FRANKLIN COUNTY DISTRICT SCHOOL BOARD

RFP 2021-002 – GROUP HEALTH INSURANCE

April 1, 2021

REQUEST FOR PROPOSAL

FOR GROUP HEALTH INSURANCE

SUBMISSIONS DUE

10:00 A.M., Monday, April 12, 2021

GROUP HEALTH INSURANCE

Although every effort was made to ensure such, Franklin County School District does not vouch for the accuracy of the information provided by existing insurance companies.

INFORMATION AND REQUIREMENTS

The Franklin County School Board (FCSB) is requesting information for the following coverages/services as further described in this Request for Proposal (RFP) as detailed below, and extends an invitation to all interested insurance companies licensed in the State of Florida to submit proposals for providing a group health plan to eligible employees and retirees.

BACKGROUND
The FCSB insures approximately 200 insured employees and retirees.

SUBMISSION DUE DATE
One (1) original and four (4) copies of proposal responses shall be submitted in a sealed package clearly marked **RFP 2021-002 – GROUP HEALTH INSURANCE** and delivered in person, by courier, or by U.S. Mail to Shannon Venable, Director of Financial Services, 85 School Road, Suite One, Eastpoint, FL 32328 by 10:00 a.m., EST, April 12, 2021.

Submission of responses within the deadline will be governed by FCSB's receipt. As long as FCSB receives the five copies of the submission on time, the submission will be considered.

ADDITIONAL INFORMATION
If more information is needed, requests must be in writing to Director of Financial Services, Shannon Venable, by email to svenable@franklincountyschools.org.

AGENT OF RECORD
U.S. Employee Benefits Services Group has been appointed the broker for health insurance for FCSB and a commission of 2% should be built into the proposals submitted.

NARRATIVE: HEALTH INSURANCE

FCSB health insurance is currently with Florida Blue and Capital Health Plan (CHP). FCSB is interested to see if any other companies are capable of providing competitive rating structures, adequacy of provider networks, advanced administration services, superior quality of care management and overall exceptional value.

The plans are fully insured and have no downside risk to FCSB. Employees and retirees currently have the option to choose either the Florida Blue high deductible plan or CHP traditional copay plan during qualifying periods. Both plans offer two (2) benefit options: Single or Family Coverage.

Benefit Summaries are attached further outlining the details of the current plans. Prospective companies are encouraged to offer similar plan designs in addition to alternative plans they believe would be considered by the district. Please provide the current 2 tier structure as well as rates for 4 tier (Employee Only, Employee & Spouse, Employee & Children, Family).

The successful proposer will agree to offer a program in compliance with all known laws and regulations, including the Affordable Care Act.

The past two year monthly rates may be found on the attached worksheet. FCSB requests 2 tier rates for both active employees and retirees. Please also provide 4 tiers (Employee Only, Employee & Spouse, Employee & Children, Family) for active and retirees. Please keep in mind that current rates are monthly rates.

Proposers should also provide a GeoAccess report for their network specific to FCSB and surrounding areas.

CONTRACT SPECIFICATIONS AND REQUIREMENTS

FINANCIAL ARRANGEMENT

At this time FCSB is only considering fully-insured financial arrangements. FCSB will, however, consider fully-insured programs that allow the group to participate in surplus premiums due to a favorable claims year.

CONTRACT DURATION

The anniversary date is currently set at July 1st of each year. The minimum duration for rate guarantees for the health plan is one (1) year.

NOTICE REQUIREMENTS

FCSB may cancel these contracts off-cycle with a 30-day written notice. Contracted companies will agree to provide FCSB with notice of any rate increase by April 1st for the following contract year.

EMPLOYEE ELIGIBILITY

Employees are eligible for health insurance on the 1st of the month following their Date of hire. This includes all full-time employees working 20 or more hours per week and those otherwise eligible for FMLA, COBRA, or other legislated coverage requirements. Eligible dependents may also participate in the programs.

In accordance with Florida Statutes, retirees may participate in a health program.

ACTIVELY AT WORK WAIVER

All active employees (as deemed by FCSB) will be eligible for the health insurance regardless if they are actively-at-work based on any state or federal regulations.

ADMINISTRATION

MATERIALS AND IMPLEMENTATION

Companies awarded the business are expected to build in the costs for implantation and on-going materials. This is to include, but is not limited to, benefit summaries; certificates; ID cards; enrollment forms; claims forms and billing.

ELECTRONIC SUBMISSION OF ENROLLMENT

The successful proposer(s) will agree to accept electronic submission of enrollment from the benefit administration system.

WAIVER/REJECTION OF SUBMISSIONS

FCSB reserves the right to waive formalities or informalities in the proposals, to reject any or all submissions, to accept any submissions deemed to be in the best interests of FCSB and to

negotiate or not negotiate with and/or interview or not interview any or all submitting carriers. FCSB may reject any or all proposals. FCSB does not discriminate on the basis of race, color, National origin, sex, religion, age, handicap/disability or marital status in employment or provision of service.

