CONTRACT, LEASE, AGREEMENT CONTROL FORM

Date: <u>06/24/2020</u>

Contract/Lease Control #: C08-1608-RM

Procurement#: NA

Contract/Lease Type: <u>AGREEMENT</u>

Award To/Lessee: <u>BLUE CROSS & BLUE SHIELD OF FLORIDA</u>

Owner/Lessor: OKALOOSA COUNTY

Effective Date: <u>10/01/2019</u>

Expiration Date: <u>09/30/2021</u>

Description of: PROSHARE PLUS ACCOUNTY DEPARTMENT

Department: <u>KB</u>

Department Monitor: BIRD

Monitor's Telephone #: 850-689-5977

Monitor's FAX # or E-mail: KBIRD@MYOKALOOSA.COM

Closed:

Cc: BCC RECORDS

Kelly Bird

C08-1408-RM

From:

Lynn Hoshihara

Sent:

Friday, June 19, 2020 10:26 AM

To:

Kelly Bird

Subject:

Re: New Pro-Share Agreement

Kelly,

This agreement is approved by Legal and may be signed by John Hofstad.

Lynn

Lynn M. Hoshihara County Attorney Okaloosa County, Florida

Please note: Due to Florida's very broad public records laws, most written communications to or from County employees regarding County business are public records, available to the public and media upon request. Therefore, this written e-mail communication, including your e-mail address, may be subject to public disclosure.

From: Kelly Bird

Sent: Friday, June 19, 2020 11:19:02 AM

To: Lynn Hoshihara

Subject: New Pro-Share Agreement

Lynn,

Per our conversation when we met with Kay Godwin, you agreed John could sign the Pro-Share agreement. Please review and approve for John's signature.

Best regards,

Kelly Bird

Risk Manager Okaloosa County Board of County Commisioners 302 N. Wilson Street, Suite 301 Crestview, FL 32536 Phone-(850) 689-5978

BlueCross BlueShield Of Florida, Inc.

Annual Accounting & Retention Agreement

This is an agreement (hereinafter "Agreement") between Blue Cross Blue Shield of Florida, Inc. (hereinafter referred to as "Florida Blue"), located at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 and Okaloosa County Board of County Commissioners, (hereinafter "the Group") located at 1250 N Eglin Pkwy, Shalimar, FL 32579.

WHEREAS, the Group requests Florida Blue to provide a Point-of-Service insurance program, (hereinafter jointly referred to as GHP "the Group Health Plan") to its employees and their covered dependents (hereinafter "Group Member(s)"); and

WHEREAS, each of the parties to this Agreement seeks to set forth in writing the terms and conditions of their Agreement,

NOW THEREFORE, for good and valuable consideration, the parties agree to these terms and conditions:

I. TERM

The term of this Agreement shall begin on October 1, 2019, (the Effective Date) and shall end on September 30, 2021, (the Termination Date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

II. BENEFIT PLAN

Florida Blue will pay benefits to all eligible Group Members in accordance with the provisions of this agreement and the GHP.

III. PREMIUM PAYMENTS

The Premium Rates, Prepayment Fees and Supplemental Charges for the GHP are payable in advance to Florida Blue at the address set forth above. The premiums for the program are set forth in Exhibit A.

CONTRACT#: C08-1608-RM
BLUE CROSS & BLUE SHIELD OF FLORIDA
PROSHARE PLUS ACCOUNTING DEPARTMENT

EXPIRES: 09/30/2021

IV. ANNUAL ACCOUNTING

- A) Within one hundred twenty (120) days after each anniversary of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such year's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, 100% of this excess will be returned to the Group, less any prior period deficit. However, if the group cancels prior to January 31, 2022, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by Florida Blue.

V. TERMINATION

This agreement may be terminated at any anniversary of the effective date by either party by giving the other party at least forty-five (45) days prior written notice of such termination.

VI. MODIFICATION OF RATES

Rates for the first twelve (12) months of this Agreement will remain in effect, as set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by Florida Blue. Thereafter, all rates set forth in Exhibit A of this Agreement or subsequent contract periods are subject to change by Florida Blue at any time following at least forty-five (45) days prior written notice to the Group.

The renewal rates for the period October 1, 2020 through September 30, 2021, will be set forth and presented to the Group on a revised Exhibit A.

All other provisions of this Agreement shall remain in effect without modification.

VII. LATE PAYMENT/CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to Florida Blue up to ten (10) days after such due date without a late payment charge. Payments received by Florida Blue eleven (11) to thirty-one (31) days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to Florida Blue immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to Florida Blue within thirty-one (31) days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by Florida Blue that were incurred after the termination date.

All payments due for charges during the Agreement period must be received by Florida Blue in order for the Group to share in any excess.

VIII. RENEWAL

This Agreement does not automatically renew or extend upon completion of the term of the Agreement. A revised Exhibit A for subsequent periods after the initial period showing renewal rates, administrative charge and pooling charge for such subsequent period will be provided to the Group after renewal for each subsequent period within the term of the Agreement. Any revised Exhibit A does not represent a renewal or extension of the original term of the Agreement.

IX. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

X. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XI. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XII. GOVERNING LAW

This Agreement, and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XIII. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

XIV. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that Florida Blue may make changes necessary to comply with State and Federal laws upon sixty days' notice to the Group.

XV. ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and Florida Blue. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVI. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XVII. PROVIDER NETWORKS

Florida Blue's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BLUEC	CROSS & BLUE SHIELD OF FLORIDA, INC.	
Ву:	Inco	
Name:	Joseph C. Gregor, Esq.	
Title:	Vice President, Commercial Segments	
Date:	June 2, 2020	
OKALO	OSA COUNTY BOARD OF COUNTY COMMISSIONERS	
Ву:	- JEPA	
Name: Printed	John Hofstad	
Title:	County Administrator	
Date:	6/19/20	

EXHIBIT A TO THE ANNUAL ACCOUNTING AND RETENTION AGREEMENT WITH OKALOOSA COUNTY BOARD OF COUNTY COMMISSIONERS GROUP NO. 41954

A. Premium rates effective: October 1, 2019 through September 30, 2020

	BO 05770 NSTD RX \$15/\$50/\$80	BO 05781 NSTD RX \$15/\$60/\$80	H.S.A. 05192/05193 NSTD RX IN CYD, \$15/\$60/\$100
SINGLE	\$1,201.88	\$1,036.20	\$774.15
FAMILY	\$1,834.45	\$1,581.60	\$1,181.61

