Indian River County Purchasing Division
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ADDENDUM NO. 1

Issue Date: May 16, 2022

Project Name: Employee Health Clinic

RFP Number: 2022053

RFP Opening Date: **June 3, 2022 (updated)**

This addendum is being released to answer questions received to date and to extend the deadline for receipt of bids.

The information and documents contained in this addendum are hereby incorporated in the Request for Proposals. **The addendum must be acknowledged where indicated on the Vendor Organizational Information form, or the proposal may be declared non-responsive.**

Attachments
EXL Infolock OSC Data Requirements
Healthcare plans and information
Employee zip codes
Chronic Conditions

Questions and Answers

1. Is the County open to including spouses and dependents in the health center eligibility? If so, please provide member counts for these populations. **At this time the focus is on offering to employees only. However, in subsequent years allowing access to spouses. Employees – 1690 Spouses – 804.**
2. Does the County have a specific space/address selected for the health center? If so, please provide and address and floor plan. **No, this is something the County will lean on the vendor to help with.**
3. Who is the County's medical carrier and pharmacy benefit manager? **Medical Carrier: BCBS and PBM: RxBenefits (Express Scripts)**
4. Please provide the healthcare plan design information, including number and types of plans and enrollment percentages. **See attached.**
5. Please provide the member zip codes with associated member counts for the purpose of heat mapping. **See attached, includes retirees.**
6. Is the County interested in a shared-site model (community-based location that offers access to multiple like-minded employers) in place of or in addition to a dedicated onsite health center? **No.**
7. What is the intended launch date for the clinic? **A launch date has not been established.**
8. What are the County's wellness program requirements and incentives? **Employees enrolled in the medical plan are eligible to receive a $25 gift card upon completing their annual physical. This is**

not well utilized due to a "self" redemption process that needs to be completed online. Most employees do not take advantage of this.

9. What is the County's current engagement metrics for the wellness program and diabetes management programs? **For diabetes management, Improved Biometric trends: To include blood glucose, hemoglobin A1c, and blood pressure. Increased enrollment: Engagement of a minimum of fifty (50) eligible members by 12 months post-implementation for reporting and proof of concept purposes. Increased testing adherence: implement program requirements for active participants to remain eligible for the program. We will work with our consultant and clinic vendor to establish engagement metrics for our wellness program**.
10. For the purpose of ROI calculation: Please provide the total medical and pharmacy plan spend for 2019, 2020, and 2021. **2019: $20,660,000. 2020: $20,330,000. 2021: $22,120,000.**
11. For the purpose of ROI calculation: Please provide the County's top 5 conditions and attributed spend for 2019, 2020, and 2021. **See attached.**
12. Does the County have a preference on MD or NP led staffing model? **NP/ MA model.**
13. Could the County please clarify which of the below occupational health services they would like to bring into the health center AND please provide the annual utilization metrics for each?
    a. Drug testing, including pre-employment, random, and incident-related (please include panel size and indicate if tests are DOT, non-DOT, or both)
    b. BAT testing **No**
    c. Pre-employment physicals (include exam requirements) **No**
    d. DOT physicals (include exam requirements) **No**
    e. Firefighter and Police physicals (include exam requirements) **No**
    f. PPD testing **No**
    g. Immunizations **Yes**
    h. First aid & response to injury **Yes – triage & provide 1st aid or refer for W/C treatment**
    i. CPR and first aid training **No**
    j. Audiometry, Vision, and Hearing screenings **No**
14. Will the onsite clinic be available to the 1,300 employees for now with the goal to expand services to dependents/spouses in future years? **Yes, for spouses, TBD for children**
15. Are multiple languages spoken by employees? If so, would translation services be required? **Not anticipated**
16. Will children over the age of 2 years eligible to use the onsite clinic services? **Not initially, but possibly in the future as clinic grows.**
17. Is there a budget in place for the employee health clinic? **Budget will depend on model and services provided. Funding will come from the health insurance fund balance.** If so, what is the total budget?
18. Which Indian River County department is responsible for the onsite clinic budget? **Human Resources and Budget**
19. Why has Indian River County chosen to put out an RFP for an onsite clinic at this time? **The County's Board of County Commissioners approved staff proceeding with an RFP to evaluate whether an employee clinic could be an enhanced benefit and assist us in developing and supporting health and wellness for our insured members.**
20. Does Indian River County have a high-deductible plan with an HSA as part of the medical benefit offering? **No.**
    a. If yes, what % of employees have this plan?
    b. Has fair market value for the clinic visit determined?
21. Does Indian River County want health information (NOT claims) sent to the benefits carrier to

