							**$**

* Proposers should clearly state if COBRA services are to be provided by an outside firm, charging extra.

1. For how many years are these PEPM administration rates guaranteed? A minimum of three (3) years is preferred. Are there any assumptions, special requirements or contingencies involved?

2. Does your cost includes payment of run-out claims and extension of benefits claims of disabled persons (the District is obligated to pay claims as required by Florida Statute 627.667 (3) (a) for up to 12 months after plan termination). If this cost is not included, provide the additional cost for such service.

3. Is agent/broker remuneration included in your fees or rates? Yes ____ No ____

4. Please indicate the manner in which agent/broker remuneration is calculated.

5. Please provide an estimate of the annual remuneration.

MEDICAL AND RX CLAIMS PROJECTIONS

PPO PLAN 1_____(state plan name/#) CLAIMS PROJECTIONS **(Plan most similar to Florida Blue Plan – BlueChoice 0727)**	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	1.

PPO PLAN 2_____(state plan name/#) CLAIMS PROJECTIONS **(Plan most similar to Florida Blue Plan – BlueChoice 03359)**	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	1.

PPO PLAN 3_____(state plan name/#) CLAIMS PROJECTIONS **(Plan most similar to Florida Blue Plan – BlueChoice 0117)**	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	1.

PPO PLAN 4_____(state plan name/#) CLAIMS PROJECTIONS **(Plan most similar to Florida Blue Plan – BlueChoice 05901)**	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$
Medical claims trend factor	1.

TOTAL CLAIMS PROJECTIONS	**Next 12 Months**
Estimate of 10/01/2018 – 9/30/2019 paid claims	$
Estimate of 10/01/2018 – 9/30/2019 incurred claims	$

MEDICAL CLAIMS ADMINISTRATION COST INFORMATION

Attach necessary explanations and/or deviations.

1. What is the range of required enrollment for each option offered? State here if there are any required minimums.

2. For what range of employees and retirees are the proposed costs applicable (e.g., within 5%, 10%, etc. of the census)

3. If the number of enrollees is less than the plan members in the census data, but the age and sex mix are not materially different, will you honor your proposal as proposed?

4. What rate/cost guarantees will you provide beyond the thirty-six (36) months, e.g., administration or other? Provide details.

5. Will you agree to negotiate changes in proposed benefits, administration and other costs, if the District should desire to do so?

6. Are there any subrogation fees? Explain.

Network Cost Questions

1. Identify average medical network provider discounts in the following counties for the plans you are proposing:

Calhoun County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Liberty County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Jackson County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Leon County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Bay County

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

Houston County, Alabama

	Discount off billed charges	Explanation
PPO Physicians		
PPO Hospitals		

2. Are you providing any guaranteed network discounts for the District? If yes, describe in detail.

3. If providing any guaranteed network discounts, are there any claim exclusions from these discounts?

4. Describe the verification process of the network discounts proposed.

PRESCRIPTION COST QUESTIONS

Attach necessary explanations and/or deviations.

1. For the District's size and medical and prescription experience, what would you recommend to the District to control escalating prescription costs?

2. Please describe any generic prescriptions available to members at a reduced or zero cost share. Are you able to match the current "Free Preventative Medications" and "Free Preventative Generic Medications" lists?

3. What additional programs can the District consider for prescriptions? I.e., 90-day retail option, generic usage program, step therapy, etc. Please note the current programs they are participating in and also describe the options available and if there are any additional costs.

4. Provide your recommendations on how to improve generic utilization. Explain.

5. Is the mail order pharmacy owned by the proposing company or is it outsourced? If outsourced, to which mail order pharmacy company and why? Explain the benefits of this mail order service.

6. What incentives do you recommend to encourage participants to use the mail order service?

7. What controls do you recommend to minimize over-utilization and/or fraud in connection with the mail order service?

8. Is the specialty pharmacy owned by the proposing company or is it outsourced? If outsourced, to which specialty pharmacy company and why? Explain the benefits of this specialty pharmacy.

9. What initiatives do you employ against other types of claims fraud and are there any additional costs for these initiatives?

10. Describe the extent to which you perform any screening to detect possible multiple drug interactions/reactions and your procedure for notifying participants.

11. Please outline any discount guarantees being offered.

12. Please detail how rebates will be returned to the District. Are there guarantees?

FSA COST INFORMATION

Attach necessary explanations and/or deviations.

Please complete the chart below based on the coverages outlined in the Scope of Services section of the RFP:

Item	**Basis**		**Rate**	**Month**	**Annual Cost**
Per Employee Per Month*	282	X	$	X 12	$
Debit Card	282	X	$	X 12	$
FSA Plan Documents	Flat Rate	Not Applicable			$
Generic Communication Materials	282	X	$	X 12	$
Custom Communication Materials	If Any	X	$	X 12	$
Check Writing	Per Check	X	$	X 12	$
Other Charges (list/describe below)					
		X	$	X 12	$
		X	$	X 12	$
TOTAL ESTIMATED FSA ANNUAL COST					**$**

*If the Per Employee Per Month option is proposed, indicate "Included" for the annual cost of services above, and indicate the costs for services not included in the PEPM fee.

For Claims Administration and FSA services:

1. Is agent/broker remuneration included in your fees or rates? Yes ____ No ____

2. Is agent/broker remuneration left up to the agent/broker to declare in the Agents section at the end of this document?
   Yes ____ No ____

3. Please indicate the manner in which agent/broker remuneration is calculated.

4. Regardless of the remuneration method utilized, provide an estimate of the annual remuneration payable. $_____

FSA COST QUESTIONS

Attach necessary explanations and/or deviations.

1. Have you stated the range of required enrollment for each option offered or if there are no minimum requirements for any or all options offered? State here if there are any required minimums.

2. What rate/cost guarantees will you provide beyond the first 36 months?

3. Are rates subject to change based on any enrollment changes?

4. Describe here how your firm expects to be remunerated in any way that differs from above. State your total remuneration and be specific if there are any minimum and/or maximum fees.

MEDICAL COVERAGE INFORMATION

Attach necessary explanations and/or deviations.

1. Have you provided the Benefits Match-up a,b,c,d (Exhibit 4 in Word format)?

2. Are the plans proposed filed and approved with the State of Florida for 10/1/2018? If not, explain.

3. Have you provided descriptive material on all medical benefits provided and all limitations and exclusions?

4. To the extent appropriate, will you provide ongoing healthcare reform guidance, updates and resources? Explain.

5. Will you provide a Summary of Benefits and Coverage?

6. Are sample summary plan documents and other benefits plan descriptions and riders provided for analysis?

7. Will you assure that your takeover of administration of the plan from the current insurer will be on a no loss/no gain basis to participants and the District?

8. Do you agree that coverage is to be provided to those that meet the District's eligibility requirements?

9. Do you agree to cover all presently insured employees, retirees and dependents whether at work, disabled or otherwise on approved absence on the effective date of coverage?

10. Will you be responsible for takeover of the current plan's extension of benefits? Explain.

11. With regard to transition of care, how will employees under the care of a physician or specialist for a serious health condition be notified?

12. How is lab work covered if performed in a physician's office? Is a specific lab company required to be used by members? Describe your contracted arrangements for laboratory work. Is the lab arrangement capitated? Describe the discounts and terms.

13. The District's plans offer both in-network and out-of-network benefits. If an employee/dependent/spouse has services done at an in-network facility, i.e. hospital or outpatient surgical center, etc., and there are ancillary services done as well, i.e. anesthesia, radiology, pathology, etc. and that service is considered out-of-network, how is the service paid? Please be specific.

14. Briefly describe to what extent benefits are provided out of the local service area, e.g., if a participant (employee, retiree, COBRA or dependent) needs medical care elsewhere in the U.S. or abroad.

15. How are non-emergency services covered for participants who must travel for extended periods of time outside of their home location?

16. How do you propose to cover retirees whether they remain in the local area or move out of the area or out of state?

17. What specific services or programs targeted at quality health care that are not addressed in the RFP do you offer that set you apart from your competitors? What do you do that is especially innovative?

PRESCRIPTION COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Are you proposing to manage/administer prescription drug benefit equivalents to those currently offered?

2. Are you offering a generic listing of medications at no cost as currently provided to District members? Are you able to offer any other programs that members can take advantage of? If there are any additional costs, explain.

3. Is your prescription drug formulary an open, closed or restricted formulary? Explain and give your definition of these terms.

4. How often are formulary changes allowed? What controls are there on balancing District convenience with the frequency that formulary changes are made? How are members notified?

5. Have you enclosed a list of the prescription drugs your formulary includes?

6. In regards to mail order, are there any requirements for specific drugs to be filled only at mail order? If so, please explain and provide a list. The District is concerned about mandatory mail order on specific drugs due to the cost for employees. Are there options that the District can consider?

7. How do you report prior authorizations and pharmacy DUR overrides entered in your claims system?

8. How are physicians directed or otherwise influenced to write prescriptions from the formulary?

9. What is your expectation of the pharmacist, the physician, and the participant when a non-formulary prescription is written?

10. Describe any cost effective interventions that you recommend, e.g., prior authorizations, step therapies and quantity limits, and your rationale for adopting them. State which programs are mandatory and which ones are optional.

11. Explain in detail how you can assist the District in identifying if any members are potential drug abusers and the tactics you provide to contact members and prescribing physicians to alter purchase behavior and prescribing patterns. Be certain to highlight any caveats or plan parameters you require, and if there are any additional costs for such service.

FSA COVERAGE QUESTIONS

Attach necessary explanations and/or deviations.

1. Are you agreeable to take over FSA administration?

2. Have you provided details of all your costs for such administration?

3. How is the payment claims process completed? Please outline the claims payment process.

4. Please describe your specific process to achieve compliance for reimbursement of only eligible FSA Healthcare receipts with respect to FSA debit card usage (substantiation process). Include a copy of your sample FSA substantiation letter and educational brochure.

5. How will the funding be transmitted?

6. Have you provided detailed recommendations, and your plan to promote participation in the District's flexible spending account?

7. What information will you need from the District initially and on an ongoing basis? How often? In what format?

8. Will you, prior to solicitation of enrollment, provide communications materials to participants regarding options they may choose and the effect on their taxable income, especially for child/elder care deductions and for those that may have FSA accounts?

9. Will you, with regard to child/elder care, individually prepare and explain to employees their options, to allow them to knowledgeably choose between flexible spending accounts and itemizing the expense for federal income tax purposes?

10. What is your most realistic estimate of the least number of calendar days required for the education phase and the enrollment of the District's group?

11. State whether your service fees and/or other cost factors will be affected by the number of enrolled participants including any minimum costs and/or requirements.

12. List the optional methods you can offer participants for paying for services from their FSA account. Debit card is required. e.g., ID card, Check, ATM, etc.

13. Explain the full range of services available to the District and your experience, expertise and data processing capability relative to the solicited services.

14. What hours will your service be available to employees by telephone?

15. Will participants have on-line access to information about their accounts?

16. Have you provided information with your proposal on specific personnel to be assigned to the District?

17. Do you acknowledge that you shall be strictly prohibited from any sales or marketing efforts regarding insurance or other products? Do you agree that your involvement in marketing or sales activities of unauthorized (by the District) products or services will result in termination of the FSA contract and forfeiture of any fees payable by the District?

18. Will you be utilizing the services of subcontractors in rendering this service? If so, it is required that you provide the details on whom and what services they perform.

MEDICAL CLAIMS ADMINISTRATION PROVIDER/MANAGED CARE INFORMATION

1. Identify the name and address of the organization(s) providing the following services and their characteristics:

    a. Provider Network(s)
    Please list all provider networks that you are proposing.
    Organization: _____
    Contact: _____
    Phone: _____
    Address: _____

    b. Medical Case Management
    Organization: _____
    Contact: _____
    Phone: _____
    Address: _____

    c. Utilization Review
    Organization: _____
    Contact: _____
    Phone: _____
    Address: _____

2. Have you compared your network with the District's network providers (Exhibit 5, 1 tab, in Excel format) and submitted a network match-up for the most utilized providers?

3. Have you provided descriptive materials of the plan offered, including a directory of network hospitals, physicians and specialists, locations and office hours of facilities and staff and arrangements for after hours or emergency services?

4. Are there any major hospital or provider care systems whose contracts are expiring within the plan year? How does your company handle the increasing instances of insurer and provider contract conflicts? What assurances can you provide the District?

5. Will District employees have access to network providers on a statewide basis? If No, explain why not.

6. Is provider network information available on the Internet? Yes__ No___

   If Yes, indicate website address _____

   What is the date of the current directory?
   _____

   How often is the directory updated? _____

7. Please describe your proposed case management services including any enhancements and measurement of success tools.

8. What is your procedure to address the need for a primary care provider or specialist who may not be in your network?

9. The following questions are about primary care physicians (PCPs).

   a. Do any of your proposed plans require the use of a primary care physician, with referrals required to see a specialist? Which plans?

   b. If your company has a sub network of select physicians, summarize your company's selection criteria, e.g. board designations, efficiency of care, statistical evaluation.

   c. If your company has a sub network of select hospitals, summarize your company's selection criteria, e.g. board designations, efficiency of care, statistical evaluation.

10. Have you listed network hospitals in the following counties? Please copy this page and respond appropriately for any additional hospitals.

    a. Calhoun:
       Hospital #1: _____

Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

b. Liberty:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

c. Jackson:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

d. Leon:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

e. Bay:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

f. Houston County, Alabama:
Hospital #1: _____
Hospital #2: _____
Hospital #3: _____
Hospital #4: _____
Hospital #5: _____

11. Indicate the number of hospitals with the following services, by county.

Network Provider	Calhoun	Liberty
Hospital with Trauma Unit		
Hospital with Obstetrical Services		
Hospital with Cardiac Unit		
Hospital with Ambulatory Surgical Unit		

Hospital with Psychiatric Services		
Hospital with Chemical Dependency Service		

Network Provider	Jackson	Leon
Hospital with Trauma Unit		
Hospital with Obstetrical Services		
Hospital with Cardiac Unit		
Hospital with Ambulatory Surgical Unit		
Hospital with Psychiatric Services		
Hospital with Chemical Dependency Service		

Network Provider	Bay	Houston County, Alabama
Hospital with Trauma Unit		
Hospital with Obstetrical Services		
Hospital with Cardiac Unit		
Hospital with Ambulatory Surgical Unit		
Hospital with Psychiatric Services		
Hospital with Chemical Dependency Service		

12. Please provide the number of physicians in each of the following counties in the following specialties: (Count each physician once based on their primary practice.)

	Calhoun			Liberty		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Jackson			Leon		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

	Bay			Houston County, Alabama		
	Total # Drs.	**# Board Certified**	**Accepts New Pts.**	**Total # Drs.**	**# Board Certified**	**Accepts New Pts.**
Family Practice						
General Practice						
Internal Medicine						
Obstetrics						
Pediatrics						
Gynecology						
General Surgery						
Cardiovascular Surgery						
Orthopedic Surgery						
Urology						
Psychiatry						
Nephrology						
Dermatology						
Gastroenterology						
Neurology						
Oncology						
Otolaryngology						
Ophthalmology						
Endocrinology						
Chiropractic						

PRESCRIPTION PROVIDER INFORMATION

Attach necessary explanations and/or deviations.

1. Have you provided a directory of network and other pharmacies, mail order services, etc.

2. Is your directory on the Internet?

3. How often is the directory updated?

4. Have you provided a list of participating pharmacies that include major retailers and local pharmacies in the District's local area?

5. What major national or regional chains that are common sources of retail prescription drugs are not on your pharmacy list?

6. In regards to local pharmacies within the District's immediate area, there is a concern that these pharmacies are not included in the participating pharmacy listing. Please provide a specific listing of the pharmacies in Calhoun County (specifically within a 25 mile radius of zip code 32424). It is important that District members be able to fill their prescriptions at the local pharmacies (non-national chain brand pharmacies).

7. Are there any major areas in Florida or nationally where there are few or no participating pharmacies?

MEDICAL SERVICE/CUSTOMER SERVICE AND ADMINISTRATION INFORMATION

Attach necessary explanations and/or deviations.

1. Does your proposal include one experienced account manager to assist the District with managing the everyday details of the District's account? Explain their experience in this type of role.

2. Where is the account manager's office location?

3. Does your proposal include one experienced case manager to assist the District with managing high risk and high cost claims? Explain. Please detail how this position will coordinate to improve medical outcomes.

4. Does your proposal include one part-time claims representative who will be able to go on-site at District locations bi-monthly to assist with administrative issues and employee claims and other issues? Explain.

5. Where is the administration and claims payment facility located?

6. Will you require a new enrollment?

7. If so, what is your most realistic estimate of the least number of calendar days required to enroll the District's group, to include FSA setup?

8. Will you provide representation for enrollment at each work location in sufficient numbers, as requested by the District?

9. Do you agree to participate in the re-enrollment process, as needed, possibly by conducting employee orientation meetings, including explanation of the plan(s) offered, and key differences between current plans and those to be implemented?

10. Will you prepare literature describing the new plan in layman's terms and make such literature available for the employee meetings?

11. Will you provide an insurance policy/certificate/booklet, plan document, I.D. cards (coordinating with others to include pharmacy benefit information on a single card), and other appropriate literature to describe benefits to employees?

12. In addition, will you furnish an electronic version of the certificates/booklets for the District to use on their website? Confirm these documents will be provided at no additional cost to the District.

13. How will you coordinate with the District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the District's eligibility record in Excel format?

14. Will you offer online access for employees and dependents to review their medical claims, plan information, etc.? Explain.

15. To what extent do you recommend electronic enrollment? At what cost? Attach details.

16. What is your procedure and assistance for enrollment of employees who become eligible after plan inception?

17. Do you provide a 24-hour nurse "hot line" via a toll free number?

18. What service hours will you provide for the District, and what access to service representatives will be available nights, weekends and holidays, if needed (describe your accommodations other than weekdays)?

19. Will you perform the following claims functions?

    a. Verify/confirm dependent eligibility.
    b. Make any necessary investigations or consultations with plan participants, medical care providers or others necessary to assure claim validity.
    c. Establish and maintain complete claims files on each claim.
    d. Coordinate with preferred providers, utilization review services and others who have an effect on claims activity.
    e. Properly review, process and pay claims.
    f. Provide direct payment to medical providers on assignment by participants.
    g. Coordinate benefits with all available sources, if not prohibited by law.
    h. Provide explanations of benefits (EOBs) to plan participants.
    i. Continuously advise with regard to actions, procedures, etc. which will result in control of claims and cost containment.

20. Does your contract include a "hold harmless" clause to protect employees from any fees for provider services rendered that are eligible charges according to the plan (except deductible and coinsurance), regardless of the reason for non-payment? If yes, describe.

21. Do you assume fiduciary liability for administration of the plan? If yes, explain the process for settlement of a claim dispute. If not, explain both the financial and legal support that will be available to the District.

22. Have you provided a copy of your SAS-70 audit or its equivalent?

23. What percentage of claims do you audit each month? Describe the audit process. Will you supply routine audit findings to the District? Please provide a sample of this report.

24. Will your contract include a provision reserving the District the right to audit claims at its expense, as the District deems necessary?

25. Describe the instances in which an explanation of benefits (EOB) will be generated and forwarded to participants. Are EOBs in paper or electronic format, or both?

26. Will you perform all COBRA services needed by the District? Explain if there are any COBRA related services you will not provide.

27. Will you administer HIPAA and assure compliance with HIPAA law?

28. Will any costs incurred at installation of your plan be expected to be incurred by the District? What costs and what amounts?

29. Are you providing any sort of installation allowance to financially aid the District in getting through the installation?

30. Have you provided an attachment of your performance guarantees? Are they specific to the District? If not, why? What is your total/maximum at-risk amount?

31. Are you willing to negotiate alternative terms, and to recommend incentives and/or disincentives to make the performance guarantee(s) practical?

32. Will you permit the District to perform audits regarding the performance guarantees?

33. Explain how your system identifies claims with medical case management potential.

34. Please confirm that you will provide the insurance coverage as described in Section II of the RFP. If there are any deviations, please state them here.

35. Identify below any additional information about your proposal that the District should consider (*attach and identify additional pages as necessary*).

PRESCRIPTION SERVICE INFORMATION

Attach necessary explanations and/or deviations.

1. Indicate the name of the account representative that will service this account.

2. Can the District contact the administration department by a toll free number? What is the number?

3. Have you provided details of the administration services proposed, and a description of experience, staffing, locations, computer capability, etc.?

4. State and define your expected mail order turnaround time for a prescription drug the first time it is requested as mail order.

5. State and define your expected specialty drug turnaround time and any other special instructions that have to be followed with specialty drug ordering.

MEDICAL & DATA REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide monthly summaries of enrollment, rates, premiums and claims, (within 30 days of the end of the month) with cumulative totals for the plan year? Explain any differences between what is requested and what you will provide.

2. Will you provide such information separately for employees and their dependents, retirees (Medicare and non-Medicare eligible) and their dependents, COBRA and their dependents, and total for all participants and all dependents?

3. Will you provide such claims reports additionally for 12 months after plan termination, or until there are no run-out claims? State the cost, if any.

4. Will you provide and update monthly information on claims over $50,000? State the cost, if any.

5. State specifically which of the following are automatically included in your proposed costs, and which are not. For reports not automatically provided, separately state the additional cost.

    a) Total charges by provider and for all physicians collectively, total charges by hospital and for all hospitals collectively, total charges for all prescriptions by pharmacy and for all pharmacies collectively. State the cost, if any.
    b) Number of hospital admissions, number of hospital days, and number of hospital days per admission by hospital and for all hospitals collectively. State the cost, if any.
    c) Total charges in network versus out-of-network, separately for physicians and for hospitals. State the cost, if any.
    d) Frequency and severity by diagnosis (provide the top 20). State the cost, if any.
    e) Estimated cost reductions produced by pre-certification/utilization review or other cost containment method. State the cost, if any.
    f) Total dollar recoveries from subrogation and coordination of benefits. State the cost, if any.

6. Will you coordinate with the District's prescription benefit manager on the prescription claim data to be inclusive in each member's medical and prescription out-of-pocket maximum? Explain. Are there any additional fees added for this coordination?

7. Please describe other claims reports formats and management reporting systems available to the District. If there are any additional costs, please state.

8. Describe how the District can have access to its data to produce reports on its own.

PRESCRIPTION REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you provide the District with more detailed reports at least quarterly, and an annual report of claims for the policy year, within 30 days of the end of the quarter and policy year?