EX PARTE COMMUNICATION

Please note that to assure proper and fair evaluation of proposals, after proposals are received FCSB prohibits ex parte communication initiated by the proposer to any FCSB official or employee prior to the time a decision has been made.

Communication between a proposer and FCSB will be initiated by the appropriate FCSB official, employee or designated consultant in order to obtain Information or clarification needed to develop a proper and accurate evaluation of the proposal. Ex parte communication may be grounds for disqualifying the offending submitter from consideration or award of the proposal then in evaluation or any future proposal.

PUBLIC ENTITY CRIMES

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 proposal on a contract to provide services 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 Section 287.17 for Category Two for a period of 36 months from the date of being placed on the convicted vendor list.

RFP SUBMISSION REVIEW

Review of submission responses to this RFP will be conducted by FCSB within a week or two of receiving them.

TERMS AND CONDITIONS OF PROPOSAL

- Rate proposed must be final based on the census and information submitted.
- Please also provide current tiers (Single and Family) and for four (4) tiers (Employee Only, Employee & Spouse, Employee & Children, Family).
- Rates proposed will be guaranteed until July 1, 2022, regardless of the 2021 open enrollment.
- Proposals must be valid through the effective date of the contract.
- Proposals must be signed by an official authorized to bind the proposal to the resultant agreement, if any.
- Proposals must indicate underwriting assumptions, enrollment requirements and any terms and conditions associated with their prospective contract.
- Proposals must indicate any exceptions or deviations from the RFP specifications. All deviations must be clearly identified separately and all exceptions must include a written explanation as to the scope of the exception, any ramifications to the FCSB and any advantages/disadvantages to the FCSB as a result of the exception.
- Each proposing company's benefit program must comply with all applicable Florida and U.S. laws pertaining to mandated benefits.

FCSB is under no obligation to award this contract to the proposer offering the lowest rates, or to any proposal at all. Contract awards will be based on Cost, Coverage/Plan Design, Provider Network, and Service Reputation/Capability.

EVALUATION CRITERIA

The proposal received will be reviewed by the Insurance Committee. Based on the responses interviews may be conducted with selected proposers. The selection will be based upon the criteria below. If more than one (1) firm is designation qualified enough to be considered as a finalist, the committee has the ability to hear finalist interviews, maybe conducted, but is not require. The School Board may also conduct simultaneous negotiations with vendors regarding qualifications, quality, price and plan alternatives, prior to recommending to FCSB award of the contract to the vendor believed to provide the most responsive and responsible proposal that is most advantageous to FCSB. Any negotiations will be in accordance with 286.0113, Florida Statutes.

	CRITERION
1	Cost Although cost will be a major consideration in evaluation proposals, it will not be the only consideration. Cost will include (but not limited to) disclosure of rates/premiums, services/administration costs, any cost guarantees (if applicable) and other cost components.
2	Coverage/Plan Design The ability to administer benefits as is, or as close as practical. The amounts and breath of coverage and extent of deductibles, co-payments, coinsurance, restrictions, or exclusions.
3	Provider Network The number and types of providers, e.g. the number of hospitals and physicians under the contract and the number of contracted physicians who will accept new patients and the match-up between the current top providers and network providers proposed. For pharmacies, the extensiveness of the pharmacy network and pharmacy mail order.
4	Service Reputation/Capability The service reputation and administration capabilities of proposers. This includes such items as enrollment assistance, service responsiveness, and communication with our Agent and School Board staff on program administration, quality of billings, and Internet Website.

Adherence to Specifications	5%
Cost & Coverage/Plan Design	55%
Provider Network	25%
Service Reputation/Capability	15%
Total:	100%

PROPOSER RULES FOR WITHDRAWAL

Proposals may be modified or withdrawn by an appropriate document duly executed (in the manner that a proposal must be executed) and delivered to the place where proposals are to be submitted at any time prior to the opening of the proposals.

IRREVOCABILITY OF PROPOSAL

Each Proposer agrees that proposals shall remain open until the effective date of coverage, July 1, 2021, not be subject to revocation, and shall be subject to the School Board's acceptance.

RFP 2021-002 – GROUP HEALTH INSURANCE

I/We certify that I/we have carefully read all instruction pertaining to this Request for Proposal and that my/our bid proposal complies, without exception, with all instructions and specifications.