review the total health of the population? **Yes.**

22. Does Indian River County want work-related injury information (NOT claims) sent to the workers comp carrier? **No. Any work-related injury information would be provided to Risk Management who coordinates w/c care.**
23. What are the top work-related injuries at Indian River County? **Back, heart (statutory first responders), knee**
24. Does Indian River County have a preferred laboratory? **Quest Diagnostics**
25. Who is your workers' comp TPA? **John's Eastern**
26. Can you please provide a copy of the "Onsite Clinic Data Requirements" referenced in the RFP (ECL_Infolock OSC Data Requirements)? **See attached.**
27. Does Indian River County currently deploy an HRA? **The Florida Blue website wellness portal has an HRA however, it is not well utilized and we have opportunity to improve in this area. Prior to COVID we had on site biometric screenings during our health fair – participation was about 250 persons. There was an HRA component to the onsite screening.**
28. Are there annual incentives for participants of the wellness program? **Yes.** If yes, what are the requirements to receive the incentive. (**i.e. annual biometric/HRA completion, annual preventive examination) $25 gift card – opportunity to enhance and improve**
29. What is the current volume of monthly new hires? **Approximately 20 Full Time new hires per month.**
30. Will the onsite staff be responsible for triaging symptomatic, potentially COVID-exposed patients at the onsite clinic? **Yes.**
31. Will work-related medical surveillance examinations (police, fire, hazmat) be part of the scope of services? **No.**
32. Will hearing tests be part of the scope of services? (Since this is expensive equipment, we just need to understand if this should be included as part of the start-up costs.) **No.**
33. Are respiratory fit tests or pulmonary function testing part of the scope of services? **Possibly.**
34. Are there Indian River County departments that would benefit from the access to after-hours occupational health treatment (i.e. Fire, Police, and Water/Streets)? **Yes, but not sure if those would be utilized.**
35. Do you currently have any onsite staff, either directly employed or managed by a vendor providing onsite health care in any capacity? **No.** If no to above, does Indian River County have space identified for an onsite clinic? **No, the County will lean on the vendor to help with this.**
36. Will the awarded vendor need to price furniture/equipment, and/or medical supplies? **Yes.**
37. Would Indian River County consider an alternative staffing recommendation that would provide the same scope of work (i.e. an Advanced Practitioner with Physician Oversight versus a physician)? **Yes.**
38. What are the desired operating hours for the onsite clinic? **40 hours/ week.**
39. Does Indian River County want backfill (coverage) when staff takes vacation or is sick? **Yes.**
40. Is it your intention to own the facility? For the vendor to own and lease back to the County? For the vendor to own and operate all aspects of the facility? **We are open to options.**
41. Does the client currently conduct a health risk assessment event? **Prior to COVID, HRA and biometrics were conducted on site by Florida Blue.** Who is the vendor for these assessments? **Florida Blue.** What are the participation levels for current events OR expected participation for the event? **Approx. 250 persons participated in the past. We would hope to improve participation.**
42. What are the parameters for offering incentives for health center participation or participation in wellness events? **Not defined, open to options.**
43. How much do you spend as a whole on all wellness programs offered by the County? **Annual budget for health fair is currently $25,000 (have not had onsite health fair since COVID). Onsite**

mammography is offered every quarter and billed to health plan. $8,000 set aside for gift cards. $50k annual wellness contribution from Florida Blue. Open to expanding wellness program and benefits.

44. Define "limited Occupational Health Services". What services are provided and volumes associated with each of the services? **Work related injuries are annually 75-100. Would expect to triage and provide first aide to approximately 50-75 annually. Work related immunizations such as Hepatitis B series.**

45. What's the driving initiative to open a new clinic? Are there key metrics that will measure the success of the clinic (e.g. engagement, savings)? **The County's Board of County Commissioners approved staff to proceed with an RFP to evaluate whether an employee clinic could be an enhanced benefit and assist us in developing and supporting health and wellness for our insured members.**

46. Can the vendor assist with design/best practices for the buildout of the space? **Yes, we will seek vendor input.**

47. Are you open to a virtual and in-person approach to care? **Yes.**

48. Does the County's self-funded plan include a Health Savings account option? **No** If so, how many employees will participate?