B. Administrative charges effective: October 1, 2019 through September 30, 2020

11.45% of earned premium

C. Pooling effective: October 1, 2019 through September 30, 2020

Pooling Level: \$230,000 Per Individual
 Pooling Charges: 5.48% of earned premium

EXHIBIT B

CONTRACT & LEASE AGREEMENT CONTROL FORM

Date: 2/27/2008

Contract/Lease Control #: C08-1608-Pm

Bid #: N/A

Contract/Lease Type: AGREEMENT

Award to/Lessee: BLUE CROSS & BLUE SHIELD OF FLORIDA

Lessor:

Effective Date: 10/1/2007 Amount: \$500,000

Term/Expires: 9/30/1/6 W/ANNUAL RENEWALS

Description of Contract/Lease: PROSHARES PLUS ACCOUNTING

AGREEMENT

Department Manager: RISK MANAGEMENT

Department Monitor: J. TAYLOR CONTRACT # C08-1608-RM

BLUE CROSS & BLUE SHIELD

Monitor's Telephone #: 689-5977 PROSHARE PLUS ACCT AGREEMENT

EXPIRES: 9/30/2011

Monitor's Fax #: 689-5973

Date Closed:

RENEWED 8/5/2008 BY BCC WHEN THEY APPROVED AWARDING OF NEW HEALTH CARE CONTRACT AGAIN TO BCBS.

PROCUREMENT/CONTRACT/LEASE INTERNAL COORDINATION SHEET

Procurement/Contract/Lease Number: (08-1408	
Procurement/Contractor/Lessee Name: BC/BS	Grant Funded: YES NO
Purpose: Prashmo Opelant	1
Date/Term: <u>9-30-19</u>	1. GREATER THAN \$100,000
Amount:	2. Greater than \$50,000
Department:	3. \$50,000 OR LESS
Dept. Monitor Name: 61550	
Purchasing Review	V
Procurement or Contract/Lease requirements are met:	Date: 7-37-19
Purchasing Manager or designee Jeff Hyde, DeRita	Mason, Victoria Taravella
2CFR Compliance Review	(if required)
Approved as written:	Grant Name:
Grants Coordinator Danielle Garcia	Date:
Risk Management Re	view /
Approved as written:	setould
Risk Manager or designee Laura Porter or Krystal I	Date: 7-3 (-19
County Attorney Rev	, /·
Approved as written: Upproved wt	
County Attorney Gregory T. Stewart, Lyn	Date: n Hoshihara, Kerry Parsons or Designee
Following Okaloosa County	approval:
Clerk Finance Document has been received:	
DOCUMENTIAS DECITECENTON.	Dato
Finance Manager or designee	Date:

DeRita Mason

From:

Edith Gibson

Sent:

Wednesday, July 31, 2019 3:08 PM

To:

DeRita Mason

Subject:

Re: ProShare Agreement

Yes, this approved by Risk Mgt.

Thanks,

Edith

Sent from my Verizon, Samsung Galaxy smartphone

----- Original message -----

From: DeRita Mason <dmason@myokaloosa.com>

Date: 7/31/19 2:14 PM (GMT-06:00)

To: Edith Gibson <egibson@myokaloosa.com>

Subject: RE: ProShare Agreement

I didn't see it, I am sending it now. Is this approved for risk?

From: Edith Gibson

Sent: Tuesday, July 30, 2019 4:31 PM

To: DeRita Mason <dmason@myokaloosa.com>

Subject: ProShare Agreement

Importance: High

Hi DeRita,

Can you please look back in your records to see if this was ever reviewed and approved. If not, can you please have it reviewed for approval.

Thanks,

Edith Z. Gibson Risk Manager Okaloosa County Risk Management 5479-B Old Bethel Rd. Crestview, FL 32536

Office: 850-689-5979 Cell: 850-585-8915

egibson@myokaloosa.com

BlueCross BlueShield Of Florida, Inc.

Annual Accounting & Retention Agreement

This is an agreement (hereinafter "Agreement") between Blue Cross Blue Shield of Florida, Inc. (hereinafter referred to as "Florida Blue"), located at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 and Okaloosa County Board of County Commissioners, (hereinafter "the Group") located at 5479 Old Bethel Road #B, Crestview, FL 32536.

WHEREAS, the Group requests Florida Blue to provide a Point-of-Service insurance program, (hereinafter jointly referred to as GHP "the Group Health Plan") to its employees and their covered dependents (hereinafter "Group Member(s)"); and

WHEREAS, each of the parties to this Agreement seeks to set forth in writing the terms and conditions of their Agreement,

NOW THEREFORE, for good and valuable consideration, the parties agree to these terms and conditions:

I. TERM

The term of this Agreement shall begin on October 1, 2017, (the Effective Date) and shall end on September 30, 2019, (the Termination Date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

II. BENEFIT PLAN

Florida Blue will pay benefits to all eligible Group Members in accordance with the provisions of this agreement and the GHP.

III. PREMIUM PAYMENTS

The Premium Rates, Prepayment Fees and Supplemental Charges for the GHP are payable in advance to Florida Blue at the address set forth above. The premiums for the program are set forth in Exhibit A.

CONTRACT: CO8-1608-RM
BLUE CROSS & BLUE SHIELD
PROSHARE PLUS ACCOUNTING DEPT
EXPIRES: 09/30/2019 W/RENEWALS

IV. ACCOUNTING FOR OCTOBER 1, 2017 THROUGH SEPTEMBER 30, 2019

- A) Within one hundred twenty days of September 30, 2019 of this Agreement, Florida Blue shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, 100% of this excess will be returned to the Group, less any prior period deficit. However, if the group cancels prior to January 31, 2020, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by Florida Blue.

V. TERMINATION

This agreement may be terminate at any anniversary of the effective date by either party by giving the other party at least forty-five (45) days prior written notice of such termination.

VI. MODIFICATION OF RATES

Rates for the first twelve (12) months of this Agreement will remain in effect, as set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by Florida Blue. Thereafter, all rates set forth in Exhibit A of this Agreement or subsequent contract periods are subject to change by Florida Blue at any time following at least forty-five (45) days prior written notice to the Group.

The renewal rates for the period October 1, 2017 through September 30, 2018 and October 1, 2018 through September 30, 2019 of this Agreement will be calculated based on:

A) Incurred Claims (less claims in excess of the \$175,000 pooling level),

B) An Adjusted Trend factor, based on an Annual Trend factor guaranteed not to exceed 10.8% (not including the impact of health reform),

C) Pooled Claim Charges equal to 5.57% of Premium and

D) Administrative Expenses equal to 14.29% of Premium (Includes Administrative Fees and \$59,800 AOR Fees).