_____
Company Name

_____ _____
Authorized Representative Printed Name

_____
Title

_____
Address

_____
City State Zip Code

Contact Numbers:

Business Number: (_____)_____

Cell Number: (_____)_____

Fax Number: (_____)_____

	2020/2021
Capital Health Plan EE Only	748.39
Capital Health Plan Family	1,567.34
Florida Blue Employee Only	748.39
Florida Blue family	1,567.34
Florida Blue Medicare D	$149.15
Capital Health Plan Medicare Advantage	$260.74

	2019/2020
Capital Health Plan EE Only	$690.99
Capital Health Plan Family	$1,447.14
Florida Blue Employee Only	$690.99
Florida Blue family	$1,447.14
Florida Blue Medicare D	$128.42
Capital Health Plan Medicare Advantage	$260.74

Capital Selection $15/$30/$50 Rx

Coverage Period: Plans beginning on or after 10/01/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Employee or Family | Plan Type: HMO

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

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not Covered	————none————
	Specialist visit	$40 / visit	Not Covered	Prior authorization required for certain specialist visits. Your benefits/services may be denied.
	Preventive care/screening/ immunization	No Charge for covered services	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	Diagnostic tests other than x-ray or blood work may incur a cost share.
	Imaging (CT/PET scans, MRIs)	$100 / visit	Not Covered	Prior authorization required for certain imaging services. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.capitalhealth.com/MedCenter	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	The formulary is a closed formulary. This means that all available covered medications are shown.
	Tier 2 drugs	$30/30-day supply $60/60-day supply $90/90-day supply (retail & mail order)	Not Covered	Prior authorization and/or quantity limit may apply. Your benefits/services may be denied.
	Tier 3 drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Prior authorization and/or quantity limit may apply. Your benefits/services may be denied.
	Specialty drugs	$50 /30-day supply	Not Covered	Limited to 30 day supply and may be limited to certain pharmacies. Prior authorization and/or quantity limit may apply. Your benefits/services may be denied.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $100 / visit Hospital: $250 / visit	Not Covered	Prior authorization may be required. Your benefits/services may be denied. Cost share applies to all outpatient services.
	Physician/surgeon fees	$40 / provider	Not Covered	
If you need immediate medical attention	Emergency room care	$300 / visit $250 / observation	$300 / visit $250 / observation	Copayment is waived if inpatient admission occurs; however, if moved to observation status, an additional copayment may apply based on services rendered.
	Emergency medical transportation	$100 / transport	$100 / transport	Covered if medically necessary.
	Urgent care	Urgent care: $25 / visit Telehealth: $15 / visit	Urgent care: $25 / visit Telehealth: $15 / visit	Telehealth services are available through our contracted vendor in all states where telehealth services are permitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission $250 / observation	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Physician/surgeon fees	No Charge if admitted $40 /provider for observation	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 / visit	Not Covered	————none————
	Inpatient services	$250 / admission	Not Covered	Prior authorization required. Your benefits/ services may be denied.
If you are pregnant	Office visits	$40 / visit	Not Covered	————none————
	Childbirth/delivery professional services	No Charge	Not Covered	————none————
	Childbirth/delivery facility services	$250 / admission	Not Covered	Prior authorization required. Your benefits/ services may be denied.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required. Your benefits/ services may be denied.
	Rehabilitation services	$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	Not Covered	Not Covered	————none————

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)	
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices. Your benefits/services may be denied.
	Hospice services	No Charge	Not Covered	Prior authorization required for inpatient services. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	$15 / visit	Not Covered	————none————
	Children's glasses	Not Covered	Not Covered	————none————
	Children's dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic care
- Routine eye care (Adult)

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

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

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

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

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 850-383-3311, 1-877-247-6512
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 850-383-3311, 1-877-247-6512.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 850-383-3311, 1-877-247-6512.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 850-383-3311, 1-877-247-6512.

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

About these Coverage Examples:

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

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

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

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

Total Example Cost	$13,400

In this example, Peg would pay:

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

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

The plan's overall deductible	$0
Specialist *copayment*	$40
Hospital (facility) *copayment*	$250
Other *copayment*	$15

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

Total Example Cost	$7,500

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,160

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

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

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

Total Example Cost	$2,000

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$700

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

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

Nondiscrimination and Accessibility Notice (ACA §1557)

Capital Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Capital Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
Capital Health Plan provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at one of the numbers listed below.

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

Capital Health Plan's Compliance and Privacy Officer:
2140 Centerville Place
Tallahassee, Fl 32308
Phone: Member Services 850-383-3311, 1-877-247-6512, TTY 850-383-3534 or 1-877-870-8943, Fax: 850-523-7419, Email: memberservices@chp.org. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m.