49. Will Police and Fire and other County departments be involved in the decision process? **RFP Review committee comprised of these departments; Fire Support Services, Risk management, Library Services, Road & Bridge, Public Works, Utilities, Office of management & Budget, Human Resources.**

50. What vendor partners of the County will you want the health center to interact and share data with? **Current vendors are Florida blue, RX benefits, Kannact, Lockton, health advocate.**

51. On the Excel Cost template, does the County want the pricing form to include the estimated vaccines and dispensed RX costs in addition to the estimated lab fees? If so, is it acceptable for bidders to add lines to the cost template form? **Yes, per instructions on the Cost Summary page, you may add line items as necessary.**

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EXL/Infolock® Onsite Clinic Data Integration Requirements:

- Provide a monthly claim level extract with the required data elements shown below to EXL/InfoLock or be able to submit claims to client's medical carrier partner.
- Track every medical procedure performed in the clinic with a CPT code (including health coaching, blood pressure checks, etc.). If an onsite clinic provides a fee schedule it may be used in InfoLock reporting.
- Collect employee and member SSN as member ID that is congruent or can be tracked back to medical carrier partner.
- If applicable, track every prescription dispensed with a NDC code, metric quantity and days' supply.
- For clients with a HDHP currently, we are interested in learning your firm's ability to support sending data to the medical carrier partner for financial integration (deductibles, out of pocket max):
    - How will payments be processed?
    - Will claims be reprocessed to provide an allowable amount? If so, how? Will a fee schedule be used?
    - How will your firm set the value of the service to calculate coinsurance/copay for the onsite clinic?
- To satisfy EXL/Infolock reporting requirements, the following required medical data elements must be provided from the onsite clinic vendor to EXL analytics (Infolock).

Data element	Description
Claim ID	This field is used to receive the unique ID used to identify the claim or a specific encounter at the onsite clinic.
Claim line ID	This field is used to receive the claim line ID within the claim ID
Claim status code	This field tells us whether the claim was paid, pended, denied etc.
Date of service	First date of service for the claim referenced in Claim ID
Subscriber SSN	Subscriber SSN
Member SSN	Member's SSN
Gender	Patient gender
Patient last name	
Patient first name	
Relationship	Employee, spouse or dependent
DOB	Patient date of birth
ICD10 Dx code 1	Primary ICD10 diagnosis code
ICD9 Dx code 1	Primary ICD9 diagnosis code
ICD10 Dx code 2	Secondary ICD10 diagnosis code
ICD9 Dx code 2	Secondary ICD9 diagnosis code
ICD indicator	Code to confirm if the ICD code on the claims are ICD 9 or ICD 10
Place of service	Place of service code, standard CMS values for onsite clinic is 18. All claims should have this POS.
Procedure code	CPT or HCPCS code associated with the claim
Claim type	The standard values could be: M — Medical D — Dental P — Pharmacy O — OSC U — Others/unknown identifies the type of claims (medical, dental, pharmacy, OSC and others/unknown)

Data element	Description
CPT modifier	Code modifiers help further describe a procedure code without changing the definition of the code. This field is mandatory unless ONLY CPT codes are being provided (as opposed to both CPT and HCPCS)
Procedure code type	1/2 — Type (level) of HCPCS code provided in procedure code field: 1 — Level 1 HCPCS — Numeric American Medical Association's Current Procedural Terminology (CPT) code 2 — Level 2 HCPCS — Alphanumeric code, primarily non-physician services such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services
Units	The number of units associated with a particular procedure
Plan type	Plan type code — Examples include PPO, HMO, not enrolled
Plan type Description	See above
Case ID	Contract number, identification number, or policy number for participating employer groups. Used to differentiate each employer.
Case desc.	Employer name.
Provider ID	A unique ID used to identify the provider of the service. This should be the Provider's NPI.
Provider name	Name of provider
Provider group ID	Provider group ID
Provider group name	Name of provider group
Specialty code	Specialty code
Specialty desc.	Specialty description