All other provisions of this Agreement shall remain in effect without modification.

VII. LATE PAYMENT/CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to Florida Blue up to ten (10) days after such due date without a late payment charge. Payments received by Florida Blue eleven (11) to thirty-one (31) days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to Florida Blue immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to Florida Blue within thirty-one (31) days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by Florida Blue that were incurred after the termination date.

All payments due for charges during the Agreement period must be received by Florida Blue in order for the Group to share in any excess.

VIII. RENEWAL

This Agreement does not automatically renew or extend upon completion of the term of the Agreement. A revised Exhibit A for subsequent periods after the initial period showing renewal rates, administrative charge and pooling charge for such subsequent period will be provided to the Group after renewal for each subsequent period within the term of the Agreement. Any revised Exhibit A does not represent a renewal or extension of the original term of the Agreement.

IX. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

X. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XI. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XII. GOVERNING LAW

This Agreement, and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XIII. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

XIV. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that Florida Blue may make changes necessary to comply with State and Federal laws upon sixty days' notice to the Group.

XV. ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and Florida Blue. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVI. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XXI. PROVIDER NETWORKS

Florida Blue's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BLUE C	ROSS & BLUE SHIELD OF FLORIDA, INC.
Ву:	TheCC
Name:	Joseph C. Gregor, Esq.
Title:	Vice President, Commercial Segments
Date:	6/9/17
OKALOC	OSA COUNTY, FLORIDA
Ву:	Charle K, while (SM)
Name:	Charles K. Windes, Jr., Chairman
Printed Title:	Chairman
i ilie.	
Date:	AUG 0 6 2019



Cross	and Blue Shield Association							
	New Business	★ Renewa	al Business C	Other				
I	 I. Group Informatio	n Group	# (Florida Blue): 419:	54 (Florida	a Blue HMO):			
A.	. Name of Group:	OKALOOSA	CO BOARD OF CO	COMMISSIONERS				
Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199 Mailing Address:						9199		
	5479 OLD BETHEL RD # B CRESTVIEW,FL 32536-5512							
	Email Address: List below Subsidiary of application. Name		1YOKALOOSA.COM npanies whose emplo	oyees are to be eligible and	d included with	this		
В.	Blue Shield of Florida,	Inc., D/B/A Flo nis application b	rida Blue and/or Heal	rein referred to as a Policy th Options, Inc., D/B/A Flo Florida Blue HMO, it will b	rida Blue HMC).	ed to	
C.	Prior Insurance Carrie	r: Insurance	HUMANA					
		НМО	NO GROUP INSURA	NCE				
D.	The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.							
E.	Workers Compensation	n Carrier is:	SELF INSURED					
II. I	Effective Date/Eligibil	ity Informati	on					
A.	Effective Date of this Po	olicy shall be	10/01/2000					
	Effective Date of this Ch	-	•	10/01/2019				
	written notice to the other	er party except	in the case of non-pa	-				
B.	Only eligible employees			<u> </u>	week and thei	r eligible depen	dents,	
C.	shall be eligible for coverage upon the Effective Date of this Policy. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.							
D.	New eligible employees	•		1st of the month	after		days	
	of employment, so long 30 days of the date the			application to Florida Blue	/Florida Blue F	HMO within		
E.	At least 65 % c	of the eligible er	nployees must be enr	olled under the Policy on t				
F.	participation requirement Florida Blue/Florida Blue	nts. e HMO shall ha rerage, includin	we the right to audit the granticipation percen	and continue to meet Florione applicant's payroll recortage criteria required by F	ds at any time	to		
G.	Employer Contribution:	Employee:	100 % Depend	dents: 0 %				



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.								
Included in Product	Accept	Decline						
×			Mental & Nervou	s Disor	der			
×			Alcohol and drug	depen	dency			
×			Mammograms W	aiver c	of Deductible & Co	oinsurance		
\boxtimes			Enteral Formulas	;				
Sing	Single Plan Blue Packages							
Health Plan Nar	ne					licate copaymei		· · · · · · · · · · · · · · · · · · ·
HSA Compatible	e Plans 0519	3 - NSTD			BlueScript G I	n-Network DEE	+ \$15/\$60/\$	100C - NSTD
Benefit Period	d: 01/01	/2019 - 12/3	/2019		Coinsurance	:		
Deductible :					In-Network / P	articipating		80% / 20%
Per Person	\$5,00	0 / \$10,000			Out-of-Networ	k/Non-Participa	ting	60% / 40%
Per Family	\$5,00	0 / \$10,000			Office Visit C	Сорау:		
Pre-Existing	N/A				Family Physic	ian		DED + 20%
Rates					All Other Prov	iders		DED + 20%
Employee N/A	Emp	oloyee/Spous	e N/A] Emp	loyee/Child(ren)	N/A Fam	nily [N/A
Spouse N/A	Chil	d(ren)	N/A	Spc	ouse/Child(ren)	N/A Emp	oloyee + 1	\$1010.55



Health Plan Name			Rx Option (inc	licate copayments)	
Predictable Cost Pla	n 05781 - NSTD			OOP Int \$15/\$60/\$80C - I	NSTD
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance	:	
Deductible :			In-Network / P	articipating	70% / 30%
Per Person	\$1,500 / \$4,500		Out-of-Networ	k/Non-Participating	50% / 50%
Per Family	\$4,500 / \$13,500		Office Visit C	Сорау:	
Pre-Existing	N/A	•	Family Physic	ian	\$30
Rates			All Other Prov	iders	\$55
Employee N/A Spouse N/A	Employee/Spouse Child(ren)		Employee/Child(ren) Spouse/Child(ren)	N/A Family N/A Employee + 1	N/A \$1352.61
Single P	lan 🔰	Blue Pack			
Treatmin tan marie			Bx Ontion (inc	dicate copayments)	
Predictable Cost Pla	n 05770 - NSTD			dicate copayments) OOP Int \$15/\$50/\$80C - 1	NSTD
Predictable Cost Pla Benefit Period : Deductible :	o1/01/2019 - 12/31/2019			OOP Int \$15/\$50/\$80C -	NSTD 80% / 20%
Benefit Period :			BlueScript Rx Coinsurance In-Network / F	OOP Int \$15/\$50/\$80C -	
Benefit Period : Deductible :	01/01/2019 - 12/31/2019		BlueScript Rx Coinsurance In-Network / F	OOP Int \$15/\$50/\$80C - Int \$15/\$	80% / 20%
Benefit Period : Deductible : Per Person	01/01/2019 - 12/31/2019 \$750 / \$1,500		BlueScript Rx Coinsurance In-Network / F Out-of-Network	OOP Int \$15/\$50/\$80C - Set Participating rk/Non-Participating	80% / 20%
Benefit Period : Deductible : Per Person Per Family	01/01/2019 - 12/31/2019 \$750 / \$1,500 \$2,250 / \$4,500		Coinsurance In-Network / F Out-of-Network Office Visit C	OOP Int \$15/\$50/\$80C - Int \$15/\$	80% / 20% 50% / 50%
Benefit Period : Deductible : Per Person Per Family Pre-Existing	01/01/2019 - 12/31/2019 \$750 / \$1,500 \$2,250 / \$4,500	N/A I	Coinsurance In-Network / F Out-of-Networ Office Visit C	OOP Int \$15/\$50/\$80C - Int \$15/\$	80% / 20% 50% / 50% \$30