2. Describe the information and reports that the District has access to via the web interface.

3. Describe the District's participants' ability to access online information via web interface.

4. Will your reports provide details of brand (and preferred brand, where applicable) versus generic utilization, and will you proactively assist the District in promoting increased use of generics if there is less utilization than should be expected?

5. Will your reports provide details of retail versus mail order utilization?

6. Please list the types of reports you can provide and provide examples.

7. Provide sample communication materials you have concerning:
    a) Formulary
    b) Medical conditions for which generic medications are available
    c) Merits of generic substitution
    d) Advantages of mail order service
    e) Step Therapy programs for specific drugs
    f) Any additional drug programs available

FSA SERVICES REPORTING SERVICES

Attach necessary explanations and/or deviations.

1. Will you prepare and mail quarterly individual account status reports to participants?

2. Will you provide a biweekly participation and account status reports to the District?

3. Will you provide a summary Annual Report for employees?

4. Will you prepare an annual forfeiture report to the District?

5. Will you fulfill federal report filing requirements, including issuing 1099s to providers?

6. Do you agree to the District retaining property rights, for the District's own use, to all materials, reports, produced by the administrator specifically for the District?

7. What information do you need from the District initially and on an ongoing basis? How often? In what format and media?

8. Will you maintain books, records, documents, and evidence on costs and expenses for services provided?

9. Will such records be presented to the District for audit, if desired by the District?

10. Will you establish records necessary for maintaining account balances?

WELLNESS/DISEASE MANAGEMENT

Attach necessary explanations and/or deviations.

1. Are you able to offer a wellness/disease management program?

2. Does your proposal include any additional wellness benefits such as health screenings (i.e., skin cancer screening, vision screening, etc.), flu shot program and/or mini health fairs?

3. Does you proposal include an annual wellness incentive fund or similar program fund for the District?

4. What incentives do you provide for complying with wellness initiatives? E.g., prevention screenings, reduction in premium for compliance, etc.

5. What type of return on investment should be expected from the wellness program you are proposing? How are you able to measure and demonstrate such a return?

6. What other services or programs do you offer that set you apart from your competitors? What do you do that is especially innovative?

7. Do you have experience either administering or participating in a health fair?

8. Does your proposal include any online and/or telephonic coaching services?

9. What extent of health coaching do you expect to provide, for what conditions?

10. Will an employee being health coached for a condition be able to talk to the same health coach each time, or will the employee have to take whatever health coach is available at the time?

11. Do you have any programs specifically designed for diabetes? Explain.

12. Do you have any programs specifically designed for allergies? Explain.

13. Do you have any programs specifically designed for high blood pressure? Explain.

14. Do you have any programs specifically designed for high cholesterol? Explain.

15. Do you have any programs specifically designed for weight loss? Explain.

16. Do you have ready-made programs for implementation, such as smoking cessation and nutrition?

17. What is your approach to the following items regarding disease management programs?
    h. Identifying persons at risk (i.e., Health Risk Assessment).
    i. Intervention and your basis for such.
    j. Educating targeted persons to take an active role in disease prevention/ management.
    k. Conduct of on-going (e.g., monthly) activities and programs to encourage continuous commitment by participants
    l. Coordination of providers and cost-efficiently maximizing their involvement.
    m. Management of chronic diseases.
    n. Measuring the results.

18. Which of the following diseases/conditions/procedures are targeted in your disease management program? Check in the column left of each item, if you are involved.

	Acid Related Disorders		High Cholesterol
	Allergies		Hypertension
	ALS (Amyotrophic Lateral Sclerosis)		Inflammatory Bowel Disease
	Arthritis (Rheumatoid)		Irritable Bowel Syndrome
	Asthma		Joint Pain
	Atrial Fibrillation		Kidney Disease (Chronic)
	Back pain		Lung disease (chronic obstructive)
	Cancer, incl breast, colon, prostate, skin		Lupus Erythematosis (Systemic)
	COPD		Maternity
	Congestive heart failure		Migraine
	Coronary artery disease		Multiple Sclerosis
	Crohn's Disease		Musculoskeletal (excluding low back)
	Cystic Fibrosis		Myasthenia Gravis
	Depression		Osteoarthritis
	Dermatomyositis		Osteoporosis
	Diabetes		Parkinson's Disease
	Fibromyalgia		Prostatic Hyperlasia (Benign)
	Gastroesophageal reflux		Renal Disease (End Stage)
	Gaucher Disease		Scleroderma
	Hemophilia		Seizure Disorders
	Hepatitus		Sickle Cell Anemia
	HIV		Transplants
	High Blood Pressure		Uterine Conditions (Benign)

19. Which of these diseases/conditions/procedures are prime targets in your involvement?

20. How do you plan to coordinate medical claims, pharmacy and other sources of data to maximize the effectiveness of the wellness program?

21. Do your disease management programs take into consideration care for males versus females, age differences, etc.?

22. What specific services or programs do you offer towards age-recommended testing (i.e., PSA tests, mammograms, etc.)?

23. What kind of credentials are held by the persons who are going to provide the basic wellness/disease management services you are proposing; e.g., will they include nurses, doctors, etc.?

24. What supplemental support for non-covered services can you make available? Do you have wellness items/services that are automatically included as part of your program, such as fitness club memberships, Nutri-System, discount bicycle helmets, Jenny Craig, Weight Watchers, etc.

25. What local partnerships can you help develop, e.g., discounts at local gyms, YMCA, YWCA, etc.

MEDICAL CLAIMS ADMINISTRATOR STABILITY

Attach necessary explanations and/or deviations.

1. Provide your current financial rating from A.M. Best and your current Financial Outlook.

Rating Firm	Rating
A.M. Best	_____
Financial Outlook	_____

2. Are you rated by NCQA? What is your rating?

3. Is the insurer authorized to do business in Florida?

4. Does your proposed program comply with all applicable Federal and Florida Statutes regarding group insurance/self-insurance and PPOs, and will you assure future compliance?

5. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

6. What year did the insurer begin business in Florida?

7. How many employees does your company have?

8. How many employees does your company have in Florida?

9. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to the District and surrounding counties?

FSA ADMINISTRATOR STABILITY

Attach necessary explanations and/or deviations.

1. Is the administrator authorized to do business in Florida?

2. Does your proposed program comply with all applicable Federal and Florida Statutes regarding FSAs, and will you assure future compliance?

3. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

4. What year did the administrator begin business in Florida?

5. How many employees does your company have?

6. How many employees does your company have in Florida?

7. What comments can you offer in assurance of your financial stability and your long term commitment to the Florida market, especially with regard to District and surrounding Counties?

MEDICAL CLAIMS ADMINISTRATOR CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Number of Employees

    Please note: references must be specific to the proposed service.

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form.

The absence of any notation will be presumed to indicate full compliance.

Section	RFP Provisions	Will	Will Not
II	Minimum Qualifications of Proposer		
II	Insurance Requirements		
II	Late Proposals, Late Modifications and Late Withdrawals		
II	Costs Incurred by Proposers		
II	Proprietary Information		
II	Waiver/Rejection of Proposals		
II	Rules, Regulations and Licensing Requirement		
II	Records/Audit		
II	Investigation of Alleged Wrongdoings, Litigation/Settlement/Fines/Penalties		
II	Conduct of Proposers		
II	Conflict of Interest		
II	Legal Requirements		
II	Public Entity Crimes Statement		
II	Anti-Discrimination Clause		
II	Discriminatory Vendor's List		
II	Drug Free Workplace		
II	Use of Proposal Forms		
II	Irrevocability of Proposal		
II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		
III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
V	Contract Period		
V	Rate Guarantee Period		
V	Remuneration		
V	Access to Claim Files		
V	Ownership of Claim Data		
V	Audit Requirement		
V	Audit Report		
V	Eligibility & Enrollment		
V	Continuity of Coverage (No Loss/No Gain)		
V	Scope of Coverage		
V	Scope of Services		
V	Managed Care Services		
V	Administration Services		
V	Healthcare Reform Services		
V	Prescription Benefit Services		
V	Flexible Spending Account Administration		
V	Medical and Prescription Reporting and Data Services		
V	Performance Guarantees		

ADDITIONAL COMMENTS/DEVIATIONS

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

ACKNOWLEDGMENT OF RECEIPT OF ADDENDA

The Proposer hereby acknowledges receipt of the following addenda:

1. _____ 2. _____ 3. _____ 4. _____

CHECKLIST OF MATERIAL TO BE INCLUDED

The following material should be included as part of each of the completed responses to this RFP including: one (1) paper original and five (5) paper copies (total of six (6) paper proposals) and an electronic copy, either on CD or flash drive (with all documents in their original format: Word, Excel, etc.):

1. Completed Proposal Forms, and specimen contracts or policies as described in this RFP.

2. Acknowledgment of any addenda.

3. Specimen copy or samples of the following:

    a. Benefit booklets
    b. Benefits Match-Up a,b,c,d Exhibit 4– In Word format
    c. Network provider (and pharmacy directories)
    d. Most Utilized Providers Exhibit 5– In Excel format
    e. Explanation of Benefits Statement
    f. ID cards and claim forms
    g. Claims and exposure report samples

4. Descriptive literature on Utilization Management Services Program, Medical Case Management and Prescription Drug Program and FSA System/Capabilities.

5. Completion of financial ratings as outlined under "Medical and Prescription Insurer Stability" and "FSA Administrator Stability."

6. Information on experience and references as requested on Proposal Forms.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (administrator/insurer) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided on the firm's proposal on behalf of the firm, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the firm is in full compliance with the Minimum Qualifications of Proposer set forth in this RFP;

4. The firm authorizes the District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the firm offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

_____

Name of Firm

_____

Signature of Authorized Representative

_____

Printed Name of Authorized Representative

_____

Title of Authorized Representative

_____

Date Signed by Authorized Representative

CALHOUN COUNTY SCHOOL DISTRICT

Section X

Proposal Forms for Stop-Loss Insurance

SECTION X

CALHOUN COUNTY SCHOOL DISTRICT

STOP-LOSS INSURANCE

PROPOSAL FORMS

A. PROPOSER'S IDENTIFICATION

Name of Insurer: _____

FEIN/SS#: _____

Address: _____

_____

_____

Contact: _____

Telephone Numbers
Daytime/After Hours: _____

E-mail: _____

B. IF APPLICABLE – INSURANCE AGENCY(IES)/AGENT(S)

Name of Agent: _____

Address: _____

_____

_____

Contact: _____

Telephone Numbers
Daytime/After Hours: _____

E-mail: _____

NOTE: If an agent(s) is/are listed, the Agents proposal forms at the end of this document, Section XI - Agent/Broker Services must be completed by each of such agent(s).

STOP-LOSS COST INFORMATION

For the purpose of responding to these questions, the distribution of employees and dependents is to be proposed exactly as indicated. Complete the following chart with the rates/information for providing the stop-loss coverage.

Please complete the charts below based on the proposed coverage:

Unlimited Specific Coverage
Same as or as reasonably to:
Current Florida Blue Plan – BlueChoice 0727 PPO Medical Plan, including Rx

	Specific Stop-Loss		Aggregate Stop-Loss	
Limit of Liability Per Covered Unit	Unlimited		$1,000,000	
Retention (Deductible)	$45,000		125% of expected claims	
Basis	Paid		Paid	
Reimbursement Factor	100%		100%	
Monthly Premium Per Covered Unit	EE Only 65	EE + Family 11	EE Only 65	EE + Family 11
Composite Rate	$		$	
Single/Family Rate	$	$	$	$
Annual Premium	$		$	
Expected Annual Claims	N/A		$	
Aggregate Attachment Point	N/A		$	

Unlimited Specific Coverage
Same as or as reasonably to:
Current Florida Blue Plan – BlueChoice 03359 PPO Medical Plan, including Rx

	Specific Stop-Loss		Aggregate Stop-Loss	
Limit of Liability Per Covered Unit	Unlimited		$1,000,000	
Retention (Deductible)	$45,000		125% of expected claims	
Basis	Paid		Paid	
Reimbursement Factor	100%		100%	
Monthly Premium Per Covered Unit	EE Only 60	EE + Family 23	EE Only 60	EE + Family 23
Composite Rate	$		$	

Single/Family Rate	$	$	$	$
Annual Premium	$		$	
Expected Annual Claims	N/A		$	
Aggregate Attachment Point	N/A		$	

Unlimited Specific Coverage
Same as or as reasonably to:
Current Florida Blue Plan – BlueChoice 0117 PPO Medical Plan, including Rx

	Specific Stop-Loss		Aggregate Stop-Loss	
Limit of Liability Per Covered Unit	Unlimited		$1,000,000	
Retention (Deductible)	$45,000		125% of expected claims	
Basis	Paid		Paid	
Reimbursement Factor	100%		100%	
Monthly Premium Per Covered Unit	EE Only 15	EE + Family 4	EE Only 15	EE + Family 4
Composite Rate	$		$	
Single/Family Rate	$	$	$	$
Annual Premium	$		$	
Expected Annual Claims	N/A		$	
Aggregate Attachment Point	N/A		$	

Unlimited Specific Coverage
Same as or as reasonably to:
Current Florida Blue Plan – BlueChoice 05901 PPO Medical Plan, including Rx

	Specific Stop-Loss		Aggregate Stop-Loss	
Limit of Liability Per Covered Unit	Unlimited		$1,000,000	
Retention (Deductible)	$45,000		125% of expected claims	
Basis	Paid		Paid	
Reimbursement Factor	100%		100%	
Monthly Premium Per Covered Unit	EE Only 74	EE + Family 30	EE Only 74	EE + Family 30
Composite Rate	$		$	
Single/Family Rate	$	$	$	$
Annual Premium	$		$	
Expected Annual Claims	N/A		$	
Aggregate Attachment Point	N/A		$	

STOP-LOSS COST QUESTIONS

1. When the specific cap is reached, when will the District receive reimbursement?
    a) Monthly
    b) End of Calendar Year
    c) End of Contract/Plan Year
    d) Other (explain)

2. Recite the policy wording for the definition of experimental procedure and indicate specifically what is not covered.

3. Does the aggregate contract include a monthly advance feature? If so, please describe.

4. Is an intermediary or Managing General Underwriter (MGU) utilized in connection with this proposal? If so, please provide details.

5. Are rates subject to change at final underwriting? If Yes, specify conditions.

6. Please provide a complete copy of the assumptions used in this proposal.

7. Is agent/broker remuneration included in your fees or rates?

8. Please state the amount of remuneration.

9. Also, provide an estimate of the annual remuneration payable.

STOP-LOSS COVERAGE QUESTIONS

1. Is the coverage separable from your administration proposal?

2. Which medical provider network(s) does your stop-loss proposal assume?

3. Which pharmacy provider network(s) does your stop-loss proposal assume?

4. Is coverage based on the current benefits described in the Exhibits? If not, please describe.

5. Is the coverage on a Paid basis? If not, explain the basis on which the coverage is proposed. If a broader coverage basis is available, please describe.

6. Describe the aggregate coverage proposed.

7. Please confirm that transplants and prescription drugs are covered.

8. Are the costs of clinical trials included in the coverage?

STOP-LOSS SERVICE INFORMATION

1. Indicate the location of the office that will service this account, as well as the name of the account representative.

2. Who will be responsible for filing the medical and prescription claims?

3. Describe the process for filing claims and the accounting and reconciliation of claims.

4. Where is the servicing facility located?

5. Are you offering any specialized services as part of your proposal that you consider unique or different to your competitors?

6. Can you provide a quarterly report of claims nearing eligibility for specific coverage?

STOP-LOSS INSURER STABILITY

1. Is the stop-loss insurer authorized to do business in Florida?

2. Briefly describe your organization and its history, number of years of providing services, legal structure, and ownership.

5. What is your current A.M. Best financial rating and financial outlook?

STOP-LOSS CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form.
The absence of any notation will be presumed to indicate full compliance.

Section	RFP Provisions	Will	Will Not
II	Minimum Qualifications of Proposer		
II	Insurance Requirements		
II	Late Proposals, Late Modifications and Late Withdrawals		
II	Costs Incurred by Proposers		
II	Proprietary Information		
II	Waiver/Rejection of Proposals		
II	Rules, Regulations and Licensing Requirement		
II	Records/Audit		
II	Investigation of Alleged Wrongdoings, Litigation/Settlement/Fines/Penalties		
II	Conduct of Proposers		
II	Conflict of Interest		
II	Legal Requirements		
II	Public Entity Crimes Statement		
II	Anti-Discrimination Clause		
II	Discriminatory Vendor's List		
II	Drug Free Workplace		
II	Use of Proposal Forms		
II	Irrevocability of Proposal		
II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		
III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
VI	Contract Period		
VI	Rate Guarantee Period		
VI	Remuneration		
VI	Ownership of Claim Data		
VI	Eligibility & Enrollment		
VI	Continuity of Coverage (No Loss/No Gain)		
VI	Scope of Coverage		
VI	Account Management		

ADDITIONAL COMMENTS/DEVIATIONS FROM MODEL PROGRAM

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (insurer) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided on the insurer's proposal on behalf of the insurer, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the insurer is in full compliance with the Minimum Qualifications of Proposer set forth in this RFP;

4. The insurer authorizes the District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the insurer offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

_____
Name of Firm/Insurer

_____
Signature of Authorized Representative

_____
Printed Name of Authorized Representative

_____
Title of Authorized Representative

_____
Date Signed by Authorized Representative

CALHOUN COUNTY SCHOOL DISTRICT

Section XI

Proposal Forms for Agent/Broker Services

SECTION XI

CALHOUN COUNTY SCHOOL DISTRICT

AGENT/BROKER SERVICES

PROPOSAL FORMS

For agents who are not employees of the insurance company proposed.

AGENT IDENTIFICATION

Agent Account Representative: _____

Agent's Firm: _____

FEIN/SS#: _____

Address: _____

_____

_____

Telephone Numbers

Daytime: _____

After Hours: _____

E-mail: _____

COST INFORMATION

Indicate the amount of remuneration you anticipate receiving for:

Coverage/Service	Method of Remuneration	Each Year
Fully Insured Medical Insurance		$
Medical Claims Administration		$
Stop-Loss Insurance		$

1. Is the above amount subject to a minimum and/or maximum? Explain.

2. State any remuneration guarantees for subsequent years if the District should accept your proposal for the first year.

3. Do you agree to full disclosure of all remuneration, whether in the form of commission or fees or other?

4. Are you willing to negotiate services and remuneration?

5. The District currently utilizes Gallagher Benefit Services. Do you understand that if the District chooses you and your firm to supplement the services automatically provided by the successful insurer that the District reserves the right to determine if it will continue your services for a second and/or subsequent year(s) subject to the District's option to return to utilization of the insurer's employee/agent?

Insurers may also quote on a "direct" basis through an employee agent.

The District assumes that some insurers who propose medical benefits will permit more than one independent insurance agent to represent them, subject to the District's choice of which one, if the District should want an independent insurance agent. However, the District will limit its selection to only those agents designated by such insurers in their proposals.

Medical insurers are encouraged to provide proposals for their benefit plans "net" of independent agent remuneration. The District will review agent remuneration separate from medical proposals.

Proposing agents are expected to explain the full extent of services to be provided to the District for the remuneration paid.

SERVICE INFORMATION

Background information should be furnished on proposing agents and/or other key agency personnel that will service the District.

1. Briefly describe your organization and its history, number of years of providing services, legal structure, ownership and personnel. Such information should include size of agency, experience in providing insurance for public entities, personnel and qualifications (particularly of the agent who will serve the District).

2. Where is your office located?

   a. If not local, can the District contact your office by a toll-free number?

      Yes____ No____

   b. Indicate the name of the individual that will service this account.

   c. Provide details on the service(s) your firm would provide to the District.

3. If selected by the District, do you agree to provide the services to the District that are listed in the Scope of Services in the Model Program for Agent Services in the RFP? If not, please explain which services you are unable or unwilling to provide.

4. If you are the proposing agent on the medical claims administration services, do you agree to provide the following services to the District, including, but not limited to:

   a. Provide assistance with elevated claims issues?
   b. Provide enrollment assistance, including attending enrollment meetings?
   c. Provide renewal assistance?
   d. Provide assistance with any disputes arising between the Plan Sponsor and the selected claims administrator?
   e. Attend regular meetings with staff/committee?

   Explain any deviations.

5. If you are the proposing agent on the stop-loss coverage, do you agree to provide the following services to the District, including, but not limited to:

   a. Provide assistance with stop-loss claim filing?
   b. Provide renewal assistance to include stop-loss negotiations?
   c. Provide assistance with any disputes arising between the Plan Sponsor and the selected stop-loss carrier?

   Explain any deviations.

6. In addition, if you are the proposing agent on the stop-loss coverage, explain in detail the process for filing claims, who files claims and the accounting and reconciliation of claims.

7. Identify below any additional information about your proposal that the District should consider (attach and identify additional pages as necessary).

WELLNESS/DISEASE MANAGEMENT

The District is interested in all Wellness and Disease Management services offered by proposers. Please provide details in your proposal of all current program offerings you can provide as an agent/agency including, if applicable, any additional cost.

The District is interested in proactive wellness and disease management initiatives, including participation incentives, including but not limited to health screenings, flu shot programs, health risk assessments and health fairs. Proposals should detail the support staff and other assistance that will be provided.

1. Have you indicated (provide an attachment if appropriate) the extent to which you proactively and/or automatically involve yourself with wellness and disease management and similar services?

2. Please describe the wellness initiatives/services you will provide for the District.

CLIENT REFERENCES

1. Indicate the number of currently contracted employers in the State of Florida.

2. Indicate the number of currently contracted public-sector employers in the State of Florida.

3. List a minimum of four (4) current clients with similar size and/or industry as the District with the following information:

    - Client Name
    - Contact Name and Title
    - Address
    - Phone and Fax
    - Email Address
    - Length of Client Relationship
    - State if a current or past client
    - Insurance Services Provided
    - Number of Employees

Please note: references must be specific to the proposed coverage(s) and/or service(s).

DEVIATIONS FROM MODEL PROGRAM

Indicate whether your proposal will or will not comply with the RFP with respect to the coverage, service or provision listed below. All endorsements set forth in the RFP are to be included VERBATIM in the contract unless indicated to the contrary on the Proposal Form. The absence of any notation will be presumed to indicate full compliance.

