FRANKLIN COUNTY DISTRICT SCHOOL BOARD

RFP 18-200 – GROUP HEALTH INSURANCE

March 29, 2018

REQUEST FOR PROPOSAL
FOR GROUP HEALTH INSURANCE

SUBMISSIONS DUE

10:00 A.M., Thursday, April 12, 2018

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 250 employees and retirees.

SUBMISSION DUE DATE
Five (5) original proposal responses shall be submitted in a sealed package clearly marked **RFP 18-200 – 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, 2018.

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 fax to (850) 670-8579, or by email to svenable@franklin.k12.fl.us.

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.

<u>NARRATIVE: HEALTH INSURANCE</u>

FCSB health insurance is currently with Florida Blue Cross Blue Shield of Florida, Inc. d/b/a (“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 and certificates of coverage 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. 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 keep in mind that current rates are per 24 pay periods.

Detailed claims experience is attached from March 2017 – February 2018. This is the only experience that will be made available and proposals will need to be binding based on the provided data.

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 March 1st for the following contract year.

EMPLOYEE ELIGIBILITY

Employees are eligible for health insurance on the 1st of the month following their 30th day of employment (31st day.) 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.

COBRA ADMINSTRATION

Each company will be asked to indicate as to whether COBRA administration is provided and to provide details on the services including cost.

CLAIMS AND ENROLLENT REPORTING

The successful health insurance proposer will agree to provide detailed monthly claims

(including ongoing large claims reports), premium and enrollment information similar to the Florida Blue information provided.

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 claims information submitted.
- 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	<u>Cost</u> 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	<u>Coverage/Plan Design</u> 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	<u>Provider Network</u> 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	<u>Service Reputation/Capability</u> 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, 2018, not be subject to revocation, and shall be subject to the School Board’s acceptance.

RFP 18-200 – 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: (_________)__________________________

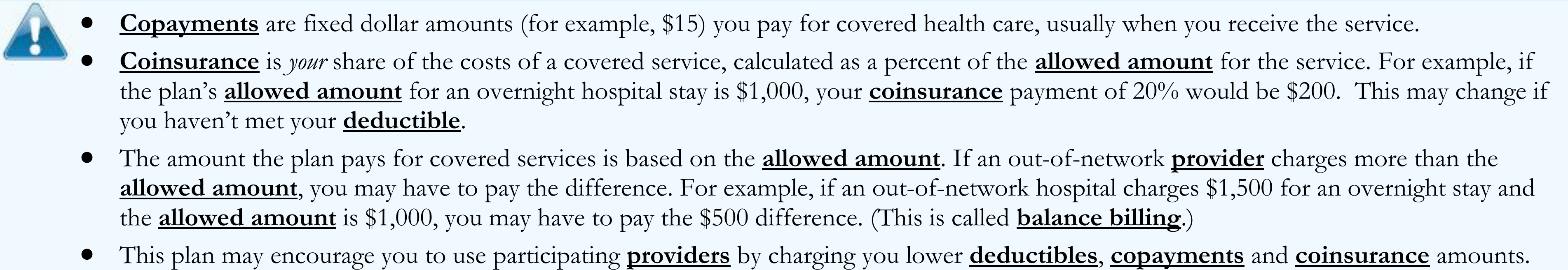
Fax Number: (_________)__________________________

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee or Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.capitalhealth.com/sbc or by calling 1-850-383-3311.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, for medical: $2,000 single coverage / $4,500 family coverage Yes, for pharmacy: $4,600 single coverage / $8,700 family coverage	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, prescription drug brand additional charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating **providers**, see www.capitalhealth.com **or call 850-383-3311**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Some **specialists** require a referral. For a list of **specialists** that require a written referral, see www.capitalhealth.com.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 850-383-3311 or visit us at www.capitalhealth.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.capitalhealth.com or call 850-383-3311 to request a copy.