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Member Services Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:
U.S. Department of Health and Human
Services, 200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
800–368–1019, 800–537–7697 (TDD)
Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

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

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

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

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

Haben Sie eine Behinderung? Möchten Sie mit uns in einer anderen Sprache als Englisch kommunizieren? Rufen Sie an, um kostenlos Unterstützung zu erhalten. 1-877-247-6512, TTY/TDD 850-383-3534 oder 1-877-870-8943

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

ناتوانی خاصی دارید؟ به زبانی بجز انگلیسی صحبت می کنید؟ برای دریافت کمک رایگان با این شماره ها تماس بگیرید.
1-877-247-6512 یا DDT/YTT به شماره 850-383-3534 یا 1-877-870-8943

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

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

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

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

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

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

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

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

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

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

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

If you have any questions or concerns related to this, please call our Member Services Department, Monday through Friday 8:00 am – 5:00 pm at 850-383-3311 or 1-877-247-6512. Medicare members or prospective members call 850-523-7441 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. - 8:00 p.m., seven days a week, October 1 - March 31; 8:00 a.m. - 8:00 p.m., Monday - Friday, April 1 - September 30. State of Florida members call 1-877-392-1532, 7:00 a.m. - 7:00 p.m. Capital Health Plan contact information is located on our website: https://capitalhealth.com/contact

Approved by Compliance Committee: 8/23/2016; Revised 5/3/17; Revised 11/14/17; Revised 8/21/18; Revised 7/17/19

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.floridablue.com/plancontracts/group. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.floridablue.com/plancontracts/group or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$2,500** Per Person. Out-of-Network: **$5,000** Per Person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** 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: **$5,800** Per Person. Out-Of-Network: **$11,600** Per Person.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 20%	Per Admission Deductible + Deductible + 40%	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Coinsurance	Coinsurance	share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Inpatient services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 20% Coinsurance	Per Admission Deductible + 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 + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 20% 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 + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% 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

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

Excluded Services & Other Covered Services:

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

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

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

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

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

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

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

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

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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	**$2,500**
Specialist Coinsurance	**20%**
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$30
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,390**

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

The plan's overall deductible	**$2,500**
Specialist Coinsurance	**20%**
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$1,500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,160**

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

The plan's overall deductible	**$2,500**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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What is the overall deductible?	In-Network: **$5,000** Per Person/**$5,000** Family. Out-of-Network: **$10,000** Per Person/**$10,000** 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** 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: **$6,850** Per Person/**$11,600** Family. Out-Of-Network: **$23,200** Per Person/**$23,200** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 20% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
	Emergency medical transportation	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Urgent care	Deductible + 20% Coinsurance	Deductible + 20% Coinsurance	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 20%	Per Admission Deductible + Deductible + 40%	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Coinsurance	Coinsurance	share.
	Physician/surgeon fees	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	————none————
	Inpatient services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 20% Coinsurance	In-Network Deductible + 20% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 20% Coinsurance	Per Admission Deductible + 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 + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 20 visits.
	Rehabilitation services	Deductible + 20% 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 + 20% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 20% 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

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

Excluded Services & Other Covered Services:

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

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

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

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

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

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

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

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

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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	**$5,000**
Specialist Coinsurance	**20%**
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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$30
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,590**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**20%**
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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$5,000
Copayments	$800
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,880**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**20%**
Hospital (facility) Coinsurance	**20%**
Other Coinsurance	**20%**

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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Florida Blue | MEDICARE

2021 Summary of Benefits
Medicare Prescription Drug Plan

BlueMedicare Group Rx (Employer PDP)

1/1/2021 – 12/31/2021

BlueMedicare Platinum Rx

Franklin County School District #43016

The plans' service area includes:
Nationwide

The benefit information provided is a summary of what we cover and what you pay. To get a complete list of services we cover, call us and ask for the "**Evidence of Coverage**." You may also view the "Evidence of Coverage" for this plan on our website, **www.floridablue.com/medicare**.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Who Can Join?

You and your dependent(s) can join this plan if you are a retired employee of the group and the following conditions are met:

- You and your dependent(s) are entitled to Medicare Part A and/or enrolled in Medicare Part B
- You and your dependent(s) live in the plan service area, and
- You are identified as an eligible participant by your former employer

Neither you nor your dependent(s) are eligible for this plan if:

- You are an active employee of the group, or
- You are a retired employee of the group with a dependent who is an active employee of the group and has coverage through the group's plan for active employees

Our service area includes all 50 states and the District of Columbia.

Which pharmacies can I use?

- In most situations, you must use our network pharmacies to fill your prescriptions for covered Part D drugs
- You can also use our mail-order pharmacy to have your prescription delivered to your home
- Want to see if your pharmacy is in our pharmacy network, or if these plans cover your prescription drugs? Just visit our website at **www.floridablue.com/medicare**. Or see how we cover any medication you may be taking in our comprehensive formulary (list of covered Part D drugs)

Have Questions? Call Us

- If you have questions about this plan, call us at 1-800-926-6565, TTY: 1-800-955-8770
  - From October 1 through March 31, we are open seven days a week, from 8:00 a.m. to 8:00 p.m. local time, except for Thanksgiving and Christmas
  - From April 1 through September 30, we are open Monday through Friday, from 8:00 a.m. to 8:00 p.m. local time, except for major holidays
- Or visit our website at **www.floridablue.com/medicare**

Important Information

Our plans group each medication into a tier. The number of tiers may vary based on the plan you choose. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible (for BlueMedicare Advanced Rx only), Initial Coverage, Coverage Gap and Catastrophic Coverage.