Section	RFP Provisions	Will	Will Not
II	Minimum Qualifications of Proposer		
II	Insurance Requirements		
II	Late Proposals, Late Modifications and Late Withdrawals		
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II	Rules, Regulations and Licensing Requirement		
II	Records/Audit		
II	Investigation of Alleged Wrongdoings, Litigation/Settlement/Fines/Penalties		
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II	Conflict of Interest		
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II	Discriminatory Vendor's List		
II	Drug Free Workplace		
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II	Irrevocability of Proposal		
II	Contract Awards		
II	Agent/Broker Services		
II	Agent of Record		
II	Deviations from Model Program		
III	Prohibition of Warranty Endorsement		
III	Sole Agent Endorsement		
III	Hold Harmless/Indemnification Provision		
III	Termination and Non-Renewal Endorsement		
III	Rerating Endorsement		
VII	Contract Period		
VI	Scope of Services		
VI	Remuneration		

ADDITIONAL COMMENTS/DEVIATIONS FROM MODEL PROGRAM

If your proposal does not fully comply with any provision, condition or requirement in this RFP, explain fully (*attach and identify additional pages as necessary*) the alternative provision, condition or requirement proposed.

ACKNOWLEDGMENT OF RECEIPT OF ADDENDA

The Proposer hereby acknowledges receipt of the following addenda:

1. _____ 2. _____ 3. _____ 4. _____

CHECKLIST OF MATERIAL TO BE INCLUDED

The following material should be included as part of each of the completed responses to this RFP including: one (1) original, six (6) hard copies, and an electronic copy (pdf, either CD or Thumb Drive) of each proposal:

1. Completed Proposal Forms, and specimen contracts or policies as described in this RFP.

2. Acknowledgment of any addenda.

3. Information on experience and references as requested on Proposal Forms.

PROPOSER'S WARRANTY

The undersigned person, by the undersigned's signature affixed hereon, warrants that:

1. The undersigned is an officer, partner or a sole proprietor of the firm (proposer) and the enclosed proposal is submitted on behalf of the firm;

2. The undersigned has carefully reviewed all the materials and data provided in the proposer's proposal on behalf of the proposer, and, after specific inquiry, believes all the material and data to be true and correct;

3. The proposal offered by the proposer is in full compliance with the Minimum Qualifications of Proposer set forth in this RFP;

4. The proposer authorizes the District, its staff or consultants to contact any of the references provided in the proposal and specifically authorizes such references to release either orally or in writing any appropriate data with respect to the insurer offering this proposal;

5. The undersigned has been specifically authorized to issue a contract in full compliance with all requirements and conditions, as set forth in this RFP, other than those deviations noted above;

6. If this proposal is accepted, the contract will be issued as proposed.

_____

Name of Firm/Insurer

_____

Signature of Authorized Representative

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Printed Name of Authorized Representative

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Title of Authorized Representative

_____

Date Signed by Authorized Representative

CALHOUN COUNTY SCHOOL DISTRICT

Section XII

Exposure, Loss Data, and Contract Provisions

SECTION XII

EXPOSURE, LOSS DATA AND CONTRACT PROVISIONS

SOURCE OF INFORMATION

The Calhoun County School District and current vendors and carriers supplied all data and statistical information. In some instances, data was retyped for clarity. If there are omissions, additional data is not readily available.

Exhibit 1 – Historical Plan Information

Exhibit 2 – Historical Plan Rates for 2017

Exhibit 3 – Medical Experience Reports

Exhibit 4 – Benefits Match-Up – a,b,c,d (In Word format) – Please email Laura Rybka at Siver Insurance Consultants (lrybka@siver.com) for this exhibit in Word format

Exhibit 5 – Most Utilized Provider Comparison Match-Up (In Excel format)

Exhibit 6 – Medical Census (In Excel format)

Exhibit 7 – Benefits Summary – 2017-2018

Exhibit 8 – Additional Plan Claim Detail

Exhibit 1

Historical Plan Information

BlueChoice

Schedule of Benefits

Covered Plan Participants should carefully review this Schedule of Benefits, which is part of the Evidence of Coverage, to be aware of important information concerning the Covered Plan Participant's share of the expenses for Covered Services. The Covered Plan Participant's share of the expenses, including any applicable Deductibles and Coinsurance responsibilities, **will vary** depending upon the Provider the Covered Plan Participant chooses and the setting in which the Services are rendered. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

Benefit Period (BP) ..... 01/01 – 12/31

Deductible and Coinsurance Amounts

Benefit Description	PPO	Providers Not Participating in PPO
Individual Deductible (DED) per BP	$500	
Family Deductible (DED) per BP	$1,000	
Hospital Per Admission Deductible (PAD)	$0 In addition to the DED and applicable Coinsurance	$0 In addition to the DED and applicable *Coinsurance
Emergency Room Per Visit Deductible (PVD)	$0	$0
Amount Payable by the Plan	80% of the Allowed Amount	60% of the Allowed Amount
Amount Payable by the Plan for Ambulance Services	80% of the Allowed Amount after PPO DED	
Amount Payable by the Plan for Mammograms	100% of the Allowed Amount	100% of the Allowed Amount
Individual Out-of-Pocket Maximum per BP	$2,000	
Family Out-of-Pocket Maximum per BP	$4,000	
Note: Out-of-Pocket Maximums do not include any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount.		

*If an Insured is admitted to a Hospital that is not a PPO Participating Provider as an inpatient at the time of the emergency room visit to the same facility, the Deductible applicable to Providers not Participating in PPO and the PPO Coinsurance will apply to that admission.

Office Services

Benefit Description	PPO	Providers Not Participating in PPO
Office Services Rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine, and Pediatrics	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Office Services Rendered by: 1. Physicians other than Family Physicians; and 2. Other health care professionals licensed to perform such services	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Allergy Injections	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Durable Medical Equipment, Prosthetics and Orthotics	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
E-visit 1. Rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine, and Pediatrics	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
2. Rendered by Physicians other than Family Physicians and other health care professionals licensed to perform such Services	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Urgent Care	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED
*These Services are subject to the Copayment only.		
Note: A Covered Plan Participant should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, a Covered Plan Participant may access the PPO Provider directory on our website at www.floridablue.com or contact the local BCBSF office.		

Medical Pharmacy

Benefit Description	PPO	Providers Not Participating in PPO
Medical Pharmacy Services - Prescription Drugs administered by:		
1. Family Physicians	80% of the Allowed Amount	50% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	80% of the Allowed Amount	50% of the Allowed Amount after DED
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to the Evidence of Coverage for a description of Medical Pharmacy.		
Medical Pharmacy Out-of-Pocket Maximum per Covered Plan Participant per Month	$200	Not Applicable

Preventive Health Services

Benefit Description	PPO	Providers Not Participating in PPO
Adult Wellness Services		
1. Physician Office		
a. Family Physicians (Family Practice, General Practice, Internal Medicine, and Pediatrics)	100% of the Allowed Amount	60% of the Allowed Amount
b. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	100% of the Allowed Amount	60% of the Allowed Amount
2. All other Locations	100% of the Allowed Amount	60% of the Allowed Amount
Adult Well Woman Services		
1. Physician Office		
a) Family Physicians (Family Practice, General Practice, Internal Medicine, and Pediatrics)	100% of the Allowed Amount	60% of the Allowed Amount
b) Physicians other than Family Physicians and other health care professionals licensed to perform such Services	100% of the Allowed Amount	60% of the Allowed Amount
2. All other Locations	100% of the Allowed Amount	60% of the Allowed Amount
Well Child Services		
1. Physician Office		
a. Family Physicians (Family Practice, General Practice, Internal Medicine, and Pediatrics)	100% of the Allowed Amount	60% of the Allowed Amount
b. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	100% of the Allowed Amount	60% of the Allowed Amount
2. All other Locations	100% of the Allowed Amount	60% of the Allowed Amount

Benefit Description	PPO	Providers Not Participating in PPO
Mammograms	100% of the Allowed Amount	100% of the Allowed Amount
Routine Colonoscopy	100% of the Allowed Amount	60% of the Allowed Amount

Behavioral Health Services

Benefit Description	PPO	Providers Not Participating in PPO
Mental Health and Substance Dependency Care and Treatment Services		
Outpatient Facility Services rendered at:		
1. Emergency Room	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED
2. Hospital	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
3. Physician Services at Hospital and ER	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED t
Physician and other health care professionals licensed to perform such Services rendered at:		
1. Family Physicians Office	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
2. Specialist Office	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
3. All other locations	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Inpatient		
1. Facility Services	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
2. Physician and other health care professionals licensed to perform such Services	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED

Other Services

Benefit Description	PPO	Providers Not Participating in PPO
Emergency Room Facility	80% of the Allowed Amount after DED and applicable PVD	80% of the Allowed Amount after DED and applicable PVD
Physician Services at Hospital and ER	80% of the Allowed Amount after DED	80% of the Allowed Amount after DED
Home Health Care	100% of the Allowed Amount	100% of the Allowed Amount
Hospice	100% of the Allowed Amount	100% of the Allowed Amount
Radiologist, Pathologist and Anesthesiologist Provider Services at Hospital or Ambulatory Surgical Center	80% of the Allowed Amount after DED	60% of the Allowed Amount after DED
Skilled Nursing Facility	100% of the Allowed Amount	100% of the Allowed Amount

Benefit Maximums

Home Health Care visits per Covered Plan Participant per BP 58

Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations visits (combined) per Covered Plan Participant per BP 75

Note: Refer to the Evidence of Coverage for reimbursement guidelines.

Skilled Nursing Facility Days per Covered Plan Participant per BP 120

Note: If immediately before the Effective Date of the Group, a Cover Plan Participant was covered under a prior group policy issued by BCBSF to the Group, amounts applied to a Covered Plan Participant's Benefit Period maximums under the prior BCBSF policy, will be applied toward the Covered Plan Participant's Benefit Period maximums under the Evidence of Coverage.

Additional Benefits

4th Quarter Deductible Carry-over

Any charges credited by BCBSF toward an Insured's Individual DED for claims for Covered Services incurred during the last three months of the prior Benefit Period will be carried over to reduce the Insured's Individual DED requirement for the current Benefit Period.

Prescription Drug Program

The Group purchased optional pharmacy coverage from BCBSF. Please refer to the pharmacy program Endorsement issued to the Group.

BlueScript® Pharmacy Program

Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the BlueScript Pharmacy Program Endorsement, both of which should be reviewed carefully. To verify if a Pharmacy is a Participating Pharmacy, the Covered Plan Participant may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service phone number on the Identification Card. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

	Participating Pharmacy	**Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased at: Retail Pharmacy – For up to a One-Month Supply	$5	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$5	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$10	50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$30	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$30	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$60	50% of the Non-Participating Pharmacy Allowance

	Participating Pharmacy	Non-Participating Pharmacy
Non-Preferred Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$60	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$60	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$120	50% of the Non-Participating Pharmacy Allowance

Other Important Information affecting what you will pay:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

     Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request.

  2. Diaphragms indicated as covered in the Medication Guide; and
  3. Emergency contraceptives indicated as covered in the Medication Guide.

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

  1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**
  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

- The Specialty Pharmacies designated, solely by us, are the only “In-Network” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes under this BlueScript Pharmacy Program.
- Some Specialty medications may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

BlueOptions

Schedule of Benefits – Plan 03359

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period..... **01/01 – 12/31**

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period	$1,000	$2,000
Per Family per Benefit Period	$3,000	$6,000
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	20%	40%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$3,000	$5,000
Per Family per Benefit Period	$6,000	$10,000

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office visits and Services not otherwise outlined in this table rendered by		
Family Physicians	$25	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	$125	DED + 40%
Other health care professionals licensed to perform such Services	$125	DED + 40%
Allergy Injections rendered by		
Family Physicians	$10	DED + 40%
Other health care professionals licensed to perform such Services	DED + 20%	DED + 40%
E-Visits rendered by		
Family Physicians	$10	DED + 40%
Other health care professionals licensed to perform such Services	$10	DED + 40%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 20%	DED + 40%
Convenient Care Centers	$25	DED + 40%

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by: Family Physicians	20%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	20%	DED + 50%
Out-of-Pocket Maximum per Person per Month	$200	Not Applicable
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services Rendered by Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Adult Well Woman Services Rendered by Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Child Health Supervision Services Rendered by Family Physicians	$0	40%
Other health care professionals licensed to perform such Services	$0	40%
All other locations	$0	40%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 40%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$125	DED + 40%
All other diagnostic Services (e.g., X-rays)	$50	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 20%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 20%	DED + 20%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Facility (per visit)	$100	DED + 40%
Radiologists, Anesthesiologists, and Pathologists	DED + 20%	In-Network DED + 20%
Other health care professional Services rendered by all other Providers	DED + 20%	DED + 40%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient			
Facility Services (per admission)	$750	$1,000	**DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Outpatient			
Facility (per visit)	$150	$250	DED + 40%
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%
Therapy Services	$45	$60	DED + 40%
Emergency Room Visits			
Facility	$200 (Copayment waived if admitted)		$200
Physician and other health care professional Services	DED + 20%		In-Network DED + 20%

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

**If you are admitted to an Out-of-Network Hospital as an inpatient at the time of the emergency room visit to the same facility the Out-of-Network Deductible and Emergency Room Copayment will apply to that admission.

Important:

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room physicians. This Plan will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Treatment Services Outpatient Facility Services rendered at: Emergency Room (Per Visit Deductible) (PVD)	$50 PVD + $100	$50 PVD + $100
Hospital a) Option 1	$150	DED + 40%
Option 2 and Out-of-State BlueCard® Participating	$250	DED + 40%
Physician Services at Hospital and ER	DED + 20%	In-Network DED + 20%
Physician and other health care professionals licensed to perform such Services Family Physician office	$25	DED + 40%
Specialist office	DED + 20%	DED + 40%
All other locations	DED + 20%	DED + 40%
Inpatient Facility Services a) Option 1	$750	DED + 40%
b) Option 2 and Out-of-State BlueCard® Participating	$1,000	DED + 40%
Physician and other health care professionals licensed to perform such Services	DED + 20%	In-Network DED + 20%

Benefit Maximums

Home Health Care Visits per Benefit Period..... 20

Inpatient Rehabilitation days per Benefit Period..... 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... 35

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility days per Benefit Period..... 60

Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.

Prescription Drug Program

Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.

BlueOptions

Florida Blue

For Large Groups
Predictable Cost Health Benefit Plan 03359

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Financial Features		
Deductible (DED[1]) (PBP[2]) (DED is the amount the member is responsible for before Florida Blue pays)	$1,000 per person $3,000 per family	$2,000 per person $6,000 per family
Coinsurance (Coinsurance is the percentage the member pays for services)	20% of the allowed amount	40% of the allowed amount
Out-of-Pocket Maximum (PBP) (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$3,000 per person $6,000 per family	$5,000 per person $10,000 per family
Office Services		
Physician Office Services Primary Care Physician Specialist Convenient Care	 $25 Copay 20% after Deductible $25 Copay	 40% after Deductible 40% after Deductible 40% after Deductible
Maternity (Cost Share for initial visit only) Primary Care Physician Specialist	 $25 Copay 20% after Deductible	 40% after Deductible 40% after Deductible
Allergy Injections (per visit) Primary Care Physician Specialist	 $10 Copay 20% after Deductible	 40% after Deductible 40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$125 Copay	40% after Deductible
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors) In-Network Monthly Out-of-Pocket (OOP) Maximum[3] Provider	 $200 20%	 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	40%
Mammograms	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	$0	$0
Emergency Medical Care		
Urgent Care Centers	20% after Deductible	20% after Deductible
Emergency Room Facility Services (per visit) (copayment waived if admitted)	$200 Copay	$200 Copay[4]
Ambulance Services	20% after Deductible	20% after In-Network Deductible

[1] DED = Deductible

[2] PBP = Per Benefit Period

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

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

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

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For Large Groups
Predictable Cost Health Benefit Plan 03359

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Out-of-Network
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services)		
Diagnostic Services (except AIS)	$50 Copay	40% after Deductible
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	$125 Copay	40% after Deductible
Independent Clinical Lab (e.g., Blood Work)	$0	40% after Deductible
Outpatient Hospital Facility Services (per visit) (e.g., Blood Work and X-rays)		
Option 1	$150 Copay	40% after Deductible
Option 2	$250 Copay	40% after Deductible
Hospital / Surgical		
Ambulatory Surgical Center Facility (ASC)	$100 Copay	40% after Deductible
Outpatient Hospital Facility Services (per visit)		
Therapy Services Option 1	$45 Copay	40% after Deductible
Option 2	$60 Copay	40% after Deductible
All other Services Option 1	$150 Copay	40% after Deductible
Option 2	$250 Copay	40% after Deductible
Inpatient Hospital Facility and Rehabilitation Services (per admit)		
Option 1	$750 Copay	40% after Deductible[4]
Option 2	$1,000 Copay	40% after Deductible[4]
Mental Health / Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)	$750 Copay	40% after Deductible[4]
Option 1 and Option 2	$1,000 Copay	40% after Deductible[4]
Outpatient Hospitalization Facility Service (per visit)	$150 Copay	40% after Deductible
Option 1 and Option 2	$250 Copay	40% after Deductible
Emergency Room Facility Services (per visit)	$50 PVD DED + $100 Copay	$50 PVD DED + $100 Copay
Provider Services at Hospital and ER	20% after Deductible	20% after In-Network Deductible
Primary Care Physician / Specialist		
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Outpatient Office Visit	$25 Copay	40% after Deductible
Primary Care Physician / Specialist	20% after Deductible	40% after Deductible
Other Provider Services		
Provider Services at Hospital and ER	20% after Deductible	20% after In-Network Deductible
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	20% after Deductible	20% after In-Network Deductible
Provider Services at Locations other than Office, Hospital and ER		
Primary Care Physician	20% after Deductible	40% after Deductible
Specialist	20% after Deductible	40% after Deductible
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations		
Outpatient Rehabilitation Therapy Center	20% after Deductible	40% after Deductible
Outpatient Hospital Facility Services (per visit) Option 1	$45 Copay	40% after Deductible
Option 2	$60 Copay	40% after Deductible

BlueOptions

For Large Groups
Predictable Cost Health Benefit Plan 03359

Summary of Benefits for Covered Services	Amount Member Pays In-Network	Amount Member Pays Out-of-Network
Other Special Services (continued)		
Durable Medical Equipment, Prosthetics and Orthotics	20% after Deductible	40% after Deductible
Home Health Care	20% after Deductible	40% after Deductible
Skilled Nursing Facility	20% after Deductible	40% after Deductible
Hospice	20% after Deductible	40% 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.**

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida Blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueScript Pharmacy Benefits - $10/$30/$60

For BlueOptions Plans (Mail Order Available)

The BlueOptions® health benefit plan your employer is offering you is paired with our BlueScript® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain prescription drugs at a location convenient to you.

You may also be able to receive more savings on prescription drugs by purchasing your drugs through the mail order program.

See below for your specific plan details.

	In-Network	Out-of-Network	Mail Order* (90 days)
Pharmacy Deductible	$0		
Preferred Generic Prescription Drugs	$10	50%	$20
Preferred Brand Name Prescription Drugs	$30	50%	$60
Non-Preferred Prescription Drugs	$60	50%	$120
Oral Chemotherapy Drugs	$10	50%	$25

*Specialty drugs are not available through mail order.

Advantages of our Pharmacy Program

With our BlueScript Pharmacy Program, you'll receive coverage for Preferred Generic, Preferred Brand Name, and Non-Preferred Prescription Drugs, as well as self-administered injectables and specialty medications. You have easy access to Participating Pharmacies throughout Florida and to National Network Pharmacies with over 60,000 locations.

Save When Purchasing Your Prescription Drugs

You can reduce your out-of-pocket costs by purchasing Covered Prescription Drugs listed on our Preferred Mediation List. These prescription drugs should cost you less than prescription drugs not on the list.

Generic Prescription Drugs

You pay a lower cost for Generic Prescription Drugs that appear on the Preferred Medication List. If you request a Brand Name Prescription Drug when a Generic is available, you will be responsible for:

1. The copayment applicable to Brand Name Prescription Drugs; and
2. The difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated on the BlueOptions pharmacy Program Schedule of Benefits.

More Convenient Than Ever

Take your prescriptions to a participating pharmacy to have them filled. Or, if you are taking a prescription medication on an ongoing basis, you have a couple of convenient options:

1. Your doctor can prescribe a 3-month supply and you can have it filled at select participating retail pharmacies. A 3-month out-of-pocket cost (copay, coinsurance, and/or deductible) applies.
2. For additional savings, fill prescriptions via our mail order program. This program allows covered members taking prescription drugs to receive up to a 3-month supply for one Mail Order Copayment, after Pharmacy Deductible, if applicable. Prescription drugs ordered through this program are provided by Prime Therapeutics'® mail order facility, PrimeMail®.

Contraceptive Coverage

Generic oral contraceptives and diaphragms are covered under your pharmacy benefit and are available at no cost to you. These contraceptives must be prescribed and obtained by a participating pharmacy.

Diabetic Supplies

Diabetic supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/or syringes and needles are covered under your pharmacy benefit. Diabetic supplies require a prescription and can be obtained from a participating pharmacy.

Medication Guide

The Preferred Medication List, which is part of the Medication Guide, is available online at floridablue.com. Changes in the formulary can occur over time and the most up-to-date listing can always be found by viewing the Medication Guide online or by calling the customer service number listed on your member ID card. For the hearing impaired, call Florida TTY Relay Services 711. The Medication Guide also identifies specialty drugs, and drugs requiring prior authorization. When reviewing the Preferred Medication List with

your doctor, ask your provider to consider a prescription drug from the Preferred Medication List, particularly a Preferred Generic Prescription Drug.

Pharmacy Options Affect Your Out-of-Pocket
There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled—retail pharmacies and specialty pharmacies. To save the most money, before you get a prescription filled you should confirm which pharmacy is considered 'in-network' for that particular medication.

- **Retail Pharmacy Network**
  Non-specialty 'Generic' medications and 'Brand Name' medications listed on the Medication Guide can be filled at these pharmacies at a lower cost to you than other pharmacies in your area. If you go to a non-participating pharmacy, your prescription will cost you more.
- **Specialty Pharmacy Network**
  We have identified certain drugs as 'specialty drugs' due to requirements such as special handling, storage, training, distribution, and management of the therapy. These drugs are listed as a 'Specialty Drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy. These pharmacies are different than the retail pharmacies and are identified in both the Provider Directory and the Medication Guide. Using an in-network Specialty Pharmacy to provide these Specialty Drugs lowers the amount you pay for these medications.
- **Non-Participating Pharmacy**
  Choosing a non-participating pharmacy will cost you more money. You may have to pay the full cost of the medication and then file a claim to be reimbursed. Our payment will be based on our Non-Participating Pharmacy Allowance minus your deductible and/or coinsurance. You will be responsible for the deductible and/or coinsurance and the difference between our allowance and the cost of the medication.
- **The National Pharmacy Network**
  The National Pharmacy Network includes more than 50,000 chain and Independent Pharmacies across the United States. The National Network Pharmacies are available to our members traveling or residing outside of Florida. Simply present your member ID card at time of purchase.