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

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
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.
	Other practitioner office visit	$40 / visit for chiropractor	Not Covered	——————none——————
	Preventive care/screening/immunization	No charge	Not Covered	As defined in "Section 2713 - Coverage for Preventive Health Services" of the Patient Protection and Affordable Care Act.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$100 /visit	Not Covered	Prior authorization required for certain imaging services.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.capitalhealth.com	Tier 1 drugs	$15/30-day supply $30/60-day supply $45/90-day supply (retail & mail order)	Not Covered	If a generic drug is available, and a more expensive brand name drug is dispensed at the request of the member or the prescriber, the member must pay the copayment amount for the brand name drug plus pay the pharmacist 100% of the additional cost for the more expensive brand name prescription drug.
	Tier 2 Preferred drugs	$30/30-day supply $60/60-day supply $90/90-day supply (retail & mail order)	Not Covered	Excluding Preferred Specialty products. Additional rules may apply. See www.capitalhealth.com for more information.
	Tier 3 Non-preferred drugs	$50/30-day supply $100/60-day supply $150/90-day supply (retail & mail order)	Not Covered	Additional rules may apply. See www.capitalhealth.com for more information.
	Specialty drugs	$50 /30-day supply	Not Covered	Additional rules may apply.
If you have outpatient surgery	Facility fee (ambulatory surgery center)	$100/ visit	Not Covered	Prior authorization may be required. Cost share applies to all outpatient services.
	Facility fee (hospital)	$250/ visit	Not Covered	
	Physician/surgeon fees	$40 /visit/provider	Not Covered	
If you need immediate medical attention	Emergency room services	$250 / visit	$250 / visit	Copayment is waived if admission occurs.
	Emergency medical transportation	$100 / transport	$100 / transport	Covered if medically necessary.
	Urgent care	$25 / visit	$25 / visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 / admission	Not Covered	Prior authorization required.
	Physician/surgeon fee	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 / visit	Not Covered	————none————
	Mental/Behavioral health inpatient services	$250 / admission	Not Covered	Prior authorization required.
	Substance use disorder outpatient services	$40 / visit	Not Covered	————none————
	Substance use disorder inpatient services	$250 / admission	Not Covered	Prior authorization required.
If you are pregnant	Prenatal and postnatal care	$40 / visit	Not Covered	————none————
	Delivery and all inpatient services	$250 / admission	Not Covered	Prior authorization required.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization required.
	Rehabilitation services	$40 / visit	Not Covered	Limited to the consecutive 62-day period immediately following the first service date.
	Habilitation services	Not Covered	Not Covered	————none————
	Skilled nursing care	No Charge	Not Covered	Covers up to 60 days per admission with subsequent admission following 180 days from discharge date of previous admission.
	Durable medical equipment	No Charge	Not Covered	Prior authorization required for certain devices.
	Hospice service	No Charge	Not Covered	Prior authorization required for inpatient services.
If your child needs dental or eye care	Eye exam	$15 / visit	Not Covered	————none————
	Glasses	Not Covered	Not Covered	————none————
	Dental check-up	Not Covered	Not Covered	————none————

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric Surgery
- Cosmetic surgery
- Dental care (Adult)
- 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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Routine eye care (Adult)
- Weight loss programs

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 850-383-3311. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Capital Health Plan Member Services at 850-383-3311, or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or contact the Florida Department of Financial Services at 1-877-693-5236, the Agency for Health Care Administration at 1-888-419-3456, or the Federally Administered External Review Program at 1-877-549-8152.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

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

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,520
- **Patient pays** $1,020

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$870
Coinsurance	$0
Limits or exclusions	$150
Total	**$1,020**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

Sample care costs:

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

Patient pays:

Deductibles	$0
Copays	$1,000
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,080**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

In the pursuit of health®

Franklin County School District #43016
2018 BlueMedicare Group Rx (Employer PDP)

Benefits	BlueMedicare Group Rx Option 2
Premium	$100.81 for Rx2-Only
Annual Deductible	$75 for Tiers 3, 4 and 5 Drugs Only
Retail	**31-day Supply**
Tier 1 - Preferred Generics	$15 Copayment
Tier 2 - Generics	$15 Copayment
Tier 3 - Preferred Brand	$45 Copayment
Tier 4 - Non-Preferred Brand	$85 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Mail Order	**90-day Supply with Mail Order**
Tier 1 - Preferred Generics	$8 Copayment
Tier 2 - Generics	$8 Copayment
Tier 3 - Preferred Brand	$135 Copayment
Tier 4 - Non-Preferred Brand	$255 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance (31-day supply only)
Gap	**31-day Supply**
Tier 1 - Preferred Generics	$15 Copayment
Tier 2 - Generics	$15 Copayment
Tier 3 - Preferred Brand	$45 Copayment
Tier 4 - Non-Preferred Brand	$85 Copayment
Tier 5 - Specialty Drugs	25% Coinsurance
Catastrophic	$3.35 Copayment for generic drugs $8.35 Copayment for brand drugs