Monthly Premium, Deductible and Limits

Monthly Plan Premium	**$149.15 for Platinum Rx** You must continue to pay your Medicare Part B premium.
Deductible	This plan does not have a deductible.

Part D Prescription Drug Benefits

Deductible Stage

This plan does not have a prescription drug deductible.

Initial Coverage Stage

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

You remain in this stage until your total yearly drug costs (total drug costs paid by you *and* any Part D plan) reach **$4,130**. You may get your drugs at network retail pharmacies and mail order pharmacies. Cost sharing below applies to a one-month (31-day) supply.

	Preferred Retail	Standard Retail	Mail Order
Tier 1 - Preferred Generic	$3 copay	$10 copay	$0 copay
Tier 2 - Generic	$8 copay	$15 copay	$8 copay
Tier 3 - Preferred Brand	$35 copay	$40 copay	$35 copay
Tier 4 - Non-Preferred Drug	$65 copay	$85 copay	$65 copay
Tier 5 - Specialty Tier	33% of the cost	33% of the cost	33% of the cost

Coverage Gap Stage

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The Coverage Gap Stage begins after the total yearly drug cost (including what any Part D plan has paid and what you have paid) reaches **$4,130**.

You stay in this stage until your year-to-date “out-of-pocket” costs reach a total of **$6,550**.

<u>During the Coverage Gap Stage:</u>

- You pay the same copays that you paid in the Initial Coverage Stage for all drugs, throughout the coverage gap

Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,550**, you pay the *greater* of:

- **$3.70** copay for generic, (including brand drugs treated as generic) and **$9.20** copay for all other drugs, or **5%** of the cost.

Additional Drug Coverage

- Please call us or see the plan's "Evidence of Coverage" on our website (**www.floridablue.com/medicare**) for complete information about your costs for covered drugs. If you request and the plan approves a formulary exception, you will pay Tier 4 cost sharing.
- Your cost-sharing may be different if you use a Long-Term Care pharmacy, a home infusion pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 90 days) of a drug

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

If you have any questions, please contact our Member Services number at 1-800-926-6565. (TTY users should call 1-800-955-8770.) Our hours are 8:00 a.m. to 8:00 p.m. local time, seven days a week, from October 1 through March 31, except for Thanksgiving and Christmas. From April 1 through September 30, our hours are 8:00 a.m. to 8:00 p.m. local time, Monday through Friday, except for major holidays.

Health coverage is offered by Blue Cross and Blue Shield of Florida, Inc., dba Florida Blue, an Independent Licensee of the Blue Cross and Blue Shield Association.

Section 1557 Notification: Discrimination is Against the Law

We 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.

We 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)
- 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:

- Health and vision coverage: 1-800-352-2583
- 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 discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation, you can file a grievance with:

Health and vision coverage (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

Dental, life, and disability coverage:
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 **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. 20211
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at **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 ákonínzin: Diné bizaad bee yáníłti’go, saad bee áká anáwo’, t’áá jíík’eh, ná hóló. Kojį’ hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígíí éí kojį’ hodíílnih 1-800-333-2227.

Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

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

Schedule of Copayments

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

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

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

Outpatient Prescription Drugs

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

Exclusions

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

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

MEDICAL CENSUS

STATUS	Date Of Birth	Gender	Date Of Hire	Zip	Plan Type	Plan Name	Tier Name
ACTIVE	04/08/1990	F	08/01/2019	32329	Medical	Capital Health Plan	Employee Only
ACTIVE	04/20/1964	F	08/01/2017	32327	Medical	Capital Health Plan	Employee and Family
ACTIVE	05/15/1966	F	08/09/1990	32322	Medical	Capital Health Plan	Employee and Family
ACTIVE	11/17/1962	F	08/01/2019	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	05/07/1978	F	08/06/2018	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	08/07/1964	F	09/11/2017	32346	Medical	Capital Health Plan	Employee Only
ACTIVE	02/09/1975	M	08/03/2020	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	07/10/1982	F	10/01/2001	32328	Medical	Capital Health Plan	Employee and Family
ACTIVE	02/04/1994	F	08/01/2017	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	11/15/1962	F	07/27/2020	32320	Medical	Capital Health Plan	Employee and Family
ACTIVE	11/09/1998	F	08/03/2020	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	05/26/1970	F	08/10/1995	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	10/02/1990	M	11/17/2020	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	05/14/1990	M	08/14/2020	32327	Medical	Capital Health Plan	Employee Only
ACTIVE	12/24/1962	F	10/25/2017	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	03/02/1967	F	07/29/2020	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	12/12/1964	F	01/25/2016	32321	Medical	Capital Health Plan	Employee Only
ACTIVE	07/18/1969	F	11/03/2016	32327	Medical	Capital Health Plan	Employee and Family
ACTIVE	04/18/1964	F	08/09/2007	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	02/07/1968	F	07/24/2019	32320	Medical	Capital Health Plan	Employee and Family
ACTIVE	02/11/1959	F	01/05/2021	32320	Medical	Capital Health Plan	Employee and Family
ACTIVE	08/20/1984	F	01/04/2016	32320	Medical	Capital Health Plan	Employee and Family
ACTIVE	03/25/1993	M	08/06/2018	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	07/24/1963	F	08/01/2019	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	12/21/1961	M	08/21/2018	32327	Medical	Capital Health Plan	Employee Only
ACTIVE	09/15/1957	F	10/29/2019	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	05/16/1970	F	08/05/1999	32320	Medical	Capital Health Plan	Employee and Family
ACTIVE	05/02/1973	F	07/24/2019	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	02/05/1962	M	11/18/2014	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	07/02/1988	F	01/04/2021	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	07/11/1970	F	07/24/2019	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	04/24/1958	F	11/19/2014	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	06/27/1979	F	08/01/2019	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	07/05/1958	F	03/31/1993	32329	Medical	Capital Health Plan	Employee Only
ACTIVE	12/07/1963	F	08/01/2019	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	05/05/1972	F	03/03/1995	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	03/04/1988	F	09/03/2009	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	06/04/1974	F	08/01/2017	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	09/10/1960	M	05/01/1997	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	05/09/1970	F	08/10/1993	32322	Medical	Capital Health Plan	Employee and Family
ACTIVE	02/15/1960	F	01/03/2011	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	05/09/1981	F	01/03/2019	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	12/30/1955	F	02/17/2021	32301	Medical	Capital Health Plan	Employee Only
ACTIVE	02/03/1998	F	12/03/2018	32358	Medical	Capital Health Plan	Employee Only
ACTIVE	10/24/1969	F	08/12/1994	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	11/15/1986	F	08/02/2019	32346	Medical	Capital Health Plan	Employee Only
ACTIVE	04/14/1967	M	08/12/2013	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	02/23/1972	F	08/10/2015	32320	Medical	Capital Health Plan	Employee and Family
ACTIVE	06/29/1976	F	01/22/2008	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	03/27/1976	F	09/29/2017	32456	Medical	Capital Health Plan	Employee Only
ACTIVE	11/13/1964	F	06/08/2015	32456	Medical	Capital Health Plan	Employee Only
ACTIVE	02/27/1971	F	10/01/2001	32328	Medical	Capital Health Plan	Employee and Family
ACTIVE	04/26/1969	F	05/18/2007	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	07/12/1991	F	02/15/2016	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	11/18/1967	F	08/01/2017	32328	Medical	Capital Health Plan	Employee and Family
ACTIVE	06/01/1970	F	08/01/2019	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	07/18/1978	F	09/01/2017	32321	Medical	Capital Health Plan	Employee Only
ACTIVE	08/27/1991	F	01/26/2017	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	05/04/1966	F	04/19/2018	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	12/20/1969	F	09/18/2015	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	02/12/1989	F	09/12/2017	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	04/29/1982	F	01/04/2018	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	08/03/1996	F	10/10/2017	32322	Medical	Capital Health Plan	Employee Only