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.[insert].com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ircgov.com or call 1-800-664-5295 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$600** Per Person/**$1,200** Family. Out-of-Network: **$1,200** Per Person/**$2,400** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$200** In-Network-Option1, **$400** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$3,000** Per Person/**$6,000** Family. Out-Of-Network: **$4,000** Per Person/**$8,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-664-5295 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visits: $30 Copay per Visit Virtual (Telemedicine): $10 Copay per Visit General Medicine/ $20 Specialist	Deductible + 30% Coinsurance/ Virtual Visits (Telemedicine): Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Specialist visit	$50 Copay per Visit/ Virtual Visits: $20 Copay per Visit	Deductible + 30% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Preventive care/screening/ immunization	No Charge	30% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $15 Copay per Visit	Deductible + 30% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$200 Copay per Visit	Deductible + 30% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
	Generic drugs	$10 30 DS Retail Copay $20 90 DS Retail or Mail Order Copay	Not Covered	**Generic Policy**: If your doctor writes a prescription stating that a generic may be dispensed, we will only pay for the generic drug. If you choose to buy the brand name drug in this situation, you will be required to pay the brand copay plus the difference in cost between the generic and brand name drug. The generic policy does not apply if your doctor requires a brand name medication. **Step Therapy:** Step therapy
	Preferred brand drugs	$50 30 DS Retail Copay $100 90 DS Retail or Mail Order Copay	Not Covered	
	Non-preferred brand drugs	$75 30 DS Retail Copay $150 90 DS Retail or Mail Order Copay	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				promotes the use of generic medications first before non-preferred brand medications. If you choose to use certain non-preferred brand name drugs before trying a generic medication or a preferred brand medication, your prescription may not be covered, and you may need to pay the full cost.
	Specialty drugs	Subject to cost share based on applicable drug tier	Not Covered	**Specialty Medications:** Specialty medications are limited to 30-day supply and must be ordered from Express Scripts at 1-800-803-2523. Specialty medications require prior authorization and quantity limits may apply. Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the member shall not receive credit toward their Maximum Out-Of-Pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate. Please see "Important Questions" regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: Deductible + 20% Coinsurance/ Hospital Option 1: $200 Copay per Visit	Deductible + 30% Coinsurance	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 30%	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Coinsurance/ Hospital: Deductible + 30% Coinsurance	Out-of-Network Radiology, Anesthesiology, and Pathology Providers at a Hospital or a Surgical Center will be subject to the In-Network Deductible + 20% Coinsurance
If you need immediate medical attention	Emergency room care	Deductible + $250 Copay per Visit + 20% Coinsurance	Deductible + $250 Copay per Visit + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Urgent Care Visits: $30 Copay per Visit	Urgent Care Visits: $30 Copay per Visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Per Admission $200 Copay + Deductible + 20% Coinsurance	Per Admission $400 Copay + Deductible + 30% Coinsurance	Inpatient Rehab Services limited to 30 days. Covered Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Out-of-Network Radiology, Anesthesiology, and Pathology Providers at a Hospital or a Surgical Center will be subject to the In-Network Deductible + 20% Coinsurance
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office: $45 Copay per Visit/ Hospital Opt 1: Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Option 2 hospitals may have a higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Inpatient services	Physician Services: Deductible + 20% Coinsurance / Hospital Opt 1: Per Admission $200 Copay + Deductible + 20% Coinsurance	Physician Services: Deductible + 30% Coinsurance/ Hospital: Per Admission $400 Copay + Deductible + 30% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied. Option 2 hospitals may have a higher cost share.
If you are pregnant	Office visits	$50 Copay on initial Visit	Deductible + 30% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Out-of-Network Radiology, Anesthesiology, and Pathology Providers at a Hospital or a Surgical Center will be subject to the In-Network Deductible + 20% Coinsurance
	Childbirth/delivery facility services	Hospital Option 1: Per Admission $200 Copay + Deductible + 20% Coinsurance	Per Admission $400 Copay + Deductible + 30% Coinsurance	Option 2 hospitals may have a higher cost share.
If you need help recovering or have other special health needs	Home health care	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Physician Office: $50 Copay per Visit/ Outpatient Rehab Center: Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% Coinsurance	Deductible + 30% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Infertility treatment	• Preferred brand drugs
• Cosmetic surgery	• Long-term care	• Private-duty nursing
• Dental care (Adult)	• Non-preferred brand drugs	• Routine eye care (Adult)
• Generic drugs	• Pediatric dental check-up	• Routine foot care unless for treatment of diabetes
• Habilitation services	• Pediatric eye exam	• Specialty drugs
	• Pediatric glasses	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Most coverage provided outside the United States. See www.floridablue.com.	• Non-emergency care when traveling outside the U.S.
• Chiropractic care - Limited to 35 visits		

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-664-5295. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

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

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

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About these Coverage Examples:

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

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

The plan's overall deductible	**$600**
Specialist Copayment	**$50**
Hospital (facility) Coinsurance	**20%**
Other No Charge	**$0**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$800
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	**$600**
Specialist Copayment	**$50**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

The plan's overall deductible	**$600**
Specialist Copayment	**$50**
Hospital (facility) Coinsurance	**20%**
Other Copayment	**$250**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,410**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.[insert].com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.ircgov.com or call 1-800-664-5295 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,000** Per Person/**$2,000** Family. Out-of-Network: **$2,000** Per Person/**$4,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. **$500** In-Network/ **$1,000** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,000** Per Person/**$12,000** Family. Out-Of-Network: **$8,000** Per Person/**$16,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-664-5295 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visits: $40 Copay per Visit/ Virtual Visits (Telemedicine): $10 Copay per Visit General Medicine/ $20 Copay Specialist	Primary Care Visits: Deductible + 40% Coinsurance/ Virtual Visits (Telemedicine): Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Specialist visit	$65 Copay per Visit/ Virtual Visits: $20 Copay per Visit	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $25 Copay per Visit	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
	Generic drugs	$5 30 DS Retail Copay $10 90 DS Retail or Mail Order Copay	Not Covered	**Generic Policy:** If your doctor writes a prescription stating that a generic may be dispensed, we will only pay for the generic drug. If you choose to buy the brand name drug in this situation, you will be required to pay the brand copay plus the difference in the cost between the generic and brand name drug. The generic policy does not apply if your doctor requires a brand name medication.
	Preferred brand drugs	$65 30 DS Retail Copay $130 90 DS Retail or Mail Order Copay	Not Covered	
	Non-preferred brand drugs	$95 30 DS Retail Copay	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		$190 90 DS Retail or Mail Order Copay		**Step Therapy:** Step therapy promotes the use of generic medications first before non-preferred brand medications. If you choose to use certain non-preferred brand name drugs before trying a generic medication or a preferred brand medication, your prescription may no be covered, and you may need to pay the full cost.
	Specialty drugs	Subject to cost share based on applicable drug tier	Not Covered	**Specialty Medications:** Specialty medications are limited to 30-day supply and must be ordered from Express Scripts at 1-800-803-2523. Specialty medications require prior authorization and quantity limits may apply. Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products. For any such specialty medication where third party copayment assistance is used, the member shall not receive credit toward their Maximum Out-Of-Pocket or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate. Please see "Important Questions" regarding the plan's out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	————none————
	Physician/surgeon fees	Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital:	Out-of-Network Radiology, Anesthesiology, and Pathology Providers at a Hospital or a

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			Deductible + 40% Coinsurance	Surgical Center will be subject to the In-Network Deductible + 30% Coinsurance
If you need immediate medical attention	Emergency room care	Deductible + $500 Copay per Visit + 30% Coinsurance	In-Network Deductible + $500 Copay per Visit + 30% Coinsurance	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Urgent Care Visits: $40 Copay per Visit	Urgent Care Visits: $40 Copay per Visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Per Admission $500 Copay + Deductible + 30% Coinsurance	Per Admission $1,000 Copay + Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Out-of-Network Radiology, Anesthesiology, and Pathology Providers at a Hospital or a Surgical Center will be subject to the In-Network Deductible + 30% Coinsurance
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Physician Office: $60 Copay per Visit/ Hospital Opt 1: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share. Virtual Visit services are only covered for In-Network designated providers.
	Inpatient services	Physician Services: Deductible + 30% Coinsurance / Hospital Opt 1: Per Admission $500 Copay + Deductible + 30% Coinsurance	Physician Services: Deductible + 40% Coinsurance/ Hospital: Per Admission $1,000 Copay + Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied. Option 2 hospitals may have a higher cost share.
If you are pregnant	Office visits	$65 Copay on initial Visit	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Out-of-Network Radiology, Anesthesiology, and Pathology Providers at a Hospital or a

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Surgical Center will be subject to the In-Network Deductible + 30% Coinsurance
	Childbirth/delivery facility services	Per Admission $500 Copay+ Deductible + 30% Coinsurance	Per Admission $1,000 Copay + Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Physician Office: $65 Copay per Visit/ Outpatient Rehab Center: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Generic drugs
- Habilitation services
- Infertility treatment
- Long-term care
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Preferred brand drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Specialty drugs
- Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Chiropractic care - Limited to 25 visits	• Most coverage provided outside the United States. See www.floridablue.com.	• Non-emergency care when traveling outside the U.S.