Single Pla	an 🔀	Blue Pac	nayo	•		
Health Plan Name				Rx Option (inc	dicate copayments)	
HSA Compatible Pla	ns 05192 - NSTD			BlueScript G I	In-Network DED + \$15/\$	60/\$100C - NSTD
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	: :	
Deductible :		· 		In-Network / P	Participating	80% / 20%
Per Person	\$2,500 / \$5,000			Out-of-Networ	rk/Non-Participating	60% / 40%
Per Family	Not Applicable / Not Applicable	able		Office Visit C	Сорау:	
Pre-Existing	N/A			Family Physic	ian	DED + 20 %
Rates				All Other Prov	iders	DED + 20 %
Employee \$449.10	Employee/Spouse	N/A	Emp	loyee/Child(ren)	N/A Family	N/A
Spouse N/A	Child(ren)	N/A	Spo	use/Child(ren)	N/A Employee +	1 N/A
Single Pl	an 🔀	Blue Pad	ckage	S		
Health Plan Name			• ••	Rx Option (inc	dicate copayments)	
HSA Compatible Pla	ns 05193 - NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD		
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance:		
Deductible :				In-Network / Participating 80% / 20%		
Per Person	\$5,000 / \$10,000			Out-of-Network/Non-Participating 60% / 40%		
Per Family \$5,000 / \$10,000				Office Visit Copay:		
Pre-Existing N/A				Family Physician DED + 20%		
Rates				All Other Prov	riders	DED + 20%
Employee N/A	Employee/Spouse	N/A	Emp	oloyee/Child(ren)	N/A Family	\$1010.55
Spouse N/A	Child(ren)	N/A	Spo	ouse/Child(ren)	N/A Employee +	1 \$898.25



Single Pl	an 🔀	Blue Pac	kages					
Health Plan Name				Rx Option (indicate copayments)				
Predictable Cost Plan	n 05781 - NSTD	A.P.		BlueScript Rx (OOP Int \$	15/\$60/\$80C - I	NSTD	
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance:				
Deductible :				In-Network / Pa	articipatin	g	70	% / 30%
Per Person	\$1,500 / \$4,500			Out-of-Network	√Non-Par	ticipating	50	% / 50%
Per Family	\$4,500 / \$13,500			Office Visit C	орау:			
Pre-Existing	N/A			Family Physicia	an		\$30	0
Rates				All Other Provid	ders		\$55	5
Employee \$601.13	Employee/Spouse	N/A	Empl	oyee/Child(ren)	N/A	Family	\$1352	2.61
Spouse N/A	Child(ren)	N/A	Spot	ıse/Child(ren)	N/A	Employee + 1	\$1202	2.30
Single Pl	an 🔀	Blue Pac	ckages					
Health Plan Name				Rx Option (ind				
Predictable Cost Pla	n 05770 - NSTD			BlueScript Rx	OOP Int S	\$15/\$50/\$80C -	NSTD	
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	联			
Deductible :				In-Network / Pa	articipatin	g	80	% / 20%
Per Person	\$750 / \$1,500			Out-of-Networl	k/Non-Pa	rticipating	50	% / 50%
Per Family	\$2,250 / \$4,500			Office Visit C	орау:			
Pre-Existing	N/A			Family Physici	an		\$3	0
Rates				All Other Provi	ders		\$7	0
Employee \$696.98	Employee/Spouse	N/A	Empl	oyee/Child(ren)	N/A	Family	\$156	8.31
Spouse N/A	Child(ren)	N/A	' '	use/Child(ren)	N/A	Employee +	1 \$139	1.02
-	See the Group Master Policy for a complete description of benefits.							
IV. Health Saving	IV. Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA)							
A. Are you choosing Florida Blue's integrated HSA, HRA or FSA preferred administrator arrangement?								
(if left blank, the response is assumed to be No.)								
B. If Yes is selec	ted above, which type of acc	ounts are y	ou cho	oosing	HSA	HRA		FSA
NOTE: Applic	NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.							nistrator.
V. Rate Inform	nation							
A. Premium/Prep	ayment fee are payable mon							lst
B. Regular Billin Employee can	g - Employee applications st cellations must be submitted	nould be su I within 30 d	bmitte days of	d thirty (30) days the Effective Dat	prior to p te of the T	roposed Effect Fermination.	ive Date	>.



EMPLOYER APPLICATION (True Group Application)

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

	Date.			
D.	Funding Arrangements:	Florida Blue:	ANNUAL REFND NO SPEC STOP LOSS	
		HMO:	Not Applicable	
E.	Rate Comments:	· · · · · · · · · · · · · · · · · · ·		



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
- B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.
- E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that falling to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
- G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Charles R. Which, 179

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITTLE						
Signature of Agent	Agent License Identification Number					
	5014					

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



Γ	New Business	Renewa	l Business	Other							
I.	— . Group Information	n Group	# (Florida Bl	lue): 41954		(Florida	Blue HMO):				
	Name of Group:	OKALOOSA			MISSIONER	kS .					
	Nature of Business:	GENERAL	GOVERNM	IENT, NEC	·		SIC Code:	9199			
	Mailing Address:	5479 OLD BE	THEL RD#	R CRESTVII	EW.FL 3253	6-5512		<u> </u>			
		OTTO OLD DE									
	Email Address:	EGIBSON@N			- ara ta ba al	iaible and	inaludad with				
	List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.										
	Name			^	ddress						