MEDICAL CENSUS

STATUS	Date Of Birth	Gender	Date Of Hire	Zip	Plan Type	Plan Name	Tier Name
ACTIVE	11/01/1985	F	10/01/2019	32323	Medical	Capital Health Plan	Employee Only
ACTIVE	03/01/1965	F	09/21/2012	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	04/05/1950	M	08/11/2017	32358	Medical	Capital Health Plan	Employee Only
ACTIVE	09/19/1974	M	07/01/2015	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	11/28/1995	F	01/25/2021	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	06/02/1966	F	08/11/2016	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	10/17/1989	F	03/27/2020	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	06/29/1974	F	09/01/2014	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	01/20/1971	F	10/29/2019	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	10/08/1998	F	01/27/2021	32327	Medical	Capital Health Plan	Employee Only
ACTIVE	07/21/1994	F	08/24/2020	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	11/07/1956	F	08/22/2001	32329	Medical	Capital Health Plan	Employee Only
ACTIVE	07/04/1976	F	05/09/2013	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	08/06/1984	F	09/29/2017	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	07/11/1980	F	02/08/2010	32322	Medical	Capital Health Plan	1 /1 Non Family
ACTIVE	03/16/1977	F	08/18/2008	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	11/02/1966	M	07/23/2019	32096	Medical	Capital Health Plan	Employee Only
ACTIVE	02/17/1992	M	11/04/2019	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	12/23/2000	F	08/13/2020	32456	Medical	Capital Health Plan	Employee Only
ACTIVE	02/07/1970	F	01/06/2004	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	04/11/1959	F	03/19/1992	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	11/22/1957	F	10/01/2007	32320	Medical	Capital Health Plan	Employee and Family
ACTIVE	01/23/1981	M	11/01/2005	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	02/16/1995	F	08/17/2020	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	06/28/1979	F	08/01/2019	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	11/17/1990	F	02/28/2019	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	12/28/1956	F	01/26/2017	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	05/21/1985	F	01/09/2015	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	08/12/1960	F	01/26/2017	32329	Medical	Capital Health Plan	Employee Only
ACTIVE	11/07/1973	F	11/04/2013	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	11/08/1935	F	09/27/2016	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	10/01/1964	F	01/23/2020	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	12/29/1964	F	09/12/1986	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	10/08/1969	F	04/19/2018	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	11/03/1960	F	01/26/2016	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	05/21/1994	F	11/15/2019	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	02/03/1977	F	08/11/2016	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	11/18/1972	F	11/07/2007	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	08/18/1975	F	01/04/2016	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	09/28/1966	F	02/04/2010	32328	Medical	Capital Health Plan	Employee and Family
ACTIVE	11/18/1976	F	01/26/2017	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	01/29/1976	F	08/18/2008	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	03/28/1992	M	04/19/2016	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	05/14/1978	F	08/17/2020	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	11/26/1961	F	01/26/2016	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	10/05/1958	F	01/08/1997	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	02/24/1971	F	08/01/2017	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	06/03/1951	M	10/13/2015	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	07/08/1962	F	01/13/2020	32328	Medical	Capital Health Plan	Employee Only
ACTIVE	10/29/1954	M	01/26/2016	32320	Medical	Capital Health Plan	Employee Only
ACTIVE	06/29/1983	F	04/11/2014	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	04/21/1960	F	03/19/1990	32322	Medical	Capital Health Plan	Employee Only
ACTIVE	11/19/1968	F	02/09/2015	32322	Medical	Capital Health Plan	2 EE Non Family
ACTIVE	12/29/1955	F	03/01/2003	32323	Medical	Florida Blue	Employee Only
ACTIVE	05/19/1957	F	01/13/1998	32456	Medical	Florida Blue	Employee Only
ACTIVE	11/13/1960	F	08/01/2017	32322	Medical	Florida Blue	Employee Only
ACTIVE	03/27/1966	F	07/31/2017	32322	Medical	Florida Blue	Employee Only
ACTIVE	10/30/1977	F	07/29/2020	32322	Medical	Florida Blue	2 EE Family
ACTIVE	04/26/1969	M	08/06/2018	32322	Medical	Florida Blue	Employee Only
ACTIVE	09/03/1957	M	08/05/1999	32329	Medical	Florida Blue	Employee Only
ACTIVE	02/12/1965	F	08/01/2020	32320	Medical	Florida Blue	Employee and Family
ACTIVE	07/11/1956	F	11/17/2020	32328	Medical	Florida Blue	Employee Only
ACTIVE	07/05/1973	M	04/14/2020	32320	Medical	Florida Blue	2 EE Family