Utilization Management/Responsible Rx Programs

Prior Coverage Authorization
Drugs selected for Prior Coverage Authorization (PA) may require that specific clinical criteria be met before the drugs will be covered under your pharmacy benefit. The list of drugs requiring Prior Authorization is located in the Medication Guide and are designated with a "PA" following the product name. Florida Blue reserves the right to change the drugs that require PA at any time and for any reason.

Responsible Quantity
Drugs included in this program allow a maximum quantity per time period. Quantity limits are typically developed based upon FDA-approved drug labeling and nationally recognized therapeutic clinical guidelines. The list of drugs that have quantity limits are designated in the Formulary List with a "QL" following the product name. Florida Blue reserves the right to change the Drugs and the quantity limits subject to the Responsible Quantity Program at any time and for any reason. In cases where a larger quantity of a Responsible Quantity Drug is medically required, your doctor or health care provider can request an override. Responsible Quantity override forms are available at floridablue.com.

Responsible Steps
Drugs included in this program require that you try another designated prerequisite drug first before a drug listed in the Responsible Steps Medication Chart will be covered If due to medical reasons you cannot use the prerequisite drug and require the Responsible Steps Medication, your doctor or health care provider may request prior authorization for an override. If the override request is approved, coverage will be provided for the Responsible Steps Medication. These medications are designated in the Formulary List with "RS" following the product name. Medications included in the Responsible Steps Program are listed in the Medication Guide. Florida Blue reserves the right to change the drugs subject to the Responsible Steps Program at any time and for any reason.

Drugs that are Not Covered
Your Pharmacy benefit may not cover select medications. The Medication Guide contains a list of non-covered drugs. Some reasons a medication may not be covered are:

- The drug has been shown to have excessive adverse effects and/or safer alternatives are available.
- The drug has a preferred formulary alternative.

Prescription Discounts
With the BlueSaver® prescription savings card program, you will receive special discounted pricing on non-covered prescription medications when you show your BlueSaver ID card at select participating pharmacies. This card provides savings for you or any of your covered family members on medications that are not covered under your BlueScript pharmacy benefit. The BlueSaver savings program is not an insurance product or part of your health benefit plan.

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BlueChoice

Schedule of Benefits

Covered Plan Participants should carefully review this Schedule of Benefits, which is part of the Evidence of Coverage, to be aware of important information concerning the Covered Plan Participant's share of the expenses for Covered Services. The Covered Plan Participant's share of the expenses, including any applicable Deductibles and Coinsurance responsibilities, **will vary** depending upon the Provider the Covered Plan Participant chooses and the setting in which the Services are rendered. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

Benefit Period (BP) ..... 01/01 – 12/31

Deductible and Coinsurance Amounts

Benefit Description	PPO	Providers Not Participating in PPO
Individual Deductible (DED) per BP	$1,500	
Family Deductible (DED) per BP	$4,500	
Hospital Per Admission Deductible (PAD)	$150 In addition to the DED and applicable Coinsurance	$300 In addition to the DED and applicable *Coinsurance
Emergency Room Per Visit Deductible (PVD)	$50 In addition to the DED and applicable Coinsurance	$50 In addition to the DED and PPO Coinsurance
Amount Payable by the Plan	70% of the Allowed Amount	50% of the Allowed Amount
Amount Payable by the Plan for Ambulance Services	70% of the Allowed Amount after PPO DED	
Amount Payable by the Plan for Mammograms	100% of the Allowed AmountDED waived	100% of the Allowed Amount DED waived
Individual Out-of-Pocket Maximum per BP	$5,000	
Family Out-of-Pocket Maximum per BP	$13,200	
Note: Out-of-Pocket Maximums do not include any benefit penalty reductions, non-covered charges or any charges in excess of the Allowed Amount.		

*If an Insured is admitted to a Hospital that is not a PPO Participating Provider as an inpatient at the time of the emergency room visit to the same facility, the Emergency Room Per Visit Deductible, Deductible applicable to Providers not Participating in PPO and the PPO Coinsurance will apply to that admission.

Office Services

Benefit Description	PPO	Providers Not Participating in PPO
Office Services Rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine and Pediatrics	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Office Services Rendered by: 1. Physicians other than Family Physicians; and 2. Other health care professionals licensed to perform such services	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Allergy Injections	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Durable Medical Equipment, Prosthetics and Orthotics	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
E-visit 1. Rendered by Family Physicians with the following Specialties: Family Practice, General Practice, Internal Medicine, and Pediatrics	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
2. Rendered by Physicians other than Family Physicians and other health care professionals licensed to perform such Services	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Urgent Care	70% of the Allowed Amount after DED	70% of the Allowed Amount after DED
Note: A Covered Plan Participant should verify a Provider's participation status whenever possible prior to receiving Health Care Services. To verify a Provider's specialty or participation status, a Covered Plan Participant may access the PPO Provider directory on our web site at www.floridablue.com or contact the local BCBSF office.		

Medical Pharmacy

Benefit Description	PPO	Providers Not Participating in PPO
Medical Pharmacy Services - Prescription Drugs administered by:		
1. Family Physicians	70% of the Allowed Amount	50% of the Allowed Amount after DED
2. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	70% of the Allowed Amount	50% of the Allowed Amount after DED
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to the Evidence of Coverage for a description of Medical Pharmacy.		
Medical Pharmacy Out-of-Pocket Maximum per Covered Plan Participant per Month	$200	Not Applicable

Preventive Health Services

Benefit Description	PPO	Providers Not Participating in PPO
Adult Wellness Services		
1. Physician Office		
a. Family Physicians (Family Practice, General Practice, Internal Medicine, and Pediatrics)	100% of the Allowed Amount	50% of the Allowed Amount
b. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	100% of the Allowed Amount	50% of the Allowed Amount
2. All other Locations	100% of the Allowed Amount	50% of the Allowed Amount
Adult Well Woman Services		
1. Physician Office		
a. Family Physicians (Family Practice, General Practice, Internal Medicine, and Pediatrics)	100% of the Allowed Amount	50% of the Allowed Amount
b. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	100% of the Allowed Amount	50% of the Allowed Amount
2. All other Locations	100% of the Allowed Amount	50% of the Allowed Amount
Well Child Services		
1. Physician Office		
a. Family Physicians (Family Practice, General Practice, Internal Medicine, and Pediatrics)	100% of the Allowed Amount	50% of the Allowed Amount
b. Physicians other than Family Physicians and other health care professionals licensed to perform such Services	100% of the Allowed Amount	50% of the Allowed Amount
2. All other Locations	100% of the Allowed Amount	50% of the Allowed Amount
Mammograms	100% of the Allowed Amount	100% of the Allowed Amount
Routine Colonoscopy	100% of the Allowed Amount	50% of the Allowed Amount

Behavioral Health Services

Benefit Description	PPO	Providers Not Participating in PPO
Mental Health and Substance Dependency Care and Treatment Services		
Outpatient Facility Services rendered at:		
1. Emergency Room	$50 PVD then 70% of the Allowed Amount after DED	$50 PVD then 70% of the Allowed Amount after DED
2. Hospital	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
3. Physician Services at Hospital and ER	70% of the Allowed Amount after DED	70% of the Allowed Amount after DED
Physician and other health care professionals licensed to perform such Services rendered at:		
1. Family Physicians Office	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
2. Specialist Office	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
3. All other locations	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED
Inpatient		
1. Facility Services	$150 PAD then 70% of the Allowed Amount after DED	$300 PAD then 50% of the Allowed Amount after DED
2. Physician and other health care professionals licensed to perform such Services	70% of the Allowed Amount after DED	70% of the Allowed Amount after DED

Other Services

Benefit Description	PPO	Providers Not Participating in PPO
Emergency Room Facility	70% of the Allowed Amount after DED and $50 PVD	70% of the Allowed Amount after DED and $50 PVD
Physician Services at Hospital and ER	70% of the Allowed Amount after DED	70% of the Allowed Amount after DED
Radiologist, Pathologist and Anesthesiologist Provider Services at Ambulatory Surgical Center or Hospital	70% of the Allowed Amount after DED	50% of the Allowed Amount after DED

Benefit Maximums

Home Health Care visits per Covered Plan Participant per BP 10

Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies and Spinal Manipulations visits (combined) per Covered Plan Participant per BP 15

Note: Refer to the Evidence of Coverage for reimbursement guidelines.

Skilled Nursing Facility Days per Covered Plan Participant per BP 60

Note: If immediately before the Effective Date of the Group, a Covered Plan Participant was covered under a prior group policy issued by BCBSF to the Group, amounts applied to a Covered Plan Participant's Benefit Period maximums under the prior BCBSF policy, will be applied toward the Covered Plan Participant's Benefit Period maximums under the Evidence of Coverage.

Prescription Drug Program

The Group purchased optional pharmacy coverage from BCBSF. Please refer to the pharmacy program Endorsement issued to the Group.

BlueScript® Pharmacy Program

Schedule of Benefits

This Pharmacy Program Schedule of Benefits is part of the BlueScript Pharmacy Program Endorsement, both of which should be reviewed carefully. Covered Prescription Drugs, Covered Over-the-counter (OTC) Drugs and Covered Prescription Supplies purchased from a Pharmacy are subject to the **In-Network Medical Deductible**, which must be satisfied by you before any payment will be made by us. Refer to your BlueChoice Schedule of Benefits for Deductible amounts.To verify if a Pharmacy is a Participating Pharmacy, the Covered Plan Participant may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service phone number on the Identification Card. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

	Participating Pharmacy	**Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased at: Retail Pharmacy – For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$14	50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$40	50% of the Non-Participating Pharmacy Allowance

	Participating Pharmacy	Non-Participating Pharmacy
Non-Preferred Prescription Drugs or Supplies purchased at:		
Retail Pharmacy – For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	30% of the Participating Pharmacy Allowance after DED	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	100% of the Participating Pharmacy Allowance	50% of the Non-Participating Pharmacy Allowance

Other Important Information affecting what you will pay:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide;

     Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request.

  2. Diaphragms indicated as covered in the Medication Guide; and

  3. Emergency contraceptives indicated as covered in the Medication Guide.

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

  1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**

  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the

Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

- The Specialty Pharmacies designated, solely by us, are the only “In-Network” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes under this BlueScript Pharmacy Program.
- Some Specialty medications may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

BlueOptions

Schedule of Benefits – Plan 05901

Important things to keep in mind as you review this Schedule of Benefits:

- This Schedule of Benefits is part of your Benefit Booklet, where more detailed information about your benefits can be found.
- NetworkBlue is the panel of Providers designated as In-Network for your plan. You should always verify a Provider's participation status prior to receiving Health Care Services. To verify a Provider's specialty or participation status, you may contact the local BCBSF office or access the most recent BlueOptions Provider directory on our website at www.floridablue.com. If you receive Covered Services outside the state of Florida from BlueCard® participating Providers, payment will be made based on In-Network benefits.
- References to Deductible are abbreviated as "DED".
- Your benefits accumulate toward the satisfaction of Deductibles, Out-of-Pocket Maximums, and any applicable benefit maximums based on your Benefit Period unless indicated otherwise within this Schedule of Benefits.

Your Benefit Period..... **01/01 – 12/31**

Deductible, Coinsurance and Out-of-Pocket Maximums

Benefit Description	In-Network	Out-of-Network
Deductible (DED)		
Per Person per Benefit Period	$2,000	$6,000
Per Family per Benefit Period	Not Applicable	Not Applicable
Per Admission Deductible (PAD)	Not Applicable	Not Applicable
Coinsurance (The percentage of the Allowed Amount **you pay** for Covered Services)	50%	50%
Out-of-Pocket Maximums		
Per Person per Benefit Period	$6,350	$30,000
Per Family per Benefit Period	$12,700	$30,000

Amounts incurred for In-Network Services will only be applied to the amounts listed in the In-Network column and amounts incurred for Out-of-Network Services will only be applied to the amounts listed in the Out-of-Network column, unless otherwise indicated within this Schedule of Benefits. This includes the Deductible and Out-of-Pocket Maximum amounts.

What **applies** to out-of-pocket maximums?	• DED • PAD, when applicable • Coinsurance • Copayments • Any Prescription Drug Cost Share amounts
What **does not apply** to out-of-pocket maximums?	• Non-covered charges • Any benefit penalty reductions • Charges in excess of the Allowed Amount

Important information affecting the amount you will pay:

As you review the Cost Share amounts in the following charts, please remember:

- Review this Schedule of Benefits carefully; it contains important information concerning your share of the expenses for Covered Services you receive. Amounts listed in this schedule are the Cost Share amounts **you pay**.
- Your Cost Share amounts **will vary** depending upon the Provider you choose, the type of Services you receive, and the setting in which the Services are rendered.
- Payment for Covered Services is based on our **Allowed Amount** and may be less than the amount the Provider bills for such Service. You are responsible for any charges in excess of the Allowed Amount for Out-of-Network Providers.
- If a Copayment is listed in the charts that follow, the Copayment applies per visit.

Office Services

A Family Physician is a Physician whose primary specialty is, according to BCBSF's records, one of the following: Family Practice, General Practice, Internal Medicine, and Pediatrics.

Benefit Description	In-Network	Out-of-Network
Office visits rendered by		
Family Physicians	$35	DED + 50%
Other health care professionals licensed to perform such Services	$75	DED + 50%
Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear cardiology) rendered by		
Family Physicians	$200	DED + 50%
Other health care professionals licensed to perform such Services	$200	DED + 50%
Allergy Injections rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
E-Visits rendered by		
Family Physicians	$10	DED + 50%
Other health care professionals licensed to perform such Services	$10	DED + 50%
Durable Medical Equipment, Prosthetics, and Orthotics	DED + 50%	DED + 50%
Convenient Care Centers	$35	DED + 50%

Medical Pharmacy

Benefit Description	In-Network	Out-of-Network
Prescription Drugs administered in the office by:		
Family Physicians	20%	DED + 50%
Physicians other than Family Physicians and other health care professionals licensed to perform such Services	20%	DED + 50%
Out-of-Pocket Maximum per Person per Month	$200	Not Applicable
Important – The Cost Share for Medical Pharmacy Services applies to the Prescription Drug only and is in addition to the office Services Cost Share. Immunizations, allergy injections as well as Services covered through a pharmacy program are not considered Medical Pharmacy. Please refer to your Benefit Booklet for a description of Medical Pharmacy.		

Preventive Health Services

Benefit Description	In-Network	Out-of-Network
Adult Wellness Services		
Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Adult Well Woman Services		
Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Child Health Supervision Services		
Family Physicians	$0	50%
Other health care professionals licensed to perform such Services	$0	50%
All other locations	$0	50%
Mammograms	$0	$0
Routine Colonoscopy	$0	$0

Outpatient Diagnostic Services

Benefit Description	In-Network	Out-of-Network
Independent Clinical Lab	$0	DED + 50%
Independent Diagnostic Testing Facility Advanced Imaging Services (CT/CAT Scans, MRAs, MRIs, PET Scans and nuclear medicine)	$200	DED + 50%
All other diagnostic Services (e.g., X-rays)	$50	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Emergency and Urgent Care Services

Benefit Description	In-Network	Out-of-Network
Ambulance Services	In-Network DED + 50%	
Emergency Room Visits	See **Hospital Services Emergency Room Visits**	
Urgent Care Center	DED + 50%	DED + 50%

Outpatient Surgical Services

Benefit Description	In-Network	Out-of-Network
Ambulatory Surgical Center Facility (per visit)	DED + 50%	DED + 50%
Radiologists, Anesthesiologists, and Pathologists	DED + 50%	In-Network DED + 50%
Other health care professional Services rendered by all other Providers	DED + 50%	DED + 50%
Outpatient Hospital Facility	See **Hospital Services Outpatient**	

Hospital Services

Benefit Description	In-Network		Out-of-Network
	Option 1*	Option 2* and Out-of-State BlueCard® Participating	
Inpatient Facility Services (per admission)	$2,000	$3,000	DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Outpatient Facility (per visit)	$300	$400	DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%
Therapy Services	$80	$90	DED + 50%
Emergency Room Visits Facility	DED + 50%		DED + 50%
Physician and other health care professional Services	DED + 50%		In-Network DED + 50%

*Please refer to the current Provider Directory to determine the applicable option for each In-Network Hospital.

Important:

Certain categories of Providers may not be available In-Network in all geographic regions. This includes, but is not limited to, anesthesiologists, radiologists, pathologists and emergency room physicians. This Plan will pay for Covered Services rendered by a Physician in a Hospital setting (i.e., inpatient, outpatient, or emergency room) at the In-Network benefit level. Claims paid in accordance with this note will be applied to the In-Network DED and Out-of-Pocket Maximums.

Behavioral Health Services

Benefit Description	In-Network	Out-of-Network
Mental Health and Substance Dependency Care and Treatment Services Outpatient Facility Services rendered at:		
Emergency Room	$0	$0
Hospital	$0	50%
Physician Services at Hospital and ER	**$0**	**$0**
Physician and other health care professionals licensed to perform such Services		
Family Physician office	$0	50%
Specialist office	$0	50%
All other locations	$0	50%
Inpatient		
Facility Services	$0	50%
Physicians and other health care professionals licensed to perform such Services	$0	$0

Benefit Maximums

Home Health Care Visits per Benefit Period..... 10

Inpatient Rehabilitation days per Benefit Period..... 30

Outpatient Therapies and Spinal Manipulations Visits (combined) per Benefit Period..... 25

Note: Refer to the Benefit Booklet for reimbursement guidelines.

Skilled Nursing Facility days per Benefit Period..... 60

Additional Benefits/Features

Benefit Maximum Carryover

If, immediately before the Effective Date of the Group, you or your Covered Dependent were covered under a prior group policy form issued by BCBSF or Health Options, Inc. to the Group, amounts applied to your Benefit Period maximums under the prior BCBSF or Health Options, Inc. policy will be applied toward your Benefit Period maximums under this plan.

Prescription Drug Program

Please refer to your Pharmacy Program Endorsement for details regarding your pharmacy coverage.

BlueScript® Pharmacy Program

Schedule of Benefits

You should carefully review this Pharmacy Program Schedule of Benefits. If you did not receive, or cannot find, the BlueScript Pharmacy Program Endorsement, which this Pharmacy Program Schedule of Benefits is a part of, contact us to obtain one. To verify if a Pharmacy is a Participating Pharmacy, you may access the Pharmacy Program Provider Directory on our website at www.floridablue.com or call the customer service phone number on your Identification Card. References to Deductible are abbreviated as "DED" and references to Benefit Period are abbreviated as "BP".

	Participating Pharmacy	**Non-Participating Pharmacy**
Preferred Generic Prescription Drugs and Covered OTC Drugs purchased at: Retail Pharmacy – For up to a One-Month Supply	$15	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$15	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$40	50% of the Non-Participating Pharmacy Allowance
Preferred Brand Name Prescription Drugs or Supplies purchased at: Retail Pharmacy – For up to a One-Month Supply	$50	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$50	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$125	50% of the Non-Participating Pharmacy Allowance

	Participating Pharmacy	Non-Participating Pharmacy
Non-Preferred Prescription Drugs or Supplies purchased at:		
Retail Pharmacy – For up to a One-Month Supply	$80	50% of the Non-Participating Pharmacy Allowance
Specialty Pharmacy - For up to a One-Month Supply	$80	50% of the Non-Participating Pharmacy Allowance
Mail Order Pharmacy – For up to a Three-Month Supply	$200	50% of the Non-Participating Pharmacy Allowance

Other Important Information affecting what you will pay:

- The following are covered at no cost to the Insured when prescribed by a Physician or other health care professional (except a Pharmacist) acting within the scope of his or her license and purchased at a Participating Pharmacy:

  1. Generic Prescription oral contraceptives indicated as covered in the Medication Guide; Exceptions may be considered for Brand Name and/or Non-Preferred oral contraceptive Prescription Drugs when designated Generic Prescription Drugs in the Medication Guide are not appropriate for the Insured because of a documented allergy, ineffectiveness or side effects. In order for an exception to be considered, BCBSF must receive an "Exception Request Form" from the Insured's Physician.

     The Insured can obtain an Exception Request Form on BCBSF's website at www.floridablue.com, or the Insured may call the customer service phone number on the Insured's Identification Card and one will be mailed to the Insured upon request;

  2. Diaphragms indicated as covered in the Medication Guide; and
  3. Emergency contraceptives indicated as covered in the Medication Guide.

- If you or your Provider request a Brand Name Prescription Drug when there is a Generic Prescription Drug available; you will be responsible for:

  1. the cost share amount that applies to the Brand Name Prescription Drug you received, or in the case of a Non-Preferred Prescription Drug, the cost share amount that applies to Non-Preferred Prescription Drugs, as indicated in this Schedule of Benefits; **and**

  2. the difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug or Non-Preferred Prescription Drug you received, unless the Provider has indicated on the Prescription that the Brand Name Prescription Drug or Non-Preferred Drug is Medically Necessary.

- The Specialty Pharmacies designated, solely by us, are the only “In-Network” suppliers for Specialty Drugs. With BlueScript, you may choose to obtain Specialty Drugs from any Pharmacy; however any Pharmacy not designated by us as a Specialty Pharmacy is considered Out-of-Network for payment purposes under this BlueScript Pharmacy Program.
- Some Specialty medications may be dispensed in lesser quantities due to manufacturer package size or course of therapy and certain Specialty Pharmacy products may have additional quantity limits.
- You can also get up to a Three-Month Supply of a Covered Prescription Drug or Covered Prescription Supply (except Specialty Drugs) purchased at a retail Participating Pharmacy. Specialty Drugs are covered only up to a One-Month Supply.
- Specialty Drugs, as designated in the Medication Guide, are not covered when purchased through the Mail Order Pharmacy.