B.	Applicant hereby applie Blue Shield of Florida, Upon acceptance of the the applicant named a	Inc., D/B/A Flo is application t	rida Blue and	d/or Health O	ptions, Inc., [D/B/A Flori	da Blue HMC).	ued to		
C.	Prior Insurance Carrie	r: Insurance	HUMANA								
		НМО	NO GROUP	INSURANCE	C						
D.	The Policy excludes exwith an Insured's job of insurance) except for the by Workers' Compensithat individual. The for Compensation coveral employees in the Ground in the	or employment medically nece ation and that l egoing exclusion ge and to an in	(e.g., any ser ssary service ack of covers on applies to	vice or supply s (not otherw age did not re an individual	y which is co ise excluded sult from any who elects e	vered by V) for an inc vintentional exemption t	Vorkers' Com lividual who i al action or or from Workers	pensation s not covered nission by			
E.	Workers Compensation	n Carrier is:	SELF INS	SURED							
II. I	Effective Date/Eligibil	ity Informati	on								
A.	Effective Date of this Po	olicy shall be	10/01/2	2000							
	Effective Date of this Cl	nange to the Po	olicy shall be	10,	/01/2019						
	This Policy may be term written notice to the oth	ninated by the a er party except	applicant or F in the case o	Florida Blue/Florida non-payme	lorida Blue H nt of Premiu	MO by giv m.	ing at least 4	5 days prior			
B.	Only eligible employees					ours each v	veek and the	ir eligible depe	ndents,		
C.	shall be eligible for coverage Specify classification of described in B above.					ther than e	ligible emplo	yees as			
D.	New eligible employees				1st of the			30	day		
	of employment, so long	_					Florida Blue	HMO within			
=	30 days of the date the	individual first of the eligible e	•	-	•		e Effective C	ate and			
E. F.	At least 65 % of throughout the term of the participation requirement Florida Blue/Florida Blue confirm eligibility for confirm eligibility eligibility for confirm eligibility eligibility for confirm eligibility eligibilit	he Policy and t nts. e HMO shall ha verage, includir	the Group mu ave the right ng participation	ust meet and o to audit the ap	continue to n oplicant's pay	neet Florid yroll record	a Blue/Florid Is at any time	a Blue HMO e to	Э.		
G.	Employer Contribution:	Employee:	100 %	Dependent	s: 0	%					



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated B by the Feder	enefit Or al and/or	fferings:(0 State Law	Optional) Applicar	nt has been sion to acce	advise ept or d	d of the following ecline these ben	benefit o efits is inc	fferings mandate licated below.	əd	
Included Produc		cept [Decline							
\boxtimes			Menta	l & Nervous	s Disord	der				
			Alcoh	ol and drug	depend	dency				
×	Mammograms Waiver of Deductible & Coinsurance									
Enteral Formulas										
	Single Pl	an	Σ	Blue Pa	ckages					
Health Plan	Name					Rx Option (ind	icate cop	ayments)		
HSA Compa	itible Pla	ns 05193 -	NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD				
Benefit Pe	riod :	01/01/20	19 - 12/31/2019			Coinsurance:				
Deductible	e:					In-Network / Participating 80% / 20%				
Per Person		\$5,000 /	\$10,000			Out-of-Network/Non-Participating 60% / 40%				
Per Family		\$5,000 /	\$10,000			Office Visit C	орау:			
Pre-Existing	9	N/A				Family Physici	an		DED + 20%	
Rates						All Other Providers DED + 20%				
Employee	N/A	Employ	/ee/Spouse	N/A	Empl	oyee/Child(ren)	N/A	Family	N/A	
Spouse	N/A	Child(r	en)	N/A	Spot	use/Child(ren)	N/A	Employee + 1	\$1010.55	



Health Plan Name			Rx Option (indicate copayme	ents)				
Predictable Cost Pla	n 05781 - NSTD		BlueScript Rx OOP Int \$15/\$	BlueScript Rx OOP Int \$15/\$60/\$80C - NSTD				
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance:					
Deductible :		-	In-Network / Participating	70% / 30%				
Per Person	\$1,500 / \$4,500		Out-of-Network/Non-Particip	pating 50% / 50%				
Per Family	\$4,500 / \$13,500		Office Visit Copay:					
Pre-Existing	N/A		Family Physician	\$30				
Rates			All Other Providers	\$55				
Employee N/A	Employee/Spouse	N/A	Employee/Child(ren) N/A Fa	mily N/A				
Spouse N/A	Child(ren)	N/A	Spouse/Child(ren) N/A Em	ployee + 1 \$1352.61				
Single P	an	X Blue Pack	Rx Option <i>(indicate copaym</i>	ents)				
	L	X Blue Pack						
Health Plan Name Predictable Cost Pla	L	X Blue Pack	Rx Option (indicate copaym	\$50/\$80C - NSTD				
Health Plan Name Predictable Cost Pla Benefit Period :	n 05770 - NSTD	Blue Pack	Rx Option (indicate copaym BlueScript Rx OOP Int \$15/5					
Health Plan Name	n 05770 - NSTD	Blue Pack	Rx Option (indicate copaym BlueScript Rx OOP Int \$15/5 Coinsurance:	\$50/\$80C - NSTD 80% / 20%				
Health Plan Name Predictable Cost Pla Benefit Period : Deductible :	n 05770 - NSTD 01/01/2019 - 12/31/2019	Blue Pack	Rx Option (indicate copaym BlueScript Rx OOP Int \$15/\$ Coinsurance: In-Network / Participating	\$50/\$80C - NSTD 80% / 20%				
Health Plan Name Predictable Cost Pla Benefit Period: Deductible: Per Person	n 05770 - NSTD 01/01/2019 - 12/31/2019 \$750 / \$1,500	Blue Pack	Rx Option (indicate copaym BlueScript Rx OOP Int \$15/5 Coinsurance: In-Network / Participating Out-of-Network/Non-Particip	\$50/\$80C - NSTD 80% / 20%				
Health Plan Name Predictable Cost Pla Benefit Period: Deductible: Per Person Per Family Pre-Existing	n 05770 - NSTD 01/01/2019 - 12/31/2019 \$750 / \$1,500 \$2,250 / \$4,500	Blue Pack	Rx Option (indicate copaym BlueScript Rx OOP Int \$15/\$ Coinsurance: In-Network / Participating Out-of-Network/Non-Particip Office Visit Copay:	80% / 20% Pating 50% / 50%				
Health Plan Name Predictable Cost Pla Benefit Period: Deductible: Per Person Per Family	n 05770 - NSTD 01/01/2019 - 12/31/2019 \$750 / \$1,500 \$2,250 / \$4,500	X Blue Pack	Rx Option (indicate copaym BlueScript Rx OOP Int \$15/5 Coinsurance: In-Network / Participating Out-of-Network/Non-Particip Office Visit Copay: Family Physician All Other Providers	\$50/\$80C - NSTD 80% / 20% pating \$50% / 50%				