MEDICAL CENSUS

STATUS	Date Of Birth	Gender	Date Of Hire	Zip	Plan Type	Plan Name	Tier Name
ACTIVE	04/11/1963	F	10/24/2018	32320	Medical	Florida Blue	Employee and Family
ACTIVE	08/18/1967	M	08/03/2020	46182	Medical	Florida Blue	Employee Only
ACTIVE	03/14/2000	F	02/16/2021	32329	Medical	Florida Blue	Employee Only
ACTIVE	08/31/1991	F	08/27/2019	32328	Medical	Florida Blue	Employee Only
ACTIVE	12/06/1963	F	08/15/2018	32329	Medical	Florida Blue	Employee Only
ACTIVE	10/06/1998	F	08/13/2020	32320	Medical	Florida Blue	Employee Only
ACTIVE	08/21/1997	F	08/02/2019	32320	Medical	Florida Blue	Employee Only
ACTIVE	08/09/1990	M	07/01/2014	32322	Medical	Florida Blue	Employee Only
ACTIVE	12/25/1996	M	08/10/2020	32320	Medical	Florida Blue	Employee Only
ACTIVE	07/23/1999	M	02/08/2021	32329	Medical	Florida Blue	Employee Only
ACTIVE	06/18/1991	M	08/28/2019	32320	Medical	Florida Blue	Employee Only
ACTIVE	06/13/1964	F	03/09/2010	32328	Medical	Florida Blue	Employee Only
ACTIVE	08/17/1956	F	10/05/2006	32329	Medical	Florida Blue	Employee Only
ACTIVE	08/20/1962	M	01/06/2020	32322	Medical	Florida Blue	Employee Only
ACTIVE	08/25/1959	F	11/02/2017	32346	Waive		
ACTIVE	11/14/1961	M	11/20/2018	32320	Waive		
ACTIVE	07/14/1986	F	07/24/2019	32322	Waive		
ACTIVE	05/01/1977	F	05/01/2018	32321	Waive		
ACTIVE	02/22/1971	F	08/10/2015	32358	Waive		
ACTIVE	05/30/1996	F	06/01/2019	32322	Waive		
ACTIVE	09/13/1995	F	11/05/2018	32322	Waive		
ACTIVE	06/07/1961	F	08/06/2018	32328	Waive		
ACTIVE	08/11/1985	M	07/27/2020	32322	Waive		
ACTIVE	08/12/1973	F	09/01/2001	32322	Waive		
ACTIVE	01/29/1945	M	11/18/2020	32322	Waive		
ACTIVE	12/17/1965	M	07/01/2020	32443	Waive		
ACTIVE	10/13/1985	F	08/28/2019	32328	Waive		
ACTIVE	06/28/1974	M	11/04/2013	32322	Waive		
ACTIVE	05/13/1995	M	08/06/2018	32322	Waive		
ACTIVE	03/27/1980	F	08/07/2018	32328	Waive		
ACTIVE	01/19/1970	M	03/15/2017	32320	Waive		
ACTIVE	04/07/1989	F	08/01/2017	32328	Waive		
ACTIVE	10/15/1973	M	07/01/2015	32320	Waive		
ACTIVE	09/26/1963	M	08/01/2019	32322	Waive		
ACTIVE	06/16/1962	F	03/11/2020	32322	Waive		
ACTIVE	12/26/1985	F	08/06/2018	32320	Waive		
ACTIVE	08/28/1971	F	07/01/2020	32358	Waive		
ACTIVE	11/26/1970	F	08/03/2020	32320	Waive		
ACTIVE	01/01/1970	M	08/03/2020	32322	Waive		
ACTIVE	08/01/1981	F	11/30/2020	32305	Waive		
ACTIVE	12/18/1950	F	08/12/2017	32322	Waive		
ACTIVE	11/14/1977	M	08/19/2020	72857	Waive		
ACTIVE	03/12/1982	F	01/07/2021	32321	Waive		
ACTIVE	01/10/1989	F	10/02/2019	32320	Waive		
ACTIVE	12/22/1999	F	08/13/2020	32321	Waive		
ACTIVE	10/01/1966	M	10/28/2016	32322	Waive		
ACTIVE	04/16/1971	M	08/01/2017	32328	Waive		
RETIRED	08/31/1958	F	08/17/1989	32328	Medical	Capital Health Plan	Employee Only
RETIRED	03/28/1963	F	08/02/1994	32322	Medical	Capital Health Plan	Employee Only
RETIRED	10/06/1957	F	08/01/1986	32328	Medical	Capital Health Plan	Employee Only
RETIRED	10/08/1955	F	01/01/2014	32322	Medical	Capital Health Plan	Employee Only
RETIRED	02/19/1963	F	08/13/2018	32322	Medical	Capital Health Plan	Employee Only
RETIRED	08/19/1961	F	09/01/1985	32328	Medical	Capital Health Plan	Employee Only
RETIRED	09/21/1950	F	08/14/1989	32328	Medical	CHP Group Medicare For Retiree Only	Employee Only
RETIRED	11/02/1949	F	11/01/2016	32322	Medical	CHP Group Medicare For Retiree Only	Employee Only
RETIRED	03/20/1954	F	10/06/1988	32322	Medical	CHP Group Medicare For Retiree Only	Employee Only
RETIRED	11/22/1951	F	01/01/2014	32320	Medical	CHP Group Medicare For Retiree Only	Employee Only
RETIRED	04/02/1951	F	07/01/1991	32320	Medical	CHP Group Medicare For Retiree Only	Employee and Spouse
RETIRED	12/29/1960	F	07/01/2014	32301	Medical	CHP Group Medicare For Retiree Only	Employee and Spouse
RETIRED	04/07/1953	F	01/01/2014	32327	Medical	CHP Group Medicare For Retiree Only	Employee Only
RETIRED	12/29/1948	M	08/11/2008	32344	Medical	CHP Group Medicare For Retiree Only	Employee and Spouse
RETIRED	03/02/1954	F	06/30/2019	32321	Medical	CHP Group Medicare For Retiree Only	Employee Only

MEDICAL CENSUS

STATUS	Date Of Birth	Gender	Date Of Hire	Zip	Plan Type	Plan Name	Tier Name
RETIRED	10/10/1942	F	05/31/2016	32328	Medical	CHP Group Medicare For Retiree Only	Employee Only
RETIRED	06/09/1954	F	08/09/2004	32322	Medical	CHP Group Medicare For Retiree Only	Employee Only
RETIRED	07/04/1957	F	08/01/1980	32320	Medical	Florida Blue	Employee Only
RETIRED	02/19/1963	F	08/08/1991	78213	Medical	Florida Blue	Employee Only
RETIRED	09/24/1920	F	01/01/2014	32320	Medical	Florida Blue	Employee Only
RETIRED	01/01/1961	F	02/07/1985	32328	Medical	Florida Blue	Employee Only