Exhibit 2

Historical Plan Rates for 2017

Plan 0727 - $500 Deductible (004)	17/18 Member Cost	17/18 Dependent Cost	17/18 Total Health Cost	Total Ins Cost	17/18 School Board Contribution	17/18 Employee Cost
Individual - age 64 and under	796.24	0.00	796.24	798.92	432.32	363.92
1 Dependent - age 64 and under	796.24	723.40	1,519.65	1,522.33	432.32	1,087.33
Family	796.24	1,146.10	1,942.34	1,945.02	432.32	1,510.02
Family (2 Employees)	796.24	1,146.10	1,942.34	1,945.02	864.64	1,077.70
B7505R04						
Medicare Supplement - Retired employee	599.68	0.00	599.68	599.68	50.00	549.68
Medicare Dependent - Retired employee dependent	0.00	599.68	599.68	599.68	0.00	599.68

Plan 03359 - $1,000 Deductible (001)	17/18 Member Cost	17/18 Dependent Cost	17/18 Total Health Cost	Total Ins Cost	17/18 School Board Contribution	17/18 Employee Cost
Individual - age 64 and under	681.13	0.00	681.13	683.81	432.32	248.81
1 Dependent - age 64 and under	681.13	644.36	1,325.49	1,328.17	432.32	893.17
Family	681.13	1,020.66	1,701.79	1,704.47	432.32	1,269.47
Family (2 Employees)	681.13	1,020.66	1,701.79	1,704.47	864.64	837.15
B7505R01						
Medicare Supplement - Retired employee	520.64	0.00	520.64	520.64	50.00	470.64
Medicare Dependent - Retired employee dependent	0.00	520.64	520.64	520.64	0.00	520.64

Plan 0117 - $1,500 Deductible (003)	17/18 Member Cost	17/18 Dependent Cost	17/18 Total Health Cost	Total Ins Cost	17/18 School Board Contribution	17/18 Employee Cost
Individual - age 64 and under	572.88	0.00	572.88	575.56	432.32	140.56
1 Dependent - age 64 and under	572.88	539.54	1,112.43	1,115.11	432.32	680.11
Family	572.88	855.70	1,428.59	1,431.27	432.32	996.27
Family (2 Employees)	572.88	855.70	1,428.59	1,431.27	864.64	563.95
B7505R03						
Medicare Supplement - Retired employee	436.44	0.00	436.44	436.44	50.00	386.44
Medicare Dependent - Retired employee dependent	0.00	436.44	436.44	436.44	0.00	436.44

Plan 05901 - $2,000 Deductible (002)	17/18 Member Cost	17/18 Dependent Cost	17/18 Total Health Cost	Total Ins Cost	17/18 School Board Contribution	17/18 Employee Cost
Individual - age 64 and under	493.03	0.00	493.03	495.71	432.32	60.71
1 Dependent - age 64 and under	493.03	496.38	989.41	992.09	432.32	557.09
Family	493.03	787.25	1,280.28	1,282.96	432.32	847.96
Family (2 Employees)	493.03	787.25	1,280.28	1,282.96	864.64	415.64
B7505R02						
Medicare Supplement - Retired employee	401.52	0.00	401.52	401.52	50.00	351.52
Medicare Dependent - Retired employee dependent	0.00	401.52	401.52	401.52	0.00	401.52

Exhibit 3

Medical Experience Reports

Calhoun Schools Total Group Monitoring

Company: CALHOUN COUNTY SCHOOL BOARD
Group: B7505
Current Paid Period: From 10/2017 to 01/2018

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201710	287	432	$12,417.47	$0.00	$12,417.47	$0.00	$421.82	$421.82	$49,034.13	$15,947.31	$18,389.65	$23,964.83	$107,335.92	$53,980.23	$161,737.97
201711	286	430	$12,246.92	$0.00	$12,246.92	$0.00	$387.76	$387.76	$3,920.00	$58,829.13	$43,022.02	$36,041.41	$141,812.56	$91,107.96	$233,308.28
201712	286	429	$11,368.08	$0.00	$11,368.08	$0.00	$406.10	$406.10	$1,316.00	$39,301.68	$13,177.49	$23,547.17	$77,342.34	$68,872.90	$146,621.34
201801	269	410	$11,337.69	$0.00	$11,337.69	$0.00	$1,962.22	$1,962.22	($13,764.12)	$18,769.80	$20,949.65	$27,441.60	$53,396.93	$78,276.79	$133,635.94
Total	**1,128**	**1,701**	**$47,370.16**	**$0.00**	**$47,370.16**	**$0.00**	**$3,177.90**	**$3,177.90**	**$40,506.01**	**$132,847.92**	**$95,538.81**	**$110,995.01**	**$379,887.75**	**$292,237.88**	**$675,303.53**
Grouping Avg	**282**	**425**	**$11,842.54**	**$0.00**	**$11,842.54**	**$0.00**	**$794.48**	**$794.48**	**$10,126.50**	**$33,211.98**	**$23,884.70**	**$27,748.75**	**$94,971.94**	**$73,059.47**	**$168,825.88**
Monthly Avg	**282**	**425**	**$11,842.54**	**$0.00**	**$11,842.54**	**$0.00**	**$794.48**	**$794.48**	**$10,126.50**	**$33,211.98**	**$23,884.70**	**$27,748.75**	**$94,971.94**	**$73,059.47**	**$168,825.88**

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.

Calhoun Schools Total Group Monitoring

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201710	217	0	0	70	0	0	0	287	432
201711	218	0	0	68	0	0	0	286	430
201712	219	0	0	67	0	0	0	286	429
201801	205	0	0	64	0	0	0	269	410
Total	**859**	**0**	**0**	**269**	**0**	**0**	**0**	**1,128**	**1,701**
Grouping Avg	**215**	**0**	**0**	**67**	**0**	**0**	**0**	**282**	**425**
Monthly Avg	**215**	**0**	**0**	**67**	**0**	**0**	**0**	**282**	**425**

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.

Calhoun Schools Plan 03359 Monitoring

Company: CALHOUN COUNTY SCHOOL BOARD
Group: B7505
Division: 001, R01
Current Paid Period: From 10/2017 to 01/2018

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201710	84	128	$3,696.17	$0.00	$3,696.17	$0.00	$180.78	$180.78	$28,347.09	$5,083.31	$6,496.68	$1,832.62	$41,759.70	$13,516.80	$55,457.28
201711	83	125	$3,446.99	$0.00	$3,446.99	$0.00	$151.96	$151.96	$1,316.00	$11,112.62	$7,764.76	$8,783.94	$28,977.32	$34,085.12	$63,214.40
201712	83	125	$3,239.34	$0.00	$3,239.34	$0.00	$163.75	$163.75	$0.00	$8,681.13	$4,273.20	$3,863.38	$16,817.71	$20,016.71	$36,998.17
201801	81	123	$3,363.93	$0.00	$3,363.93	$0.00	$623.42	$623.42	$3,908.00	$8,024.30	$4,270.12	$7,799.35	$24,001.77	$24,731.55	$49,356.74
Total	**331**	**501**	**$13,746.43**	**$0.00**	**$13,746.43**	**$0.00**	**$1,119.91**	**$1,119.91**	**$33,571.09**	**$32,901.36**	**$22,804.76**	**$22,279.29**	**$111,556.50**	**$92,350.18**	**$205,026.59**
Grouping Avg	**83**	**125**	**$3,436.61**	**$0.00**	**$3,436.61**	**$0.00**	**$279.98**	**$279.98**	**$8,392.77**	**$8,225.34**	**$5,701.19**	**$5,569.82**	**$27,889.13**	**$23,087.55**	**$51,256.65**
Monthly Avg	**83**	**125**	**$3,436.61**	**$0.00**	**$3,436.61**	**$0.00**	**$279.98**	**$279.98**	**$8,392.77**	**$8,225.34**	**$5,701.19**	**$5,569.82**	**$27,889.13**	**$23,087.55**	**$51,256.65**

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.

Calhoun Schools Plan 03359 Monitoring

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201710	59	0	0	25	0	0	0	84	128
201711	61	0	0	22	0	0	0	83	125
201712	61	0	0	22	0	0	0	83	125
201801	60	0	0	21	0	0	0	81	123
Total	**241**	**0**	**0**	**90**	**0**	**0**	**0**	**331**	**501**
Grouping Avg	**60**	**0**	**0**	**23**	**0**	**0**	**0**	**83**	**125**
Monthly Avg	**60**	**0**	**0**	**23**	**0**	**0**	**0**	**83**	**125**

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.**

Calhoun Schools Plan 05901 Monitoring

Company: CALHOUN COUNTY SCHOOL BOARD
Group: B7505
Division: 002, R02
Current Paid Period: From 10/2017 to 01/2018

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201710	103	182	$4,402.18	$0.00	$4,402.18	$0.00	$241.04	$241.04	$0.00	$0.00	$768.87	$93.04	$861.91	$13,807.70	$14,910.65
201711	104	184	$4,485.24	$0.00	$4,485.24	$0.00	$235.80	$235.80	$0.00	$8,242.43	$9,525.61	$3,099.80	$20,867.84	$12,792.07	$33,895.71
201712	106	186	$4,153.00	$0.00	$4,153.00	$0.00	$242.35	$242.35	$0.00	$5,377.82	$4,611.20	$2,504.18	$12,493.20	$15,641.45	$28,377.00
201801	103	183	$4,402.18	$0.00	$4,402.18	$0.00	$940.24	$940.24	$13,434.18	$4,201.36	$8,262.35	$6,297.68	$32,195.57	$17,111.87	$50,247.68
Total	**416**	**735**	**$17,442.60**	**$0.00**	**$17,442.60**	**$0.00**	**$1,659.43**	**$1,659.43**	**$13,434.18**	**$17,821.61**	**$23,168.03**	**$11,994.70**	**$66,418.52**	**$59,353.09**	**$127,431.04**
Grouping Avg	**104**	**184**	**$4,360.65**	**$0.00**	**$4,360.65**	**$0.00**	**$414.86**	**$414.86**	**$3,358.55**	**$4,455.40**	**$5,792.01**	**$2,998.68**	**$16,604.63**	**$14,838.27**	**$31,857.76**
Monthly Avg	**104**	**184**	**$4,360.65**	**$0.00**	**$4,360.65**	**$0.00**	**$414.86**	**$414.86**	**$3,358.55**	**$4,455.40**	**$5,792.01**	**$2,998.68**	**$16,604.63**	**$14,838.27**	**$31,857.76**

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.

Calhoun Schools Plan 05901 Monitoring

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201710	74	0	0	29	0	0	0	103	182
201711	74	0	0	30	0	0	0	104	184
201712	76	0	0	30	0	0	0	106	186
201801	73	0	0	30	0	0	0	103	183
Total	**297**	**0**	**0**	**119**	**0**	**0**	**0**	**416**	**735**
Grouping Avg	**74**	**0**	**0**	**30**	**0**	**0**	**0**	**104**	**184**
Monthly Avg	**74**	**0**	**0**	**30**	**0**	**0**	**0**	**104**	**184**

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.

Calhoun Schools Plan 0117 Monitoring

Company: CALHOUN COUNTY SCHOOL BOARD
Group: B7505
Division: 003, R03
Current Paid Period: From 10/2017 to 01/2018

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201710	19	27	$872.13	$0.00	$872.13	$0.00	$0.00	$0.00	$20,687.04	$1,860.67	$4,927.58	$5,014.42	$32,489.71	$77.21	$32,566.92
201711	19	27	$872.13	$0.00	$872.13	$0.00	$0.00	$0.00	$0.00	$26,699.63	$6,442.91	$585.39	$33,727.93	$107.29	$33,835.22
201712	19	27	$706.01	$0.00	$706.01	$0.00	$0.00	$0.00	$0.00	$16,122.40	$282.96	$1,208.57	$17,613.93	$94.99	$17,708.92
201801	19	27	$747.54	$0.00	$747.54	$0.00	$101.52	$101.52	$0.00	$2,151.64	$1,103.82	$375.80	$3,631.26	$223.31	$3,956.09
Total	**76**	**108**	**$3,197.81**	**$0.00**	**$3,197.81**	**$0.00**	**$101.52**	**$101.52**	**$20,687.04**	**$46,834.34**	**$12,757.27**	**$7,184.18**	**$87,462.83**	**$502.80**	**$88,067.15**
Grouping Avg	**19**	**27**	**$799.45**	**$0.00**	**$799.45**	**$0.00**	**$25.38**	**$25.38**	**$5,171.76**	**$11,708.59**	**$3,189.32**	**$1,796.05**	**$21,865.71**	**$125.70**	**$22,016.79**
Monthly Avg	**19**	**27**	**$799.45**	**$0.00**	**$799.45**	**$0.00**	**$25.38**	**$25.38**	**$5,171.76**	**$11,708.59**	**$3,189.32**	**$1,796.05**	**$21,865.71**	**$125.70**	**$22,016.79**

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.

Calhoun Schools Plan 0117 Monitoring

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201710	15	0	0	4	0	0	0	19	27
201711	15	0	0	4	0	0	0	19	27
201712	15	0	0	4	0	0	0	19	27
201801	15	0	0	4	0	0	0	19	27
Total	**60**	**0**	**0**	**16**	**0**	**0**	**0**	**76**	**108**
Grouping Avg	**15**	**0**	**0**	**4**	**0**	**0**	**0**	**19**	**27**
Monthly Avg	**15**	**0**	**0**	**4**	**0**	**0**	**0**	**19**	**27**

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.

Calhoun Schools Plan 0727 Monitoring

Company: CALHOUN COUNTY SCHOOL BOARD
Group: B7505
Division: 004, C04, R04
Current Paid Period: From 10/2017 to 01/2018

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201710	81	95	$3,446.99	$0.00	$3,446.99	$0.00	$0.00	$0.00	$0.00	$9,003.33	$6,196.52	$17,024.75	$32,224.60	$26,578.52	$58,803.12
201711	80	94	$3,442.56	$0.00	$3,442.56	$0.00	$0.00	$0.00	$2,604.00	$12,774.45	$19,288.74	$23,572.28	$58,239.47	$44,123.48	$102,362.95
201712	78	91	$3,269.73	$0.00	$3,269.73	$0.00	$0.00	$0.00	$1,316.00	$9,120.33	$4,010.13	$15,971.04	$30,417.50	$33,119.75	$63,537.25
201801	66	77	$2,824.04	$0.00	$2,824.04	$0.00	$297.04	$297.04	($31,106.30)	$4,392.50	$7,313.36	$12,968.77	($6,431.67)	$36,210.06	$30,075.43
Total	**305**	**357**	**$12,983.32**	**$0.00**	**$12,983.32**	**$0.00**	**$297.04**	**$297.04**	**($27,186.30)**	**$35,290.61**	**$36,808.75**	**$69,536.84**	**$114,449.90**	**$140,031.81**	**$254,778.75**
Grouping Avg	**76**	**89**	**$3,245.83**	**$0.00**	**$3,245.83**	**$0.00**	**$74.26**	**$74.26**	**($6,796.58)**	**$8,822.65**	**$9,202.19**	**$17,384.21**	**$28,612.48**	**$35,007.95**	**$63,694.69**
Monthly Avg	**76**	**89**	**$3,245.83**	**$0.00**	**$3,245.83**	**$0.00**	**$74.26**	**$74.26**	**($6,796.58)**	**$8,822.65**	**$9,202.19**	**$17,384.21**	**$28,612.48**	**$35,007.95**	**$63,694.69**

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.

Calhoun Schools Plan 0727 Monitoring

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201710	69	0	0	12	0	0	0	81	95
201711	68	0	0	12	0	0	0	80	94
201712	67	0	0	11	0	0	0	78	91
201801	57	0	0	9	0	0	0	66	77
Total	**261**	**0**	**0**	**44**	**0**	**0**	**0**	**305**	**357**
Grouping Avg	**65**	**0**	**0**	**11**	**0**	**0**	**0**	**76**	**89**
Monthly Avg	**65**	**0**	**0**	**11**	**0**	**0**	**0**	**76**	**89**

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.

PANHANDLE AREA EDUCATIONAL CONSORTIUM
CALHOUN COUNTY SCHOOL BOARD
LARGE CLAIM INFORMATION
October 1, 2017 - September 30, 2018

CALHOUN COUNTY SCHOOL BOARD ($45,000 Specific Deductible w/ $191,000 Aggregate Spec Corridor)				
Name	Billed Amount	Paid Amount	Amount in Excess of $45,000 Spec	Amount in Excess of $191,000 Agg. Spec
*****0570	$72,184	$63,812	$18,812	$0
*****3678	$113,138	$49,047	$4,047	$0
*****8233	$128,083	$41,923	$0	$0
*****0135	$76,998	$35,692	$0	$0
*****1327	$106,596	$30,462	$0	
*****1225	$53,418	$28,883	$0	
*****5137	$56,314	$27,623	$0	
7	$606,731	$277,443	$22,859	$0

Monitoring by Utilization and Enrollment

Company: CALHOUN COUNTY SCHOOL BOARD
Group: B7505
Current Paid Period: From 10/2015 to 09/2016

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201510	290	459	$11,417.64	$0.00	$11,417.64	$0.00	$237.01	$237.01	$16,428.35	$26,568.48	$35,750.63	$14,252.52	$92,999.98	$60,902.10	$154,139.09
201511	290	459	$11,692.80	$0.00	$11,692.80	$0.00	$302.77	$302.77	$4,148.00	$77,417.36	$35,621.42	$11,574.80	$128,761.58	$75,545.00	$204,609.35
201512	291	462	$13,105.18	$0.00	$13,105.18	$0.00	$286.33	$286.33	$28,091.44	$42,710.63	$27,856.67	$12,812.47	$111,471.21	$101,189.39	$212,946.93
201601	290	459	$11,934.72	$0.00	$11,934.72	$0.00	$275.37	$275.37	$26,030.32	$41,642.40	$36,524.06	$10,005.26	$114,202.04	$71,528.06	$186,005.47
201602	289	458	$11,934.72	$0.00	$11,934.72	$0.00	$279.48	$279.48	$46,151.79	$49,272.72	$32,870.62	$15,770.16	$144,065.29	$67,261.44	$211,606.21
201603	285	453	$12,096.00	$0.00	$12,096.00	$0.00	$276.74	$276.74	$37,355.17	$169,319.97	$32,473.94	$24,842.82	$263,991.90	$89,559.90	$353,828.54
201604	284	451	$11,813.76	$0.00	$11,813.76	$0.00	$276.74	$276.74	$25,508.97	$35,571.65	$36,018.17	$32,716.53	$129,815.32	$71,685.56	$201,777.62
201605	283	450	$11,278.85	$0.00	$11,278.85	$0.00	$276.74	$276.74	$46,612.83	$106,073.68	$29,055.52	$11,361.72	$193,103.75	$69,424.76	$262,805.25
201606	282	449	$11,589.31	$0.00	$11,589.31	$0.00	$254.82	$254.82	$10,508.97	$67,210.49	$35,469.04	$23,155.37	$136,343.87	$99,967.75	$236,566.44
201607	282	447	$11,208.96	$0.00	$11,208.96	$0.00	$253.36	$253.36	$21,554.43	$50,034.34	$22,348.43	$32,286.79	$126,223.99	$53,314.73	$179,792.08
201608	282	448	$10,143.17	$0.00	$10,143.17	$0.00	$258.07	$258.07	$96,875.66	$36,530.54	$32,518.66	$34,107.63	$200,032.49	$99,195.58	$299,486.14
201609	282	448	$11,410.56	$0.00	$11,410.56	$0.00	$242.20	$242.20	$62,896.67	$131,418.41	$59,800.87	$31,362.96	$285,478.91	$77,507.21	$363,228.32
Total	**3,430**	**5,443**	**$139,625.67**	**$0.00**	**$139,625.67**	**$0.00**	**$3,219.63**	**$3,219.63**	**$422,162.60**	**$833,770.67**	**$416,308.03**	**$254,249.03**	**$1,926,490.33**	**$937,081.48**	**$2,866,791.44**
Grouping Avg	**286**	**454**	**$11,635.47**	**$0.00**	**$11,635.47**	**$0.00**	**$268.30**	**$268.30**	**$35,180.22**	**$69,480.89**	**$34,692.34**	**$21,187.42**	**$160,540.86**	**$78,090.12**	**$238,899.29**
Monthly Avg	**286**	**454**	**$11,635.47**	**$0.00**	**$11,635.47**	**$0.00**	**$268.30**	**$268.30**	**$35,180.22**	**$69,480.89**	**$34,692.34**	**$21,187.42**	**$160,540.86**	**$78,090.12**	**$238,899.29**

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

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201510	198	0	0	92	0	0	0	290	459
201511	198	0	0	92	0	0	0	290	459
201512	199	0	0	92	0	0	0	291	462
201601	199	0	0	91	0	0	0	290	459
201602	198	0	0	91	0	0	0	289	458
201603	195	0	0	90	0	0	0	285	453
201604	195	0	0	89	0	0	0	284	451
201605	194	0	0	89	0	0	0	283	450
201606	193	0	0	89	0	0	0	282	449
201607	194	0	0	88	0	0	0	282	447
201608	194	0	0	88	0	0	0	282	448
201609	194	0	0	88	0	0	0	282	448
Total	**2,351**	**0**	**0**	**1,079**	**0**	**0**	**0**	**3,430**	**5,443**
Grouping Avg	**196**	**0**	**0**	**90**	**0**	**0**	**0**	**286**	**454**
Monthly Avg	**196**	**0**	**0**	**90**	**0**	**0**	**0**	**286**	**454**

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.