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

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

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

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2 YEAR MEDICAL RATE HISTORY

2017-2018	
EE Only	$617.57
Family	$1,293.38
Retiree Medicare Advantage	$260.74
Retiree Group Medicare D	$91.26

2016-2017	
EE Only	559.34
Family	$1,171.43
Retiree Medicare Advantage	245.89
Retiree Group Medicare D	94.44

High Cost Claims Summary

Company: FRANKLIN CO SCHOOL BOARD
Group:
High Cost Claims Threshold: 50000
Current Paid Period: From 03/2017 to 02/2018
Prior Paid Period: From 03/2016 to 02/2017

CURRENT			Inpatient	Outpatien	Professio	Pharmacy	
Rank	**Diagnosis Description**	**Days**	**Admits**	**Visits**	**Services**	**# of Rx**	**Total Billed Amt**
1	OTHER GENERAL SYMPTOMS; HYPERTENSIVE HEART DISEASE, UNSPECIFIED, WITH HEART FAILURE; HYPERTENSIVE HEART & CHRONIC KIDNEY DISEASE, UNSPECIFIED, WITH HEART FAILURE & WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED	11	3	7	216	119	$263,815.92
Total		**11**	**3**	**7**	**216**	**119**	**$263,815.92**

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

Schedule of Copayments

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

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

Outpatient Prescription Drugs

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

Exclusions

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

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

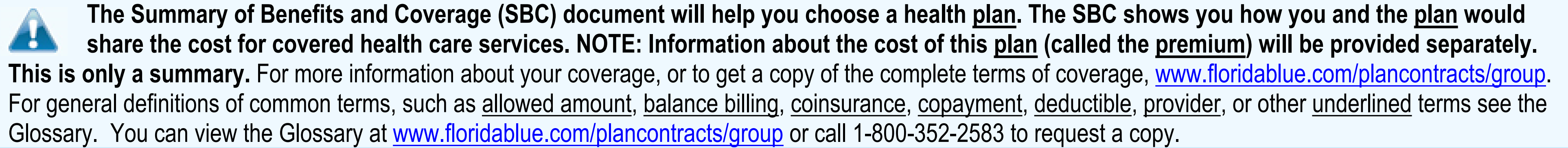
Florida Blue

BlueOptions 05192

HSA Compatible with Rx $10/$50/$80 after In-network Deductible

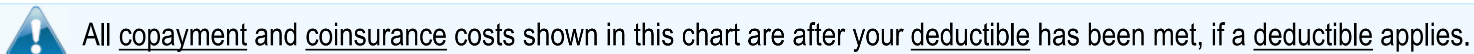
Coverage Period: 07/01/2017 - 06/30/2018

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage for:** Individual | **Plan Type:** PPO



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.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	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.
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	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.

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)	
		by mail		
	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% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-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	Hospital Option 1:	Per Admission Deductible +	Option 2 hospitals may have a higher cost-

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	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

Excluded Services & Other Covered Services:

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

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

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

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

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

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.

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	$1,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$600
The total Mia would pay is	**$1,925**

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.

Nondiscrimination and Accessibility Notice (ACA §1557)

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

Florida Blue and Florida Blue HMO:

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

If you need these services, contact 1-800-352-2583.