Single Pl	an 🔀	Blue Package	5					
Health Plan Name			Rx Option (indi	icate copayments)				
HSA Compatible Pla	ns 05192 - NSTD		BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance:					
Deductible :			In-Network / Participating 80% / 20%					
Per Person	\$2,500 / \$5,000		Out-of-Network/Non-Participating 60% / 40%					
Per Family	Not Applicable / Not Applica	ble	Office Visit C	орау:				
Pre-Existing	N/A		Family Physicia	Family Physician				
Rates			All Other Provid	ders	DED + 20 %			
Employee \$449.10	Employee/Spouse	N/A Emp	oloyee/Child(ren) N/A Family N/A					
Spouse N/A	Child(ren)	N/A Spo	oouse/Child(ren) N/A Employee + 1 N/A					
Single Pl	an 🔀	Blue Package	es					
Health Plan Name		*	Rx Option (indi	icate copayments)				
HSA Compatible Pla	ns 05193 - NSTD		BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance:					
Deductible :			In-Network / Pa	articipating	80% / 20%			
Per Person	\$5,000 / \$10,000		Out-of-Network	k/Non-Participating	60% / 40%			
Per Family	\$5,000 / \$10,000		Office Visit C	opay:				
Pre-Existing	N/A		Family Physicia	an	DED + 20%			
Rates			All Other Providers DED + 20%					
Employee N/A	Employee/Spouse	N/A Emp	oloyee/Child(ren)	N/A Family	\$1010.55			
Spouse N/A	Child(ren)	N/A Sp	ouse/Child(ren)	N/A Employee + 1	\$898.25			



Single P	lan 🗶	Blue Pac	kage	6					
Health Plan Name				Rx Option (ind	licate cop	ayments)			
Predictable Cost Pla	n 05781 - NSTD			BlueScript Rx	OOP Int S	\$15/\$60/\$80C - NS	STD		
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	:		***************************************		
Deductible :				In-Network / P	articipatin	g	70% / 30%		
Per Person	\$1,500 / \$4,500	•		Out-of-Network/Non-Participating 50% / 50%					
Per Family	\$4,500 / \$13,500			Office Visit Copay:					
Pre-Existing	N/A			Family Physici	ian		\$30		
Rates				All Other Provi	iders		\$55		
Employee \$601.13	Employee/Spouse	N/A	Emp	loyee/Child(ren)	N/A	Family	\$1352.61		
Spouse N/A Child(ren) N/A S				use/Child(ren)	N/A	Employee + 1	\$1202.30		
Single Plan Blue Packages									
Health Plan Name				Rx Option (indicate copayments)					
Predictable Cost Pla	n 05770 - NSTD			BlueScript Rx	OOP Int	\$15/\$50/\$80C - NS	STD		
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	::				
Deductible :				In-Network / P	articipatir	ng	80% / 20%		
Per Person	\$750 / \$1,500			Out-of-Network/Non-Participating 50% / 50%					
Per Family	\$2,250 / \$4,500			Office Visit Copay:					
Pre-Existing	N/A			Family Physic	ian		\$30		
Rates				All Other Prov	iders		\$70		
Employee \$696.98	Employee/Spouse	N/A	Emp	oloyee/Child(ren)	N/A	Family	\$1568.31		
Spouse N/A	Child(ren)	N/A	Spo	ouse/Child(ren)	N/A	Employee + 1	\$1394.02		
See the Group Mas	ster Policy for a complete des	cription of b	enefi	ts.					
IV. Health Saving	s Account (HSA), Health Re	eimbursem	ent A	rrangement (HR	A) or Fle	xible Spending	Account (FSA)		
A. Are you choo	sing Florida Blue's integrated	HSA, HRA	or FS	SA preferred admi	nistrator a	arrangement?	Yes X No		
(if left blank,	he response is assumed to b	e No.)							
B. If Yes is selec	ted above, which type of acc	ounts are y	ou ch	oosing	HSA	HRA	FSA		
NOTE: Applic	eant must have elected an HS	A compatib	ole pla	n to be able to of	fer an HS	A with preferred	administrator.		
V. Rate Inforn	nation								
A. Premium/Prep	ayment fee are payable mon	thly on or b	efore	the due date whic	ch will be:		1st		
	ng - Employee applications sh ncellations must be submitted						Date.		



EMPLOYER APPLICATION (True Group Application)

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

D.	Funding Arrangements:	Florida Blue:	ANNUAL REFND NO SPEC STOP LOSS	
		нмо:	Not Applicable	
E.	Rate Comments:			



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
- B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.
- E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
- G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Marler H, Went n

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITT	TLE
Signature of Agent	Agent License Identification Number
	5014

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



ľ	New Business	X Renewal	Business	Othe	r [
I.	 . Group Information		# (Florida Blu	ю): 41954	<u> </u>		(Florida	Blue HMO):		
	Name of Group:	OKALOOSA (CO BOARD C	OF CO COM	1MISSI	ONE	RS			
	Nature of Business:	GENERAL	GOVERNMI	ENT, NEC				SIC Code:	9199	
	Mailing Address:	5479 OLD BE			וישר עצייםו	3257	6 5512			
		54/9 OLD DE	I HEL RU # D	CRESTVI	IE W, K L	3433	00-3312			
		EGIBSON@M								
	List below Subsidiary o application. Name	Affiliated Con	npanies whos		es are to Address		ligible and	included with	this	
										
B.	Applicant hereby applies Blue Shield of Florida, I Upon acceptance of thi the applicant named ab	nc., D/B/A Flor s application b	rida Blue and	or Health O	options,	Inc.,	D/B/A Flor	ida Blue HMO),	ed to
C.	Prior Insurance Carrier:	Insurance	HUMANA							
		нмо	NO GROUP I	NSURANC	E					
D.	The Policy excludes exp with an Insured's job or insurance) except for m by Workers' Compensa that individual. The fore Compensation coverage employees in the Group	employment (nedically neces tion and that la going exclusion e and to an ind	e.g., any serv sary services ack of coverag on applies to a	rice or suppl (not otherw ge did not re an individual	ly which vise exc esult fro I who el	is co luded m an lects o	overed by V d) for an ind y intention exemption	Workers' Com dividual who is al action or on from Workers	pensation s not covered hission by	
E.	Workers Compensation	Carrier is:	SELF INS	URED						
II. I	Effective Date/Eligibili	ty Informatio	n							
A.	Effective Date of this Pol	icy shall be	10/01/20	000						
	Effective Date of this Ch	ange to the Po	licy shall be	10	0/01/201	9				
	This Policy may be termi written notice to the other	nated by the a r party except	pplicant or Fl in the case of	orida Blue/F f non-payme	Florida E ent of P	remiu	ım.			
B.	Only eligible employees				30	h	ours each	week and thei	r eligible deper	ndents,
C.	shall be eligible for cove Specify classification of described in B above.	rage upon the enrollees for w	hom coverag	e is being re	icy. equeste	d, if c	other than o	eligible employ	/ees as	
D.	New eligible employees						month	after		days
	of employment, so long 30 days of the date the i							/Hiorida Blue I	HIVIO WITHIN	
E.		f the eligible er ne Policy and ti ts. n HMO shall ha erage, includin	nployees mus he Group mus eve the right to g participation	st be enrolle st meet and o audit the a	ed unde I continu applican	r the ie to i it's pa	Policy on the meet Floric syroll recore	la Blue/Florida ds at any time	a Blue HMO to).
G.	Employer Contribution:	Employee:	100 %	Dependent	ts:	0	%			