Monitoring by Utilization and Enrollment

Company: CALHOUN COUNTY SCHOOL BOARD
Group: B7505
Current Paid Period: From 10/2016 to 09/2017

	Enrollment		Premium			Capitation			Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
201610	286	460	$11,757.83	$0.00	$11,757.83	$0.00	$305.23	$305.23	$10,565.66	$32,890.16	$19,724.98	$26,149.64	$89,330.44	$54,915.87	$144,551.54
201611	285	459	$11,757.83	$0.00	$11,757.83	$0.00	$290.82	$290.82	$2,238.00	$63,611.67	$41,857.22	$12,783.86	$120,490.75	$84,705.37	$205,486.94
201612	284	458	$11,877.58	$0.00	$11,877.58	$0.00	$297.37	$297.37	$36,427.00	$27,967.09	$40,344.76	$22,116.47	$126,855.32	$82,810.80	$209,963.49
201701	284	458	$11,779.89	$0.00	$11,779.89	$0.00	$298.68	$298.68	$35,076.85	$40,329.78	$20,515.54	$42,348.59	$138,270.76	$64,972.82	$203,542.26
201702	284	463	$11,669.06	$0.00	$11,669.06	$0.00	$297.37	$297.37	($17,910.27)	$86,950.76	$28,057.92	$10,253.27	$107,351.68	$69,706.55	$177,355.60
201703	282	461	$11,944.35	$0.00	$11,944.35	$0.00	$302.61	$302.61	($4,626.70)	$126,876.86	$36,230.56	$12,913.45	$171,394.17	$90,299.67	$261,996.45
201704	279	452	$11,694.05	$0.00	$11,694.05	$0.00	$290.82	$290.82	$43,119.25	$58,724.38	$25,485.72	$35,577.70	$162,907.05	$71,761.22	$234,959.09
201705	280	454	$11,457.33	$0.00	$11,457.33	$0.00	$290.82	$290.82	$30,323.48	$74,708.84	$38,602.47	$22,654.91	$166,289.70	$92,747.72	$259,328.24
201706	281	456	$11,694.05	$0.00	$11,694.05	$0.00	$290.82	$290.82	$93,632.39	$60,436.65	$48,396.82	$40,613.21	$243,079.07	$82,092.09	$325,461.98
201707	282	456	$11,569.46	$0.00	$11,569.46	$0.00	$299.99	$299.99	$21,895.34	$46,520.15	$43,492.82	$48,281.02	$160,189.33	$70,456.14	$230,945.46
201708	282	456	$11,794.52	$0.00	$11,794.52	$0.00	$294.75	$294.75	$43,342.18	$53,456.83	$48,418.91	$12,566.56	$157,784.48	$85,569.62	$243,648.85
201709	283	457	$11,735.58	$0.00	$11,735.58	$0.00	$293.44	$293.44	$29,453.92	$58,054.85	$31,681.54	$43,228.31	$162,418.62	$83,556.37	$246,268.43
Total	**3,392**	**5,490**	**$140,731.53**	**$0.00**	**$140,731.53**	**$0.00**	**$3,552.72**	**$3,552.72**	**$323,537.10**	**$730,528.02**	**$422,809.26**	**$329,486.99**	**$1,806,361.37**	**$933,594.24**	**$2,743,508.33**
Grouping Avg	**283**	**458**	**$11,727.63**	**$0.00**	**$11,727.63**	**$0.00**	**$296.06**	**$296.06**	**$26,961.43**	**$60,877.34**	**$35,234.11**	**$27,457.25**	**$150,530.11**	**$77,799.52**	**$228,625.69**
Monthly Avg	**283**	**458**	**$11,727.63**	**$0.00**	**$11,727.63**	**$0.00**	**$296.06**	**$296.06**	**$26,961.43**	**$60,877.34**	**$35,234.11**	**$27,457.25**	**$150,530.11**	**$77,799.52**	**$228,625.69**

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

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201610	196	0	0	90	0	0	0	286	460
201611	195	0	0	90	0	0	0	285	459
201612	194	0	0	90	0	0	0	284	458
201701	194	0	0	90	0	0	0	284	458
201702	193	0	0	91	0	0	0	284	463
201703	191	0	0	91	0	0	0	282	461
201704	191	0	0	88	0	0	0	279	452
201705	192	0	0	88	0	0	0	280	454
201706	193	0	0	88	0	0	0	281	456
201707	193	0	0	89	0	0	0	282	456
201708	195	0	0	87	0	0	0	282	456
201709	196	0	0	87	0	0	0	283	457
Total	**2,323**	**0**	**0**	**1,069**	**0**	**0**	**0**	**3,392**	**5,490**
Grouping Avg	**194**	**0**	**0**	**89**	**0**	**0**	**0**	**283**	**458**
Monthly Avg	**194**	**0**	**0**	**89**	**0**	**0**	**0**	**283**	**458**

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.

PANHANDLE AREA EDUCATIONAL CONSORTIUM
CALHOUN COUNTY SCHOOL BOARD
LARGE CLAIM INFORMATION
October 1, 2016 - September 30, 2017

CALHOUN COUNTY SCHOOL BOARD ($45,000 Specific Deductible w/ $191,000 Aggregate Spec Corridor)				
Name	Billed Amount	Paid Amount	Amount in Excess of $45,000 Spec	Amount in Excess of $191,000 Agg. Spec
*****0570	$202,720	$175,029	$130,029	$0
*****2708	$332,259	$140,682	$95,682	$0
*****2621	$163,903	$112,103	$67,103	$0
*****7851	$180,960	$111,559	$66,559	$0
*****3190	$161,199	$94,858	$49,858	$0
*****0774	$342,407	$86,322	$41,322	$0
*****5137	$173,426	$72,374	$27,374	$0
*****4014	$83,568	$66,512	$21,512	$0
*****3678	$172,632	$61,481	$16,481	$0
*****9184	$176,003	$55,637	$10,637	$0
*****3548	$114,362	$53,385	$8,385	$0
*****9303	$112,427	$51,544	$6,544	$0
*****5714	$211,309	$50,700	$5,700	$0
*****8233	$73,315	$49,081	$4,081	$0
*****4592	$142,506	$46,177	$1,177	$0
*****1466	$139,616	$45,640	$640	$0
*****3335	$150,303	$44,095	$0	$0
*****3200	$89,856	$42,454	$0	$0
*****3876	$105,171	$38,170	$0	$0
*****2750	$205,549	$38,085	$0	$0
*****9109	$128,845	$37,024	$0	$0
*****6120	$73,665	$34,076	$0	$0
*****8675	$78,104	$32,591	$0	$0
*****1946	$115,931	$31,018	$0	$0
*****7209	$95,400	$27,599	$0	$0
*****9040	$141,452	$27,141	$0	$0
*****1393	$84,233	$27,068	$0	$0
*****2132	$90,696	$24,927	$0	$0
*****3677	$64,335	$24,508	$0	$0
29	$4,206,152	$1,701,839	$553,082	$362,082

Exhibit 4

Benefits Match-Up – a,b,c,d
(In Word format)

If not already received, please email
Laura Rybka at lrybka@siver.com
for a copy of this file in Word
format

Exhibit 5

Most Utilized Provider Comparison Match-Up (In Excel format)

If not already received, please email Laura Rybka at lrybka@siver.com for a copy of this file in Excel format

Exhibit 6

Medical Census
(In Excel format)

If not already received, please email
Laura Rybka at lrybka@siver.com
for a copy of this file in Excel
format

Exhibit 7

Benefits Summary
2017-2018

CALHOUN COUNTY
SCHOOL DISTRICT

2017 - 2018
Benefits Summary

Table of Contents

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 15–16 for more details.

Benefits Overview

At Calhoun County School District, we believe that benefits are an integral part of your total compensation—that is why it's important that you get the maximum value from your benefit plans.

Calhoun County School District is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours or more per week. Your benefits will take effect the first day of the month following 30 days of service.

Medical Plans Offered

» Florida Blue

» HMO

- BlueChoice—0117
- BlueChoice—0727

» PPO

- Blue Options—03359
- Blue Options—05901

» Cigna—Basic Life

» Cigna—Voluntary Life

» Dental—Ameritas

Please take the time to know and understand all of your benefits and make the elections that keep pace with the changes in your life. The choices you make during the enrollment process stay in effect throughout the entire plan year of 2017/18, unless you experience a qualifying event.

Examples of Qualifying Events

» Marriage/Divorce

» Death

» Change in full-time status

» Loss of employment

» Dependent no longer eligible

» Spouse obtains or loses employment

If you experience a qualifying event during the plan year, it is your responsibility to contact your Human Resources Department to report the change within 30 days or 60 days in the case of a Children's Insurance Program Reauthorization Act of 2009 (CHIPRA) special enrollment. Otherwise, you will not be able to make your changes and will have to wait until the 2018/19 Annual Open Enrolment Period to make the change.

Accuracy of Enrollee Information

As we all work toward managing the Calhoun County School District's overall health plan costs, it is important that only individuals eligible for benefits are actually enrolled. This helps make coverage more affordable for active employees and retirees who pay the full cost for their benefits.

It is also very important when a dependent no longer qualifies for Calhoun County School District's benefits coverage, the dependent is removed and has the opportunity to continue benefits through COBRA.

Eligibility

All full-time newly hired employees are eligible to participate in the Calhoun County School District's group insurance plans starting the 1st of the month following 30 days of service. Questions regarding eligibility should be directed to Rhonda O'Bryan at 800.674.8123 ext. 30.

Dependent Eligibility

Medical

Eligible dependents are defined as follows:

- Employee's spouse under a legally valid existing marriage, as defined under Florida Law.
- The Employee's natural, newborn, adopted, Foster, or step child(ren) (or a child for whom the covered employee has been court-appointed as legal guardian or legal custodian) who has not reached the end of the Calendar Year in which he or she reaches age 26 (or in the case of a Foster Child, is no longer eligible under the Foster Child Program), regardless of the dependent child's student or marital status, financial dependency on the Covered Plan Participant, whether the dependent child resides with the Covered Plan Participant, or whether the dependent child is eligible for or enrolled in any other group health plan.
- The newborn child of a covered dependent child who has not reached the end of the calendar year in which he or she becomes 26. Coverage for such child will automatically terminate 18 months after the birth of the newborn child.

Extension of Eligibility for Dependent Children

A covered dependent child may continue coverage beyond the end of the calendar year in which he or she reaches 26, provided he or she is:

- Unmarried and does not have a dependent
- A Florida resident or a full time or part time student
- Not entitled to benefits under Title XVIII of the Social Security Act unless the child is a handicapped dependent child.

This eligibility will terminate on the last day of the calendar year in which the dependent child reaches age 30.

Handicapped Children

In the case of a handicapped dependent child, such child is eligible to continue coverage as a covered dependent, beyond the age of 26, if the child is:

- Otherwise eligible for coverage under the Group Health Plan;
- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent upon the Covered Plan Participant for support and maintenance provided that the symptoms or causes of the child's handicap existed prior to the child's 26th birthday.

This eligibility shall terminate on the last day of the month in which the dependent child no longer meets the requirements for extended eligibility as a handicapped child.

Exception for Students on Medical Leave of Absence from School

- A Covered Dependent child who is a full-time or part-time student at an accredited post-secondary institution, who takes a physician certified medically necessary leave of absence from school, will still be considered a student for eligibility purposes the earlier of 12 months from the first day of the leave of absence or the date the Covered Dependent would otherwise no longer be eligible for coverage.

Dental

» Employee's legal spouse.

» Employee's dependent children.

» **Dependent child** refers to:

a. each child through the end of the year in which they turn age 30, for whom the Insured or the Insured's spouse, is legally responsible, including:

i. natural born children, adopted

ii. any child placed with the Insured for adoption, a foster child or other child in court-ordered custody, placed pursuant to Chapter 63 of Florida Code

iii. children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

The child must be dependent upon the certificate holder for support and either living in the household of the certificate holder or is a full or part-time student.

b. each child age 30 or older who:

i. is Totally Disabled due to mental or physical reasons; and

ii. becomes Totally Disabled while insured as a dependent under b. above.

Coverage for such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limit age. Any costs for providing continuing proof will be at our expense.

Medical Benefits—Blue Choice 0117 and 0727, Blue Options 03359 and 05901

The Blue Options and Blue Choice plans offer services outside the network and provide freedom of choice for care within the network. **Services rendered outside the network are subject to balance billing, which means the member may be responsible for the difference between the negotiated fee or the facility's retail charge.**

Administered by Florida Blue | Customer Service: 800.352.2583 | www.floridablue.com

Calhoun County School District	BLUE CHOICE—0117		BLUE CHOICE—0727		BLUE OPTIONS—03359		BLUE OPTIONS—05901	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Financial Features								
Calendar Year Deductible Individual/Family	$1,500 / $4,500	Combined with In-Network	$500 / $1,000	Combined with In-Network	$1,000 / $3,000	$2,000 / $6,000	$2,000 / N/A	$6,000/ N/A
Coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	40% coinsurance	20% coinsurance	40% coinsurance	50% coinsurance	50% coinsurance
Out-of-Pocket Maximum Individual/Family	$5,000/$13,200	Combined with In-Network	$2,000 / $4,000	Combined with In-Network	$3,000/$6,000	$5,000/$10,000	$6,350 / $12,700	$30,000 / $30,000
Inpatient Hospital Services Per Admit Deductible	$150	$300	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Room Per Visit Deductible Facility and Professional Services	$50	$50	N/A	N/A	N/A	N/A	50% coinsurance after CYD	50% coinsurance after INN CYD
Office Services								
Primary Care Provider Office Visit	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	$25 copay	40% coinsurance after CYD	$35 copay	50% coinsurance after CYD
Specialist Office Visit	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	$75 copay	50% coinsurance after CYD
Convenient Care	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	$25 copay	40% coinsurance after CYD	$35 copay	50% coinsurance after CYD
Preventive Services								
Preventive Care - Adult & Children Wellness Service	$0 copay	50% coinsurance	$0 copay	40% coinsurance	$0 copay	40% coinsurance	$0 copay	50% coinsurance
Mammogram	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Routine Colonoscopy	$0 copay	50% coinsurance	$0 copay	40% coinsurance	$0 copay	$0 copay	$0 copay	$0 copay
Emergency Medical Care								
Urgent Care Facility	30% coinsurance after CYD	30% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Ambulance Service	30% coinsurance after CYD	30% coinsurance after INN CYD	20% coinsurance after CYD	20% coinsurance after INN	20% coinsurance after CYD	20% coinsurance after INN	50% coinsurance after CYD	50% coinsurance after CYD
Emergency Room Facility Services (Per Visit)	$50 PVD, then 30% coinsurance after CYD	$50 PVD, then 30% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after CYD	$200 copay		50% coinsurance after CYD	50% coinsurance after INN CYD

Under the new healthcare legislation, it is required to carry or maintain minimum essential medical insurance either through your employer or independently to avoid a penalty. Calhoun County School District provides minimum essential health insurance coverage that meets minimum value standards and is affordable. If you choose to waive the District's medical plan and enroll in Marketplace coverage, you may not be eligible for a Marketplace subsidy or tax credit, and you will also lose the subsidy provided by the District towards District-provided medical insurance.

Calhoun County School District	BLUE CHOICE—0117		BLUE CHOICE—0727		BLUE OPTIONS—03359		BLUE OPTIONS—05901	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Diagnostic Services								
Independent Diagnostic Testing Facility Services (per visit) Diagnostic Service (except AIS) Advanced Imaging Services (AIS) CT/CAT/MRA/MRI,PET scans	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	$50 copay $125 copay	40% coinsurance after CYD	$50 copay $200 copay	50% coinsurance after CYD
Independent Clinical Lab (blood work)	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	$0 copay	40% coinsurance after CYD	$0 copay	50% coinsurance after CYD
Outpatient Hospital Facility Services	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	Option 1: $150 copay Option 2: $250 copay	40% coinsurance after CYD	Option 1: $300 copay Option 2: $400 copay	50% coinsurance after CYD
Hospital Surgical								
Ambulatory Surgical Center Facility	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	$100 copay	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Outpatient Hospital Facility Services - Therapy	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	Option 1: $45 copay Option 2: $60 copay	40% coinsurance after CYD	Option 1: $80 copay Option 2: $90 copay	50% coinsurance after CYD
Outpatient Hospital Facility Services - All Other Services	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	Option 1: $150 copay Option 2: $250 copay	40% coinsurance after CYD	Option 1: $300 copay Option 2: $400 copay	50% coinsurance after CYD
Inpatient Hospital Facility/ Rehabilitation Services	$150 PAD, then 30% coinsurance after CYD	$300 PAD, then 50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	Option 1: $750 copay Option 2: $1,000 copay	40% coinsurance after CYD	Option 1: $2,000 copay Option 2: $3,000 copay	50% coinsurance after CYD
Mental Health/Substance Abuse								
Inpatient Hospital Facility Service	$150 PAD, then 30% coinsurance after CYD	$300 PAD, then 50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	Option 1: $750 copay Option 2: $1,000 copay	40% coinsurance after CYD	$0 copay	50% coinsurance
Outpatient Hospital Facility Service	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	Option 1: $150 copay Option 2: $250 copay	40% coinsurance after CYD	$0 copay	50% coinsurance
Emergency Room Facility Services (Per Visit)	$50 PVD, then 30% coinsurance after CYD	$50 PVD, then 30% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after CYD	$50 PVD Ded + $100 copay		$0 copay	

Services rendered outside the network are subject to balance billing, which means the member may be responsible for the difference between the negotiated fee or the facility's retail charge.

Calhoun County School District	BLUE CHOICE—0117		BLUE CHOICE—0727		BLUE OPTIONS—03359		BLUE OPTIONS—05901	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services								
Rehabilitation Services - Cardiac, Occupational, Physical, Speech, Massage Therapies and Spinal Manipulations Outpatient Rehab Center Outpatient Hospital Facility (per visit): Option 1: Option 2:	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	20% coinsurance after CYD $45 copay $60 copay	40% coinsurance after CYD	$75 copay $80 copay $90 copay	50% coinsurance after CYD
Durable Medical Equipment	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Home Health	30% coinsurance after CYD	50% coinsurance after CYD	0% Allowed Amount up to the PBM	0% Allowed Amount up to the PBM	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Skilled Nursing Care	30% coinsurance after CYD	50% coinsurance after CYD	0% Allowed Amount up to the PBM	0% Allowed Amount up to the PBM	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Hospice	30% coinsurance after CYD	50% coinsurance after CYD	0% Allowed Amount up to the PBM	0% Allowed Amount up to the PBM	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Provider Services (Hospital/ER)	30% coinsurance after CYD	30% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after CYD	20% coinsurance after INN CYD	50% coinsurance after CYD	50% coinsurance after INN CYD
Provider Services (Other Than Hospital/ER)	30% coinsurance after CYD	50% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	20% coinsurance after CYD	40% coinsurance after CYD	50% coinsurance after CYD	50% coinsurance after CYD
Prescription Drugs								
Pharmacy Deductible	In-Network (INN) CYD		$0		$0		$0	
Preferred Generic	30% coinsurance after CYD	50% coinsurance after INN CYD	$5	50% coinsurance	$10	50% coinsurance	$15	50% coinsurance
Preferred Brand	30% coinsurance after CYD	50% coinsurance after INN CYD	$30	50% coinsurance	$30	50% coinsurance	$50	50% coinsurance
Non-Preferred	30% coinsurance after CYD	50% coinsurance after INN CYD	$60	50% coinsurance	$60	50% coinsurance	$80	50% coinsurance
Oral Chemotherapy	$10	50% coinsurance after INN CYD	$10	50% coinsurance	$10	50% coinsurance	$10	50% coinsurance
	Mail Order (90 days)		Mail Order (90 days)		Mail Order (90 days)		Mail Order (90 days)	
Preferred Generic	$14		$10		$20		$40	
Preferred Brand	$40		$60		$60		$125	
Non-Preferred	Not covered		$120		$120		$200	
Oral Chemotherapy	$25		$25		$25		$25	

Services rendered outside the network are subject to balance billing, which means the member may be responsible for the difference between the negotiated fee or the facility's retail charge.

Dental Benefits

Administered by Ameritas | Customer Service: 800.487.5553

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Calhoun County School District dental benefit plan.

Dental Plan Summary	LOW PLAN—Policy #37431	
Plan Benefit	In-Network	Out-of-Network
Type 1	100%	100%
Type 2	50%	50%
Type 3	50%	50%
Deductible	$15/visit Type 1, 2, 3 No Family Maximum	$25/visit Type 1, 2, 3 No Family Maximum
Maximum (per person)	$1,000 per calendar year	$1,000 per calendar year
Allowance	Discounted Fee	Discounted Fee
Waiting Period	6 - Months Type 3 new Hires Only	6 - Months Type 3 new Hires Only
Annual Open Enrollment	Included	Included

Sample Procedure Listing (Current Dental Terminology© American Dental Association)

In-Network

Type 1	Type 2	Type 3
» Routine Exam (2 per benefit period) » Bitewing X-rays (1 per benefit period) » Periapical X-rays » Cleaning (2 per benefit period) » Fluoride for Children 18 and under (1 per benefit period) » Space Maintainers	» Full Mouth/ Panoramic X-rays (1 in 5 years) » Sealants (age 16 and under) » Restorative Amalgams » Restorative Composites » Denture Repair » Simple Extractions	» Onlays » Crowns (1 in 5 years per tooth) » Crown Repair » Endodontics (nonsurgical) » Endodontics (surgical) » Periodontics (nonsurgical) » Periodontics (surgical) » Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years) » Complex Extractions » Anesthesia

Out-of-Network

Type 1	Type 2	Type 3
» Routine Exam (2 per benefit period) » Bitewing X-rays (1 per benefit period) » Periapical X-rays » Cleaning (2 per benefit period) » Fluoride for Children 18 and under (1 per benefit period) » Space Maintainers	» Full Mouth/ Panoramic X-rays (1 in 5 years) » Sealants (age 16 and under) » Restorative Amalgams » Restorative Composites » Denture Repair » Simple Extractions	» Onlays » Crowns (1 in 5 years per tooth) » Crown Repair » Endodontics (nonsurgical) » Endodontics (surgical) » Periodontics (nonsurgical) » Periodontics (surgical) » Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years) » Complex Extractions » Anesthesia

Dental Plan Summary	HIGH PLAN— Policy #37431
Plan Benefit	
Type 1	100%
Type 2	80%
Type 3	50%
Deductible	$0/Calendar Year Type 2,3 Waived Type 1; No Family Maximum
Maximum (per person)	$1,000 per calendar year
Allowance	90th U&C
Waiting Period	None
Annual Open Enrollment	Included

Sample Procedure Listing (Current Dental Terminology©American Dental Association)

In-Network		
Type 1	**Type 2**	**Type 3**
» Routine Exam (2 per benefit period) » Bitewing X-rays (2 per benefit period) » Full Mouth/Panoramic X-rays (1 in 3 years) » Periapical X-rays » Cleaning (2 per benefit period) » Fluoride for Children 18 and under (1 per benefit period) » Sealants (age 16 and under) » Space Maintainers	» Restorative Amalgams » Restorative Composites » Endodontics (nonsurgical) » Endodontics (surgical) » Periodontics (nonsurgical) » Periodontics (surgical) » Denture Repair » Simple Extractions » Complex Extractions » Anesthesia	» Onlays » Crowns (1 in 5 years per tooth) » Crown Repair » Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Life and Accidental Death & Dismemberment Insurance

Insured by Cigna

Life Insurance

Life insurance provides financial security for the people who depend on you. Calhoun County School District provides $20,000 basic life insurance for all full-time employees at no cost to you.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Calhoun County School District provides $20,000 of AD&D coverage.

Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical	Florida Blue	800.352.2583	www.floridablue.com
Dental	Ameritas	800.487.5553	N/A
Life and AD&D	Cigna	800.732.1603	Rhonda O'Bryan
Rhonda O'Bryan	Calhoun County School District	850.674.8123 x.30	

Federal Notices

Please find below notices regarding Calhoun County School District's medical plan If you'd like additional information about any of these notices or your rights under them, please contact the Rhonda O'Bryan at 800.674.8123 ext. 30

1. HIPAA Special Enrollment
2. Children's Health Insurance Program (CHIP)
3. Women's Health and Cancer Rights Act
4. Newborns' and Mothers' Health Protection Act
5. Michelle's Law
6. COBRA General Notice
7. Notice of Creditable Drug Coverage
8. HIPAA Privacy Notice
9. USERRA Rights

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Rhonda O'Bryan, at 850.674.8123 x 30.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1.877.KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1.866.444.EBSA (3272).

If you live in Florida, you may be eligible for assistance paying your employer health plan premiums. The contact information is as follows:

FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Rhonda O'Bryan, at 850.674.8123 x 30.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal

delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Michelle's Law

Michelle's Law requires group health plans to provide continued coverage for certain dependents who are covered under the School District's group health plan as a student if they lose their student status because they take a medically necessary leave of absence from school. This continuation of coverage is described below.

If your dependent is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your dependent may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your dependent was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions). For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the dependent at the institution, that:

1. begins while the dependent is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the dependent to lose student status for purposes of coverage under the plan.

The coverage provided to dependents during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your dependent had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed under the plan during this one-year period, the plan will provide the changed coverage for the dependent for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for these dependents.

If you believe your dependent is eligible for this continued coverage, the dependent's treating physician must provide a written certification to the plan stating that your dependent is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

COBRA General Notice of Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

Y**ou may have other options available to you when you lose group health coverage**. For example, you may be eligible to buy an individual plan through the Health Insurance marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

» Your hours of employment are reduced, or

» Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

» Your spouse dies;

» Your spouse's hours of employment are reduced;

» Your spouse's employment ends for any reason other than his or her gross misconduct;

» Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

» You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

» The parent-employee dies;

» The parent-employee's hours of employment are reduced;

» The parent-employee's employment ends for any reason other than his or her gross misconduct;

» The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

» The parents become divorced or legally separated; or

» The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Calhoun County School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

» The end of employment or reduction of hours of employment;

» Death of the employee;

» Commencement of a proceeding in bankruptcy with respect to the employer; or

» The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Rhonda O'Bryan, Calhoun County School District 20859 Central Avenue East, G-20, Blountstown, FL 32424, 850.674.8123 x 30.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only

available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Rhonda O'Bryan, Calhoun County School District, 850.674.8123 x 30.

Certificate of Creditable Drug Coverage

Important Notice from Calhoun County School District About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Calhoun County School District and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Calhoun County School District has determined that the prescription drug coverage offered by the Calhoun County School District medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Calhoun County School District coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Calhoun County School District coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Calhoun County School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 % of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently

be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year.

You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Calhoun County School District changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

REMEMBER: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

DATE:	10/01/2017
Name of Entity:	Calhoun County School District
Contact:	Rhonda O'Bryan
Address:	20859 Central Avenue East, G-20 Blountstown, FL 32424
Phone Number:	800.674.8123, ext. 30

HIPAA Privacy Notice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

» Respond to organ and tissue donation requests and work with a medical examiner or funeral director

» Address workers compensation, law enforcement, and other government requests

» Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

» You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

» We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

» You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

» We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

» You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

» We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

» You can ask us not to use or share certain health information for treatment, payment, or our operations.

» We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

» You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

» We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

» If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

» We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

» You can complain if you feel we have violated your rights by contacting us using the information on page 1.

» You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

» We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

» Share information with your family, close friends, or others involved in payment for your care

» Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

» Marketing purposes

» Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the healthcare treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

» We can use and disclose your information to run our organization and contact you when necessary.

» We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

» Preventing disease

» Helping with product recalls

» Reporting adverse reactions to medications

» Reporting suspected abuse, neglect, or domestic violence

» Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

» We can share health information about you with organ procurement organizations.

» We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers compensation, law enforcement, and other government requests

We can use or share health information about you:

» For workers' compensation claims

» For law enforcement purposes or with a law enforcement official

» With health oversight agencies for activities authorized by law

» For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

» We are required by law to maintain the privacy and security of your protected health information.

» We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

» We must follow the duties and privacy practices described in this notice and give you a copy of it.

» We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.

Other Information

» Privacy Notice Effective Date: 9/1/2013

» Contact Information: Rhonda O'Bryan, Calhoun County School District, 20859 Central Avenue East, G-20, Blountstown, FL 2424, 850.674.8123 x 30

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.

- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date—July 2008

Notes

This benefit summary prepared by

Arthur J. Gallagher & Co.

17GBS30805A

Exhibit 8

Additional Plan Claim Detail

B7505 - CALHOUN COUNTY SCHOOL BOARD

Paid: 05/01/2016 - 07/31/2017
Inc: 05/01/2016 - 04/30/2017

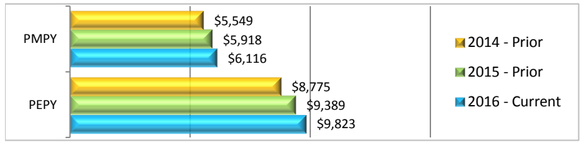
Florida Blue

PEPY Trend

2016 - Current	2015 - Prior	2014 - Prior
$ 9,823	$ 9,389	$ 8,775
4.62% - Increase	7.00% - Increase	0.00% - Baseline

PMPY Trend

2016 - Current	2015 - Prior	2014 - Prior
$ 6,116	$ 5,918	$ 5,549
3.35% - Increase	6.65% - Increase	0.00% - Baseline



Payment and Utilization Indicators

Total Spend	BM	Current	Prior	% Chng
Claims		20,324	21,079	(3.6%)
Spend Per Claim		$ 137	$ 128	6.5%
Spend		$ 2,779,108	$ 2,707,304	2.7%
PMPM	$ 371.00	$ 509.65	$ 493.13	3.3%
PEPM	$ 629.00	$ 818.59	$ 782.46	4.6%
Inpatient	**BM**	**Current**	**Prior**	**% Chng**
Admits		42	24	75.0%
Spend Per Admit	$ 15,467	$ 8,154	$ 12,475	(34.6%)
ALOS	3.98	4.02	3.83	5.0%
Total Spend		$ 342,456	$ 299,406	14.4%
Util/1000	69	92	52	76.2%
PMPM	$ 89.24	$ 62.80	$ 54.54	15.2%
Outpatient	**BM**	**Current**	**Prior**	**% Chng**
Visits		754	732	3.0%
Spend Per Visit	$ 1,038	$ 918	$ 996	(7.8%)
Total Spend		$ 692,278	$ 729,100	(5.1%)
Util/1000	792	1,659	1,600	3.7%
PMPM	$ 68.51	$ 126.95	$ 132.81	(4.4%)
ER	**BM**	**Current**	**Prior**	**% Chng**
Visits		165	184	(10.3%)
Spend Per Visit	$ 1,417	$ 711	$ 465	52.9%
Total Spend		$ 117,290	$ 85,554	37.1%
Util/1000	208	363	402	(9.7%)
PMPM	$ 24.61	$ 21.51	$ 15.58	38.0%
Urgent Care	**BM**	**Current**	**Prior**	**% Chng**
Services		55	61	(9.8%)
Spend Per Service	$ 69	$ 21	$ 25	(15.8%)
Total Spend		$ 1,140	$ 1,501	(24.1%)
Util/1000	213	121	133	(9.2%)
PMPM	$ 1.23	$ 0.21	$ 0.27	(23.5%)
Professional	**BM**	**Current**	**Prior**	**% Chng**
Services		8,697	8,999	(3.4%)
Spend Per Service	$ 85	$ 82	$ 69	17.8%
Total Spend		$ 708,984	$ 622,802	13.8%
Util/1000	14,929	19,139	19,670	(2.7%)
PMPM	$ 105.85	$ 130.02	$ 113.44	14.6%
Pharmacy	**BM**	**Current**	**Prior**	**% Chng**
Scripts		10,611	11,079	(4.2%)
Spend Per Script	$ 92	$ 86	$ 87	(1.2%)
Total Spend		$ 913,581	$ 965,840	(5.4%)
Util/1000	10,692	23,351	24,216	(3.6%)
PMPM	$ 81.73	$ 167.54	$ 175.93	(4.8%)
Capitation	**BM**	**Current**	**Prior**	**% Chng**
Total Spend		$ 3,379	$ 3,102	8.9%
PMPM		$ 0.62	$ 0.57	9.7%

BM - Benchmark
Book of Business benchmarks are based on claims incurred 01/01/2016-12/31/2016 and through 03/31/2017

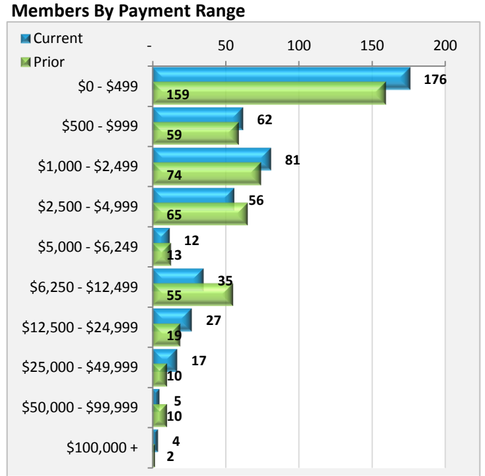
Population By Coverage Tier

Enrollment	Current	Prior	% Chng
Contracts	283	288	(1.9%)
Members	454	458	(0.7%)
Members Per Contract	1.6	1.6	1.2%

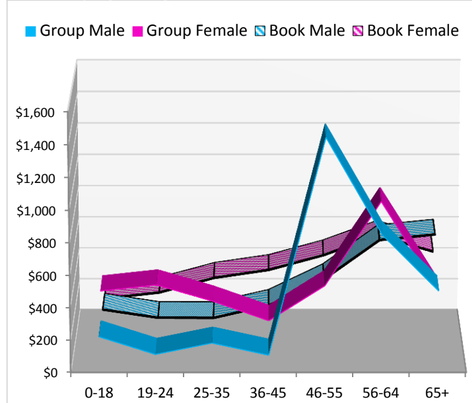
Population Average Age By Relation and Gender

Relationship / Gender	Current	Prior	% Chng
Employee	**54.1**	**53.5**	**1.0%**
Males	54.4	53.0	2.6%
Females	54.0	53.7	0.5%
Dependents	**35.4**	**36.8**	**(3.9%)**
Males	42.7	43.4	(1.5%)
Females	21.4	22.6	(5.4%)
All Members	**47.0**	**47.3**	**(0.5%)**

Members By Payment Range

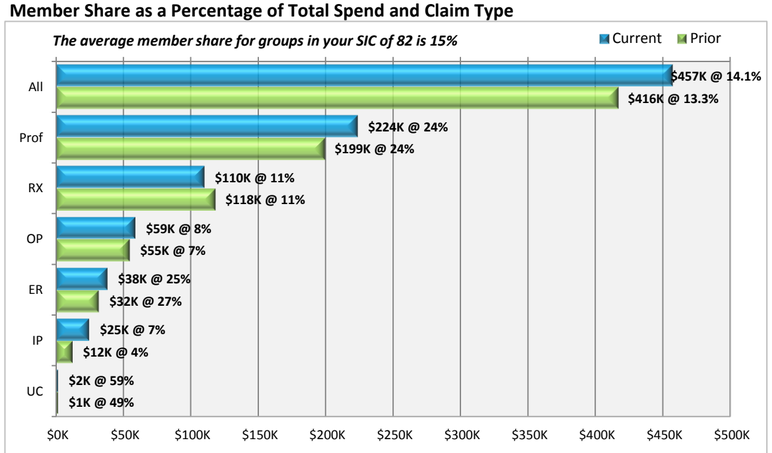


PMPM by Age Range

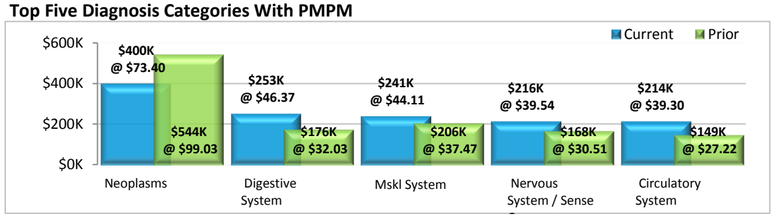


	0-18	19-24	25-35	36-45	46-55	56-64	65+
M	$ 222	$ 111	$ 182	$ 107	$1,443	$ 847	$ 504
F	$ 408	$ 446	$ 344	$ 222	$ 440	$ 964	$ 420

Member Share as a Percentage of Total Spend and Claim Type



Top Five Diagnosis Categories With PMPM



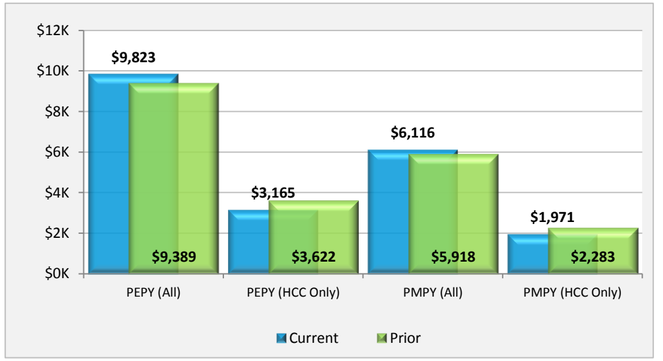
Key Facility Utilization

(Rank) Facility Name	Current	Prior
(1) Tallahassee Memorial Healthcare Inc	$ 468,166	$ 597,094
(2) Bay Medical Center - Sacred Heart Hospital System	$ 124,645	$ 116,259
(3) Capital Regional Medical Center	$ 109,852	$ 56,706
(4) Calhoun Liberty Hospital	$ 105,741	$ 55,642
(5) Gulf Coast Medical Center	$ 104,712	$ 60,918
(6) Jackson Hospital	$ 95,231	$ 88,534
(7) Triad Of Alabama Llc	$ 24,177	$ 5,363
(8) Houston County Healthcare Autho	$ 20,951	$ 26,753
(9) Tallahassee Outpatient Surgery Center	$ 18,391	$ 6,571
(10) Emerald Shores Health And Rehabilitation	$ 12,688	$ 1,032

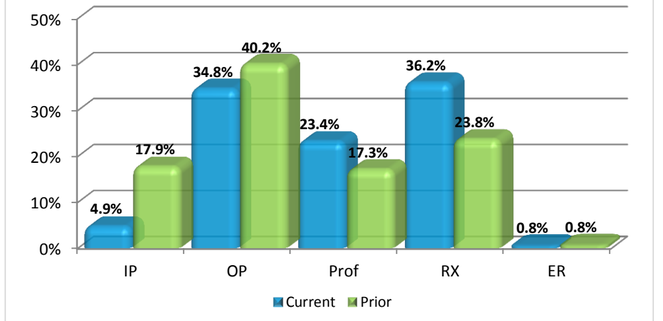
Key Findings

High Cost Member Impacts $50,000

Category	Current	Prior	% Change
High Cost Members	9	12	(25.0%)
Percent of Population	1.98%	2.62%	(24.5%)
High Cost Member Spend	$ 895,446	$ 1,044,191	(14.2%)
Average Spend Per Case	$ 99,494	$ 87,016	14.3%
High Cost PMPM Impact	$ 164.21	$ 190.20	(13.7%)
PMPM Less High Cost Mbrs	$ 345.44	$ 302.93	14.0%
Percent of Total PMPM	32.2%	38.6%	(16.5%)



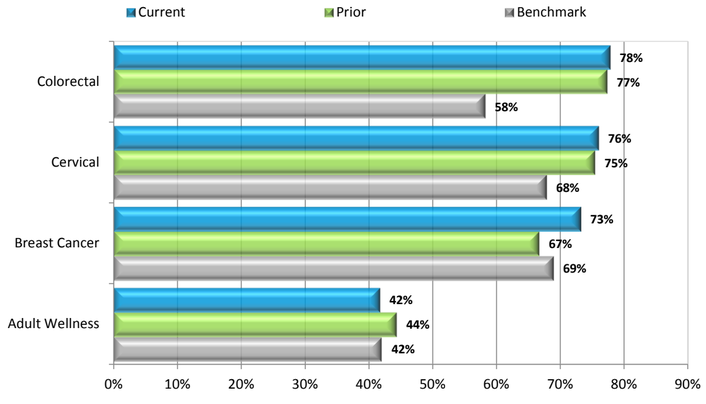
High Cost Spend as Percentage by Claim Type



B7505 - CALHOUN COUNTY SCHOOL BOARD

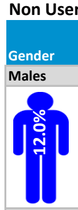
Paid: 05/01/2016 - 07/31/2017
Inc: 05/01/2016 - 04/30/2017

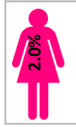
Compliance Screenings

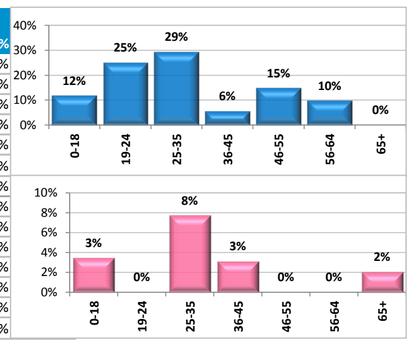


Non Users by Age Bracket

Gender	Age Bracket	Members	Non-User %
Males	0-18	2	11.8%
	19-24	3	25.0%
	25-35	5	29.4%
	36-45	1	5.6%
	46-55	4	14.8%
	56-64	4	9.8%
	65+	0	0.0%
Females	0-18	1	3.4%
	19-24	0	0.0%
	25-35	2	7.7%
	36-45	1	3.1%
	46-55	0	0.0%
	56-64	0	0.0%
	65+	1	2.0%

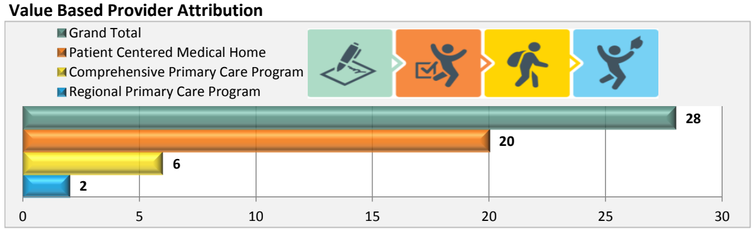






*Members with no spend and 10+ months of coverage

Value Based Provider Attribution



Pharmacy - Split by Tier and Specialty

Tier	Scripts	Plan Paid
Generic	**9,073**	**$ 151,251**
Non-Specialty	9,073	$ 151,251
Specialty	-	-
Preferred Brand	**997**	**$ 560,534**
Non-Specialty	909	$ 296,041
Specialty	88	$ 264,492
Non-Preferred Brand	**541**	**$ 201,796**
Non-Specialty	522	$ 92,727
Specialty	19	$ 109,069
Total	**10,611**	**$ 913,581**

Pharmacy - Key Performance Measures

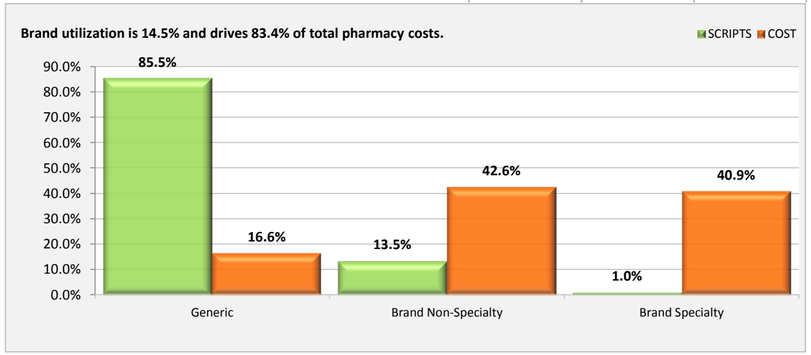
Category	Current	Prior	% Chng
Avg Members Per Month	454	458	(0.7%)
Avg Util Members Per Month	399	400	(0.4%)

Pharmacy - Total Cost and Utilization

Category	Current	Prior	% Chng
Plan Paid	$ 913,581	$ 965,840	(5.4%)
Member Share	$ 110,051	$ 117,852	(6.6%)
Total Scripts	10,611	11,079	(4.2%)
Total PMPM	$ 188	$ 197	(4.9%)
Plan Paid PMPM	$ 168	$ 176	(4.8%)
Member Share PMPM	$ 20	$ 21	(6.0%)
Scripts PMPM	1.95	2.02	(3.6%)

Pharmacy - Percent of Utilization by Tier

Category	Current		Prior	
	Scripts	*% Paid*	*Scripts*	*% Paid*
Generic	85.5%	16.6%	83.3%	18.4%
Brand	8.6%	32.4%	10.2%	33.3%
Non Preferred Brand	4.9%	10.1%	5.5%	9.8%
Specialty	1.0%	40.9%	1.0%	38.5%



Pharmacy - Average Ingredient Cost, Dispensing Fee, Plan Paid and Member Share

Category	Current	Prior	% Chng
Avg Ingredient Cost	$ 96	$ 97	(1.3%)
Avg Dispensing Fee	$ 1	$ 1	(0.7%)
Avg Plan Paid	$ 86	$ 87	(1.2%)
Average Member Share	$ 10	$ 11	(2.5%)

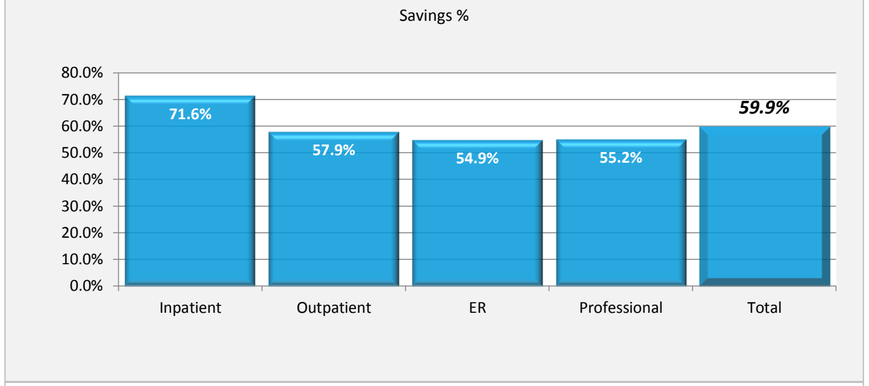
Pharmacy - Top Five Brand Drugs By Spend