If you believe that Florida Blue and Florida Blue HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Senior Manager of Business Ethics at 4800 Deerwood Campus Parkway, DC1-7, Jacksonville, FL 32246, by phone at 1-800-477-3736 X56300 (TTY:1-800-955-8770), by fax at 904-357-8203, or email compass@floridablue.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Senior Manager of Business Ethics is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Baa ákonínzin: Diné bizaad bee yáníłti’go, saad bee áká anáwo’, t’áá jíík’eh, ná hóló̜. Kojį’ hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEPígíí éí kojį’ hodíílnih 1-800-333-2227

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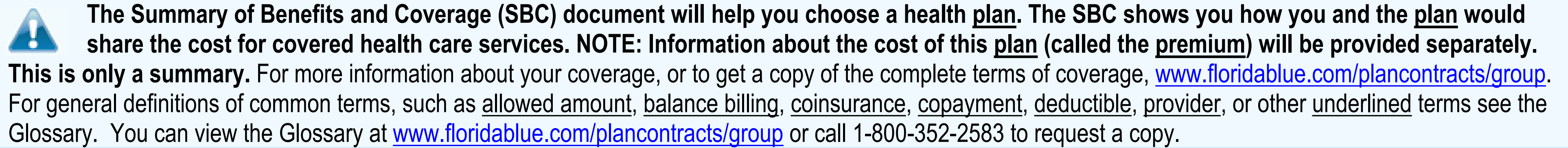

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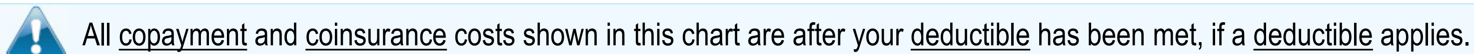
Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$5,000** Family. Out-of-Network: **$10,000** Per Person/**$10,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	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.
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	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.

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)	
		by mail		
	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)	Deductible + 20% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days.
	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	Hospital Option 1:	Per Admission Deductible +	————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)	
	services	Deductible + 20% Coinsurance	Deductible + 40% Coinsurance	
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

Excluded Services & Other Covered Services:

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

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

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

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

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

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.

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	$1,400
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$600
The total Mia would pay is	**$1,925**

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.

Nondiscrimination and Accessibility Notice (ACA §1557)

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

Florida Blue and Florida Blue HMO:

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

If you need these services, contact 1-800-352-2583.

If you believe that Florida Blue and Florida Blue HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Senior Manager of Business Ethics at 4800 Deerwood Campus Parkway, DC1-7, Jacksonville, FL 32246, by phone at 1-800-477-3736 X56300 (TTY:1-800-955-8770), by fax at 904-357-8203, or email compass@floridablue.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Senior Manager of Business Ethics is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD).

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

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló̜. Kojį' hodíílnih 1-800-352-2583 (TTY: 1-800-955-8770). FEPígíí éí kojį' hodíílnih 1-800-333-2227

Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. Dental insurance is offered by Florida Combined Life Insurance Company, Inc., an affiliate of Blue Cross and Blue Shield of Florida, Inc. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

ACTIVE EMPLOYEE CENSUS 2018

Birth	Gender	Zip
6/4/1974	Female	32320
12/17/1973	Female	32328
3/17/1967	Female	32328
6/3/1951	Female	32320
10/25/1969	Male	32320
10/20/1969	Male	32320
11/19/1968	Female	32322
2/23/1972	Female	32328
11/13/1964	Female	32329
2/22/1971	Male	32322
10/15/1973	Female	32059
7/12/1991	Female	32328
4/15/1984	Female	32322
5/2/1973	Male	32322
2/5/1962	Female	32322
10/2/1955	Female	32322
1/18/1955	Female	32322
5/14/1985	Female	32328
9/19/1974	Male	32320
7/9/1953	Female	32328
6/2/1966	Male	32409
8/28/1971	Male	32320
2/3/1977	Female	32322
8/18/1975	Female	32322
5/6/1972	Female	32322
3/2/1954	Male	32322
3/28/1992	Male	32328
9/23/1966	Female	32328
8/20/1984	Male	32322
3/26/1967	Female	32322
5/14/1978	Male	32405
10/5/1958	Female	32320
9/10/1960	Female	32328
5/9/1970	Male	32320
2/15/1960	Female	32320
8/17/1956	Female	32320
11/15/1964	Female	32456
4/28/1957	Female	32328
2/24/1971	Female	32328
1/24/1959	Female	32327
5/15/1954	Female	32328
6/29/1983	Female	32456
4/26/1960	Female	32322
10/24/1969	Female	32322
4/14/1967	Female	32320
4/18/1962	Female	32328
1/5/1960	Female	32323
2/27/1971	Female	32358
4/26/1969	Female	32320