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the insurer at 1-800-664-5295. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/consumer_info_health.html.

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$1,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**30%**
Other No Charge	**$0**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,500
Copayments	$0
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,570**

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

The plan's overall deductible	**$1,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**30%**
Other Coinsurance	**30%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

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

The plan's overall deductible	**$1,000**
Specialist Copayment	**$65**
Hospital (facility) Coinsurance	**30%**
Other Copayment	**$500**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,810**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.floridablue.com.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chronic Conditions – IRC RFP Onsite Clinic

LOCKTON®

Chronic Conditions – IRC 2019

Condition	Members	Prevalence	Prevalence Norm	Avg Paid
Other Musculoskeletal	871	23.6% ▲	21.7%	$6,576
Hypertension	810	21.9% ▲	13.5%	$8,986
Hyperlipidemia	795	21.5% ▲	10.0%	$8,662
Back Pain	506	13.7% ▲	9.3%	$9,869
Osteoarthritis	334	9.0% ▲	4.0%	$14,506
Neck Pain	298	8.1% ▲	5.6%	$8,829
Diabetes	255	6.9% ▲	5.2%	$13,929
Depression	236	6.4% ▼	6.9%	$12,054
CAD	184	5.0% ▲	1.7%	$12,285
Asthma	154	4.2% ●	4.3%	$12,599

*Includes HCCs

Chronic Conditions – IRC 2020

Condition	Members	Prevalence	Prevalence Norm	Avg Paid
Other Musculoskeletal	866	23.4% ▲	21.7%	$5,630
Hypertension	824	22.3% ▲	13.5%	$10,211
Hyperlipidemia	774	20.9% ▲	10.0%	$9,591
Back Pain	450	12.2% ▲	9.3%	$11,501
Osteoarthritis	344	9.3% ▲	4.0%	$14,175
Neck Pain	258	7.0% ▲	5.6%	$11,262
Diabetes	251	6.8% ▲	5.2%	$15,342
Depression	229	6.2% ▼	6.9%	$13,420
CAD	169	4.6% ▲	1.7%	$14,749
Asthma	149	4.0% ●	4.3%	$12,641

*Includes HCCs

Chronic Conditions – IRC 2021

Condition	Members	Prevalence	Prevalence Norm	Avg Paid
Other Musculoskeletal	865	23.2% ▲	21.7%	$7,317
Hypertension	841	22.6% ▲	13.5%	$11,437
Hyperlipidemia	810	21.8% ▲	10.0%	$10,476
Back Pain	420	11.3% ▲	9.3%	$11,886
Osteoarthritis	318	8.5% ▲	4.0%	$16,334
Depression	300	8.1% ▲	6.9%	$11,916
Diabetes	263	7.1% ▲	5.2%	$15,901
Neck Pain	244	6.6% ▲	5.6%	$8,685
Anxiety	202	5.4% ▲	4.7%	$8,756
CAD	171	4.6% ▲	1.7%	$21,657

*Includes HCCs

Row Labels	Count of Postal Code
32958	247
32967	212
32962	210
32960	177
32968	172
32966	140
34951	53
32948	45
32963	33
34953	25
32909	18
32976	18
34983	16
32907	15
34982	13
34986	12
32908	10
32961	10
34945	9
34950	9
32905	8
34946	7
34952	7
34990	7
32951	6
34947	6
34981	6
32904	5
32950	5
34949	5
32937	4
32969	4
33458	4
33478	4
34984	4
34997	4
30512	3
32970	3
33470	3
34972	3
32446	2
32901	2
32934	2
32949	2
32957	2
33405	2

33406	2
33411	2
33436	2
34987	2
01543	1
08724	1
16601	1
27207	1
28717	1
28803	1
28904	1
28906	1
29576	1
30097	1
30125	1
30445	1
30548	1
31558	1
31620	1
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32086	1
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32828	1
32832	1
32903	1
32927	1
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32955	1
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33068	1
33073	1
33403	1
33409	1
33410	1
33418	1
33430	1
33431	1
33455	1
33461	1
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33566	1
33578	1
33626	1
33860	1
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34481	1
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37385	1
37745	1
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38556	1
46825	1
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72521	1
80022	1
80918	1
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86429	1
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32958-5754	1
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32961-6172	1
32962-8303	1
32964-3626	1
32966-2833	1
32967-4440	1
32968-4021	1
33029-7185	1

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71238-9499	1
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