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.										
by the redo	ai ailaioi	Oldio Edi	r, r ippnoarit o acci	0,011 (0 4,00)	. p. c. c					
Included			Deallas							İ
Produc	t Ac	cept [Decline							
			Menta	il & Nervous	s Disor	der				
$ $ \times	[Alcoh	ol and drug	depen	dency				
	[Mamr	nograms W	aiver o	f Deductible & Co	oinsurance			
Enteral Formulas										
	Single Pl	an	Σ	Slue Pa	ckages					
Health Plan	n Name					Rx Option (ind	licate copa	ayments)		·
HSA Comp	atible Pla	ns 05193 -	NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD				
Benefit Po	eriod :	01/01/20)19 - 12/31/2019			Coinsurance	:			
Deductibl	e:					In-Network / Participating 80% / 20%				
Per Persor	1	\$5,000 /	\$10,000			Out-of-Network/Non-Participating 60% / 40%				
Per Family		\$5,000 /	\$10,000			Office Visit Copay:				
Pre-Existin	g	N/A				Family Physici	an		DEI) + 20%
Rates						All Other Providers DED + 20%				
Employee	N/A	Emplo	yee/Spouse	N/A	Empl	oyee/Child(ren)	N/A	Family	N/A	
Spouse	N/A	Child(r	ren)	N/A	Spo	ouse/Child(ren) N/A Employee + 1 \$1010.55				



Health Plan Name			Rx Option (inc	dicate copayments)				
Predictable Cost Pla	n 05781 - NSTD		BlueScript Rx	OOP Int \$15/\$60/\$80C -	NSTD			
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance	:				
Deductible :			In-Network / F	Participating	70% / 30%			
Per Person	\$1,500 / \$4,500		Out-of-Networ	Out-of-Network/Non-Participating 50% / 50%				
Per Family	\$4,500 / \$13,500		Office Visit (Сорау:				
Pre-Existing	N/A		Family Physic	ian	\$30			
Rates			All Other Prov	iders	\$55			
Employee N/A	Employee/Spouse	N/A	Employee/Child(ren)	loyee/Child(ren) N/A Family N/A				
Spouse N/A	Child(ren)	N/A	Spouse/Child(ren)	ouse/Child(ren) N/A Employee + 1 \$1352.61				
Single P	lan [X Blue Pac	ckages					
Health Plan Name			Rx Option (inc	dicate copayments)				
Health Plan Name Predictable Cost Pla	n 05770 - NSTD			dicate copayments) OOP Int \$15/\$50/\$80C -	NSTD			
	n 05770 - NSTD 01/01/2019 - 12/31/2019			OOP Int \$15/\$50/\$80C -	NSTD			
Predictable Cost Pla			BlueScript Rx	OOP Int \$15/\$50/\$80C -	NSTD 80% / 20%			
Predictable Cost Pla Benefit Period :			BlueScript Rx Coinsurance In-Network / F	OOP Int \$15/\$50/\$80C -				
Predictable Cost Pla Benefit Period : Deductible :	01/01/2019 - 12/31/2019		BlueScript Rx Coinsurance In-Network / F	OOP Int \$15/\$50/\$80C - Participating rk/Non-Participating	80% / 20%			
Predictable Cost Pla Benefit Period : Deductible : Per Person	01/01/2019 - 12/31/2019 \$750 / \$1,500		Coinsurance In-Network / F	OOP Int \$15/\$50/\$80C - Participating rk/Non-Participating Copay:	80% / 20%			
Predictable Cost Pla Benefit Period: Deductible: Per Person Per Family	01/01/2019 - 12/31/2019 \$750 / \$1,500 \$2,250 / \$4,500		Coinsurance In-Network / F Out-of-Network Office Visit (OOP Int \$15/\$50/\$80C - Participating rk/Non-Participating Copay:	80% / 20%			
Predictable Cost Plate Benefit Period: Deductible: Per Person Per Family Pre-Existing	01/01/2019 - 12/31/2019 \$750 / \$1,500 \$2,250 / \$4,500	N/A	Coinsurance In-Network / F Out-of-Netwo Office Visit (OOP Int \$15/\$50/\$80C - Participating rk/Non-Participating Copay:	80% / 20% 50% / 50% \$30			



Single Pl	an 🔀	Blue Pac	kages						
Health Plan Name				Rx Option (ina	icate copayı	ments)			
HSA Compatible Pla	ns 05192 - NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	:				
Deductible :				in-Network / P	80% / 20	%			
Per Person	\$2,500 / \$5,000			Out-of-Networ	60% / 40	%			
Per Family	Not Applicable / Not Applic	Office Visit C	орау:						
Pre-Existing	N/A			Family Physici	DED + 2	0%			
Rates		All Other Provi	ders		DED + 20	0%			
Employee \$449.10 Employee/Spouse N/A E				nployee/Child(ren) N/A Family N/A					
Spouse N/A	Child(ren)	N/A	Spot	oouse/Child(ren) N/A Employee + 1 N/A					
Single Pl	an 🔀	Blue Pac	kages						
Health Plan Name				Rx Option (indicate copayments)					
HSA Compatible Pla	ns 05193 - NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	:				
Deductible :		-		In-Network / P	articipating		80% / 20	1%	
Per Person	\$5,000 / \$10,000			Out-of-Networ	k/Non-Partic	cipating	60% / 40	1%	
Per Family	\$5,000 / \$10,000			Office Visit C	орау:				
Pre-Existing	N/A			Family Physician DED + 20%					
Rates				All Other Providers DED + 20%				0%	
Employee N/A	Employee/Spouse	N/A	Empl	oyee/Child(ren)	N/A F	amily	\$1010.55		
Spouse N/A	buse/Child(ren) N/A Employee + 1 \$898.25								