ACTIVE EMPLOYEE CENSUS 2018

Birth	Gender	Zip
11/18/1967	Female	32328
5/15/1966	Female	32322
2/26/1970	Female	32456
6/29/1976	Female	32320
12/29/1955	Female	32358
6/6/1972	Female	32320
7/17/1967	Female	32346
5/19/1957	Female	32328
7/10/1982	Female	32328
8/31/1958	Female	32322
2/7/1970	Female	32358
4/11/1959	Female	32328
7/11/1956	Female	32327
11/22/1957	Male	32328
2/2/1972	Female	32328
4/13/1953	Female	32328
5/16/1970	Female	32328
7/2/1988	Female	32322
1/4/1973	Female	32328
1/23/1981	Male	32322
2/2/1962	Female	32320
7/12/1964	Female	32320
12/20/1969	Female	32322
5/26/1970	Female	32329
2/2/1986	Female	32327
3/1/1965	Female	32320
8/12/1973	Female	32456
2/12/1965	Male	32320
4/5/1950	Female	32328
6/5/1946	Female	32328
1/8/1988	Male	32328
11/7/1973	Female	32323
12/29/1964	Male	32323
1/8/1988	Male	32305
6/27/1955	Male	32358
7/5/1958	Female	32328
11/18/1972	Male	32323
12/24/1944	Male	28792
6/13/1964	Female	32322
9/28/1966	Female	32320
5/5/1972	Female	32328
9/15/1951	Female	32328
3/4/1988	Female	32320
2/18/1983	Female	32328
1/29/1976	Male	32456
6/18/1959	Female	32322
1/14/1960	Female	32308
9/3/1957	Female	32322
11/7/1956	Female	32322

ACTIVE EMPLOYEE CENSUS 2018

Birth	Gender	Zip
4/18/1964	Female	32328
6/28/1974	Female	32328
7/11/1980	Female	32322
3/16/1977	Female	32320
1/1/1961	Female	32320
11/6/1954	Female	32320
2/22/1976	Female	32322
4/2/1951	Female	32320
11/1/1969	Male	32358
2/19/1963	Female	32328
1/3/1957	Female	32320
3/27/1976	Female	32322
12/19/1955	Female	32329
12/7/1957	Female	32329
2/4/1994	Female	32322
4/7/1989	Female	32320
12/28/1963	Female	32322
5/10/1995	Female	32320
12/28/1956	Female	32328
2/12/1989	Female	32358
8/3/1996	Female	32328
12/24/1962	Female	32320
12/12/1964	Female	32320
10/17/1989	Female	32320
5/21/1985	Female	32320
11/3/1960	Male	32425
8/20/1990	Female	32322
12/11/1975	Male	32309
5/7/1957	Female	32320
1/19/1970	Female	32328
11/26/1961	Female	32328
5/23/1986	Female	32328
9/27/1958	Female	32328
12/18/1950	Female	32328
10/29/1954	Male	32320
6/17/1992	Female	32539
4/16/1971	Female	32322
4/20/1964	Female	78213
6/5/1961	Female	32328
12/11/1953	Female	32320
4/28/1978	Female	32320
7/18/1978	Male	32322
8/27/1991	Female	32322
8/7/1964	Female	32321
11/13/1960	Male	82072
9/6/1961	Female	32328
8/9/1990	Female	32320
7/27/1971	Male	32328
11/25/1959	Male	32328

ACTIVE EMPLOYEE CENSUS 2018

Birth	Gender	Zip
11/10/1953	Female	32327
4/24/1958	Male	32329
2/24/1969	Female	32320
3/27/1966	Female	32320
4/29/1982	Female	32320
1/11/1978	Male	32332
6/29/1974	Female	32320
8/12/1960	Male	32322
11/8/1935	Female	32322
3/21/1974	Female	32320
10/24/1992	Female	32323
7/3/1976	Male	32323
11/18/1976	Male	32322
11/10/1970	Male	32320
1/1/1970	Female	32328
7/18/1969	Female	32327
7/4/1976	Female	32328
8/6/1984	Female	32320
8/24/1964	Female	32320
6/20/1991	Female	32322
8/21/1987	Female	32320
7/18/1968	Female	32322
10/22/1972	Male	32346