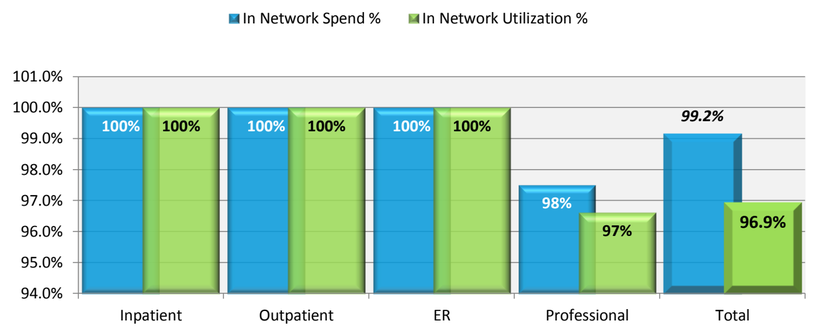
(Rank) Drug Name	Scripts		Plan Paid	
	Current	Prior	Current	Prior
(1) Ezetimibe - Cholesterol	53	71	$ 24,916	$ 26,364
(2) Januvia - Diabetes	58	50	$ 23,767	$ 18,501
(3) Eliquis - Stroke Prevention	27	9	$ 15,921	$ 3,568
(4) Janumet - Diabetes	38	27	$ 15,782	$ 12,408
(5) Basaglar Kwikpen - Diabetes	53	55	$ 15,288	$ 19,722

Pharmacy - Top Five Specialty Drugs By Spend

(Rank) Drug Name	Scripts		Plan Paid	
	Current	Prior	Current	Prior
(1) Humira - Rheumatoid Arthritis	45	41	$ 182,442	$ 139,922
(2) Gilenya - Immunosuppressant (MS)	11	11	$ 72,575	$ 64,929
(3) Aubagio - Multiple Sclerosis (MS)	9	13	$ 52,983	$ 69,731
(4) Enbrel Sureclick - Autoimmune Disorders	11	12	$ 44,178	$ 40,420
(5) Orencia Clickject - Rheumatoid Arthritis	4	0	$ 15,013	-

Network Savings and Utilization





Key Findings

BM = Benchmark

Book of Business benchmarks are based on claims incurred 01/01/2016-12/31/2016 and through 03/31/2017

B7505 - CALHOUN COUNTY SCHOOL BOARD

Paid: 08/01/2016 - 07/31/2017
Inc: 08/01/2016 - 07/31/2017

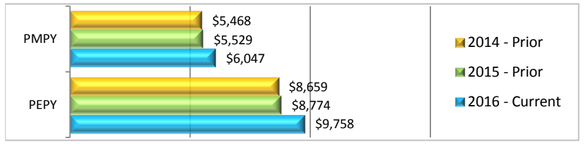
Florida Blue

PEPY Trend

2016 - Current	2015 - Prior	2014 - Prior
$ 9,758	$ 8,774	$ 8,659
11.21% - Increase	1.32% - Increase	0.00% - Baseline

PMPY Trend

2016 - Current	2015 - Prior	2014 - Prior
$ 6,047	$ 5,529	$ 5,468
9.37% - Increase	1.11% - Increase	0.00% - Baseline



Payment and Utilization Indicators

Total Spend	BM	Current	Prior	% Chng
Claims		19,710	20,184	(2.3%)
Spend Per Claim		$ 140	$ 125	12.3%
Spend		$ 2,757,404	$ 2,515,210	9.6%
PMPM	$ 371.00	$ 503.91	$ 460.75	9.4%
PEPM	$ 629.00	$ 813.15	$ 731.17	11.2%
Inpatient	**BM**	**Current**	**Prior**	**% Chng**
Admits		41	23	78.3%
Spend Per Admit	$ 15,467	$ 9,147	$ 12,334	(25.8%)
ALOS	3.98	3.80	3.48	9.4%
Total Spend		$ 375,009	$ 283,689	32.2%
Util/1000	69	90	51	77.8%
PMPM	$ 89.24	$ 68.53	$ 51.97	31.9%
Outpatient	**BM**	**Current**	**Prior**	**% Chng**
Visits		697	706	(1.3%)
Spend Per Visit	$ 1,038	$ 900	$ 914	(1.6%)
Total Spend		$ 627,043	$ 645,340	(2.8%)
Util/1000	792	1,529	1,552	(1.5%)
PMPM	$ 68.51	$ 114.59	$ 118.22	(3.1%)
ER	**BM**	**Current**	**Prior**	**% Chng**
Visits		135	175	(22.9%)
Spend Per Visit	$ 1,417	$ 763	$ 532	43.5%
Total Spend		$ 103,009	$ 93,065	10.7%
Util/1000	208	296	385	(23.0%)
PMPM	$ 24.61	$ 18.82	$ 17.05	10.4%
Urgent Care	**BM**	**Current**	**Prior**	**% Chng**
Services		54	50	8.0%
Spend Per Service	$ 69	$ 20	$ 26	(22.6%)
Total Spend		$ 1,095	$ 1,310	(16.4%)
Util/1000	213	118	110	7.7%
PMPM	$ 1.23	$ 0.20	$ 0.24	(16.6%)
Professional	**BM**	**Current**	**Prior**	**% Chng**
Services		8,383	8,478	(1.1%)
Spend Per Service	$ 85	$ 88	$ 67	31.8%
Total Spend		$ 741,796	$ 569,192	30.3%
Util/1000	14,929	18,384	18,636	(1.4%)
PMPM	$ 105.85	$ 135.56	$ 104.27	30.0%
Pharmacy	**BM**	**Current**	**Prior**	**% Chng**
Scripts		10,400	10,752	(3.3%)
Spend Per Script	$ 92	$ 87	$ 86	1.9%
Total Spend		$ 905,980	$ 919,423	(1.5%)
Util/1000	10,692	22,807	23,635	(3.5%)
PMPM	$ 81.73	$ 165.57	$ 168.42	(1.7%)
Capitation	**BM**	**Current**	**Prior**	**% Chng**
Total Spend		$ 3,473	$ 3,191	8.8%
PMPM		$ 0.63	$ 0.58	8.6%

BM = Benchmark

Book of Business benchmarks are based on claims incurred 01/01/2016-12/31/2016 and through 03/31/2017

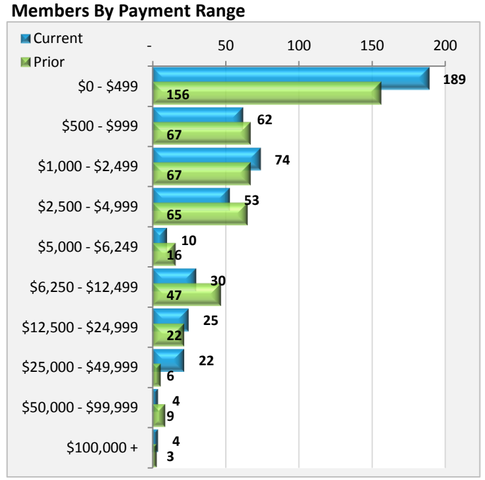
Population By Coverage Tier

Enrollment	Current	Prior	% Chng
Contracts	283	287	(1.4%)
Members	456	455	0.2%
Members Per Contract	1.6	1.6	1.7%

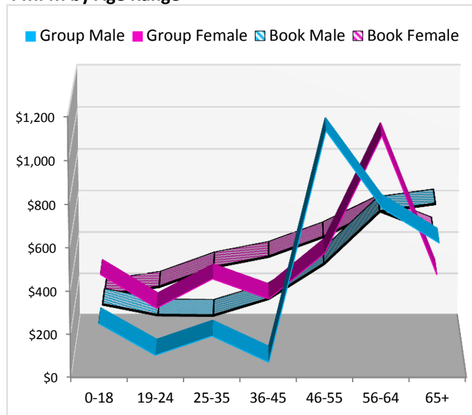
Population Average Age By Relation and Gender

Relationship / Gender	Current	Prior	% Chng
Employee	**54.1**	**53.8**	**0.5%**
Males	54.3	53.2	2.0%
Females	54.1	54.0	0.1%
Dependents	**35.0**	**36.9**	**(5.1%)**
Males	42.6	43.5	(2.0%)
Females	20.7	22.9	(9.3%)
All Members	**47.0**	**47.5**	**(1.0%)**

Members By Payment Range

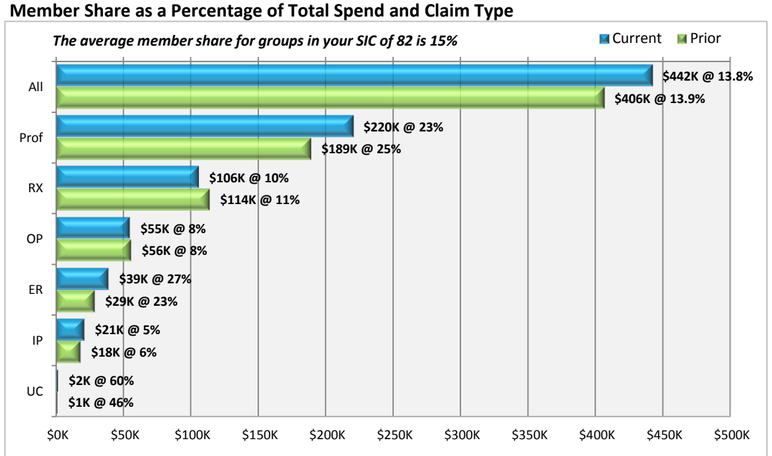


PMPM by Age Range

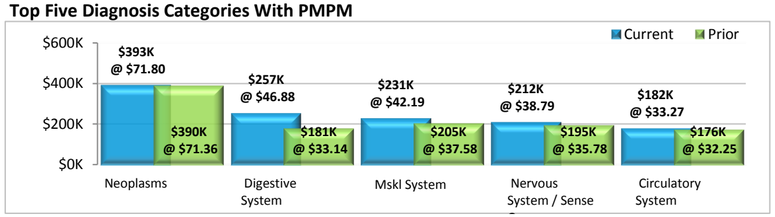


M	$ 252	$ 103	$ 192	$ 70	$1,134	$ 780	$ 622
F	$ 408	$ 249	$ 386	$ 292	$ 507	$ 1,049	$ 406

Member Share as a Percentage of Total Spend and Claim Type



Top Five Diagnosis Categories With PMPM



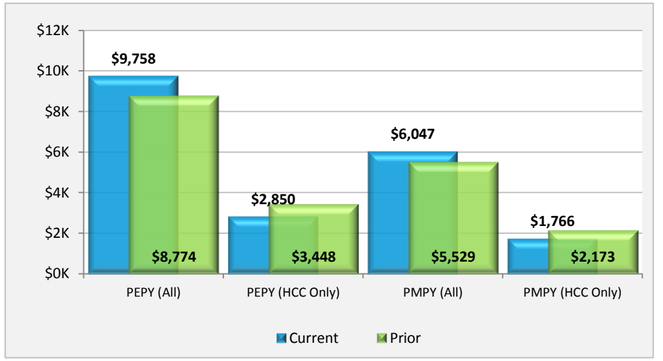
Key Facility Utilization

(Rank) Facility Name	Current	Prior
(1) Tallahassee Memorial Healthcare Inc	$ 405,908	$ 532,245
(2) Gulf Coast Medical Center	$ 151,615	$ 68,118
(3) Capital Regional Medical Center	$ 129,551	$ 77,777
(4) Bay Medical Center - Sacred Heart Hospital System	$ 123,015	$ 94,260
(5) Calhoun Liberty Hospital	$ 83,075	$ 74,417
(6) Jackson Hospital	$ 79,779	$ 86,072
(7) Houston County Healthcare Autho	$ 22,817	$ 7,744
(8) Triad Of Alabama Llc	$ 22,772	$ 9,519
(9) Tallahassee Outpatient Surgery Center	$ 17,398	$ 6,293
(10) Emerald Shores Health And Rehabilitation	$ 11,748	$ 329

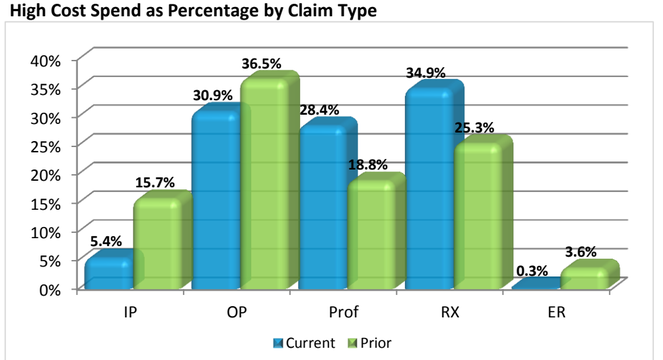
Key Findings

High Cost Member Impacts $50,000

Category	Current	Prior	% Change
High Cost Members	8	12	(33.3%)
Percent of Population	1.75%	2.64%	(33.5%)
High Cost Member Spend	$ 805,232	$ 988,336	(18.5%)
Average Spend Per Case	$ 100,654	$ 82,361	22.2%
High Cost PMPM Impact	$ 147.15	$ 181.05	(18.7%)
PMPM Less High Cost Mbrs	$ 356.76	$ 279.70	27.6%
Percent of Total PMPM	29.2%	39.3%	(25.7%)



High Cost Spend as Percentage by Claim Type



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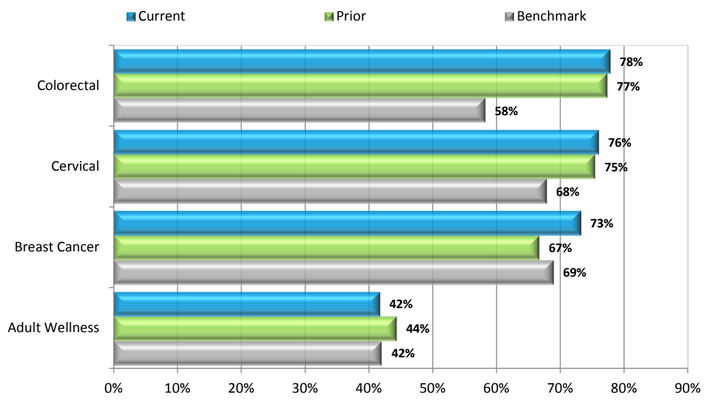
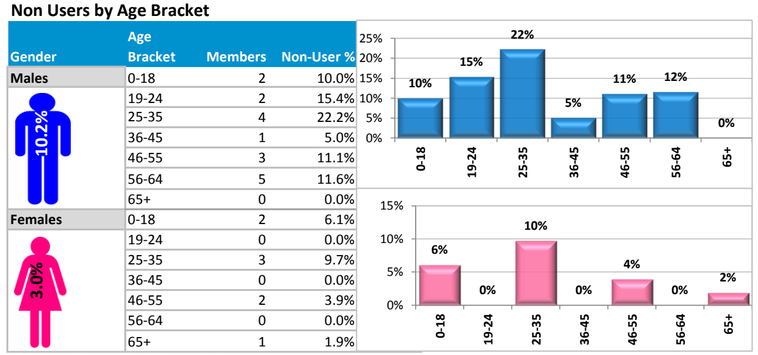
Inc: 08/01/2016 - 07/31/2017

Compliance Screenings



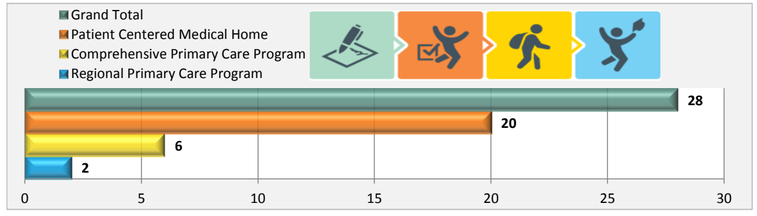
Non Users by Age Bracket

Gender	Age Bracket	Members	Non-User %
Males	0-18	2	10.0%
	19-24	2	15.4%
	25-35	4	22.2%
	36-45	1	5.0%
	46-55	3	11.1%
	56-64	5	11.6%
	65+	0	0.0%
Females	0-18	2	6.1%
	19-24	0	0.0%
	25-35	3	9.7%
	36-45	0	0.0%
	46-55	2	3.9%
	56-64	0	0.0%
	65+	1	1.9%



*Members with no spend and 10+ months of coverage

Value Based Provider Attribution



Pharmacy - Split by Tier and Specialty

Tier	Scripts	Plan Paid
Generic	**8,948**	**$ 145,577**
Non-Specialty	8,948	$ 145,577
Specialty	-	-
Preferred Brand	**938**	**$ 588,375**
Non-Specialty	849	$ 282,835
Specialty	89	$ 305,540
Non-Preferred Brand	**514**	**$ 172,027**
Non-Specialty	498	$ 89,008
Specialty	16	$ 83,019
Total	**10,400**	**$ 905,980**

Pharmacy - Key Performance Measures

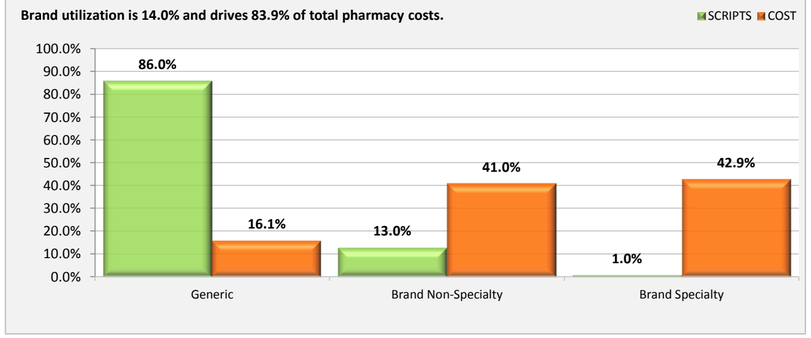
Category	Current	Prior	% Chng
Avg Members Per Month	456	455	0.2%
Avg Util Members Per Month	399	401	(0.5%)

Pharmacy - Total Cost and Utilization

Category	Current	Prior	% Chng
Plan Paid	$ 905,980	$ 919,423	(1.5%)
Member Share	$ 105,779	$ 113,924	(7.1%)
Total Scripts	10,400	10,752	(3.3%)
Total PMPM	$ 185	$ 189	(2.3%)
Plan Paid PMPM	$ 166	$ 168	(1.7%)
Member Share PMPM	$ 19	$ 21	(7.4%)
Scripts PMPM	1.90	1.97	(3.5%)

Pharmacy - Percent of Utilization by Tier

Category	Current		Prior	
	Scripts	*% Paid*	*Scripts*	*% Paid*
Generic	86.0%	16.1%	83.3%	18.1%
Brand	8.2%	31.2%	10.3%	35.1%
Non Preferred Brand	4.8%	9.8%	5.4%	10.4%
Specialty	1.0%	42.9%	1.0%	36.4%



Pharmacy - Average Ingredient Cost, Dispensing Fee, Plan Paid and Member Share

Category	Current	Prior	% Chng
Avg Ingredient Cost	$ 97	$ 95	1.3%
Avg Dispensing Fee	$ 1	$ 1	0.1%
Avg Plan Paid	$ 87	$ 86	1.9%
Average Member Share	$ 10	$ 11	(4.0%)

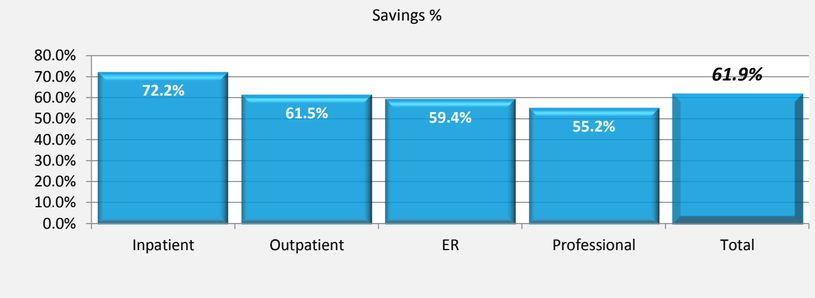
Pharmacy - Top Five Brand Drugs By Spend

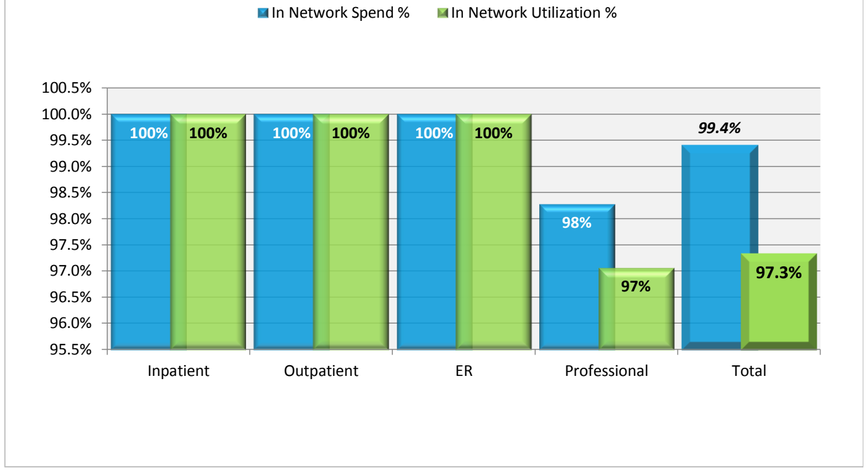
(Rank) Drug Name	Scripts		Plan Paid	
	Current	Prior	Current	Prior
(1) Januvia - Diabetes	60	52	$ 25,468	$ 19,560
(2) Ezetimibe - Cholesterol	53	58	$ 24,835	$ 22,219
(3) Eliquis- Stroke Prevention	27	13	$ 16,246	$ 6,163
(4) Janumet - Diabetes	37	29	$ 15,746	$ 13,385
(5) Basaglar Kwikpen - Diabetes	52	53	$ 14,783	$ 18,298

Pharmacy - Top Five Specialty Drugs By Spend

(Rank) Drug Name	Scripts		Plan Paid	
	Current	Prior	Current	Prior
(1) Humira - Rheumatoid Arthritis	44	42	$ 183,907	$ 149,882
(2) Aubagio - Multiple Sclerosis (MS)	10	10	$ 59,357	$ 55,258
(3) Gilenya - Immunosuppressant (MS)	7	11	$ 46,786	$ 67,278
(4) Enbrel Sureclick - Autoimmune Disorders	10	10	$ 41,588	$ 35,398
(5) Orencia Clickject - Rheumatoid Arthritis	7	0	$ 26,273	-

Network Savings and Utilization





Key Findings

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