Single Pla	an 🔀	Blue Pack	kages						
Health Plan Name				Rx Option (ind	icate copa	nyments)			
Predictable Cost Plan	05781 - NSTD			BlueScript Rx	OOP Int \$	15/\$60/\$80C - NS	STD		
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance					
Deductible :	1			In-Network / Pa	70% / 30%				
Per Person	\$1,500 / \$4,500			Out-of-Network	k/Non-Par	ticipating	50% / 50%		
Per Family	\$4,500 / \$13,500			Office Visit C	opay:				
Pre-Existing	N/A			Family Physici	an		\$30		
Rates				All Other Provi	ders		\$55		
Employee \$601.13	Employee/Spouse	N/A	Emplo	yee/Child(ren)	N/A	Family	\$1352.61		
Spouse N/A	Child(ren)	N/A	Spou	se/Child(ren)	N/A	Employee + 1	\$1202.30		
Single Pla	an X	Blue Pack	kages						
Health Plan Name		t .		Rx Option (ind		•			
Predictable Cost Plan	1 05770 - NSTD			BlueScript Rx	OOP Int \$	615/\$50/\$80C - NS	STU		
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance					
Deductible :				In-Network / Participating 80% / 20%					
Per Person	\$750 / \$1,500			Out-of-Network/Non-Participating 50% / 50%					
Per Family	\$2,250 / \$4,500			Office Visit Copay:					
Pre-Existing	N/A			Family Physici	ian		\$30		
Rates				All Other Provi	ders		\$70		
Employee \$696.98	Employee/Spouse	N/A	Emplo	yee/Child(ren)	N/A	Family [\$1568.31		
Spouse N/A	Child(ren)	N/A	Spou	se/Child(ren)	N/A	Employee + 1	\$1394.02		
See the Group Mast	er Policy for a complete des	cription of be	enefits	•					
IV. Health Savings	Account (HSA), Health Re	eimburseme	ent Arr	rangement (HR	A) or Flex	tible Spending /	Account (FSA)		
A. Are you choosi	ing Florida Blue's integrated	HSA, HRA	or FSA	preferred admi	nistrator a	rrangement?	Yes X No		
(if left blank, th	ne response is assumed to b	e No.)							
	ed above, which type of acc			L L	HSA	HRA	FSA		
NOTE: Applica	ant must have elected an HS	A compatibl	le plan	to be able to of	fer an HS/	A with preferred a	administrator.		
V. Rate Inform	ation								
·	ayment fee are payable mon						1st		
	g - Employee applications shoellations must be submitted						e Date.		



EMPLOYER APPLICATION (True Group Application)

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

D.	Funding Arrangements:	Florida Blue:	ANNUAL REFND NO SPEC STOP LOSS	_
		НМО:	Not Applicable	
E.	Rate Comments:			-



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
- B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.
- E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
- G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Charle K. What I had

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITTLE	
Signature of Agent	Agent License Identification Number
	5014

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



	New Business	X Renewal	Business	Other					
I	. Group Information		f (Florida Bl	ue): 41954		(Florida	a Blue HMO):		
Α.	Name of Group:	OKALOOSA C	O BOARD	ог со сом	MISSIO	NERS		<u> </u>	
	Nature of Business:	GENERAL	GOVERNM	ENT, NEC			SIC Code:	9199	
	Mailing Address:	5479 OLD BET	HELRD#	B CRESTVII	W.FL 3	2536-5512			
	L [
		EGIBSON@MY				!!-:! - t	-1 !11	Alaia	
	List below Subsidiary or application. Name	Affiliated Com	panies who		ddress	e eligible and	a included willi	uns	
В.	Applicant hereby applies	for issuance o	f a Group P	olicy (herein i	eferred	to as a Policy	/) by Blue Cros	s and	
	Blue Shield of Florida, I	nc., D/B/A Flori	da Blue and	l/or Health O	otions, Ir	ic., D/B/A Flo	orida Blue HMC). the Policy issue	d to
	Upon acceptance of this the applicant named ab	s application by ove.	r Florida Biu	e and/or Fiori	da biue	HIVIO, IT WIII I	become part of	the Folicy Issue	a to
C.	Prior Insurance Carrier:	Insurance E	IUMANA	·					
		HMO N	O GROUP	INSURANCE	,				
D.	The Policy excludes exp with an Insured's job or insurance) except for m by Workers' Compensa that individual. The fore Compensation coverag employees in the Group	employment (e ledically necess tion and that la going exclusion e and to an indi	e.g., any ser sary services ck of covera n applies to	vice or supply s (not otherwi ge did not re an individual	which is se exclusult from who elec	s covered by ded) for an ir any intention ets exemption	Workers' Com ndividual who is nal action or on n from Workers	pensation s not covered nission by	
E.	Workers Compensation	Carrier is:	SELF INS	URED					
II.	Effective Date/Eligibilit	ty Informatio	n		-				
A.	Effective Date of this Pol	icy shall be	10/01/2	000					
	Effective Date of this Cha	ange to the Poli	cy shall be	10/	01/2019				
	This Policy may be termi written notice to the othe	nated by the ap r party except i	plicant or F n the case o	lorida Blue/Fl f non-payme	orida Blu nt of Pre	ie HMO by g mium.	iving at least 4	5 days prior	
B.	Only eligible employees	•			30	hours each	n week and thei	ir eligible depend	dents,
C.	shall be eligible for cover Specify classification of e	age upon the E enrollees for wh	Effective Dat iom coveraç	e of this Polic je is being re	y. quested,	if other than	eligible employ	yees as	
	described in B above.			······································					
D.	New eligible employees	may be covered	d effective o	n the	1st of	the month	after	30	days
	of employment, so long a						e/Florida Blue	HMO within	_
	30 days of the date the in								
E. F.	At least 65 % of throughout the term of the participation requirement Florida Blue/Florida Blue confirm eligibility for coverage Applicant agrees to furnish	ts. HMO shall hav erage, including	e Group mu ve the right t participatio	st meet and o	continue oplicant's	to meet Flori payroll reco	ida Blue/Florida ords at any time	a Blue HMO to	
G.	Employer Contribution: E	· ·	100 %	Dependents	s: 0	%			



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.											
by the Feder	ai and/or	State Law	, Applicant's uec	ISION TO ACCE	spi or u	ecimo mese ben	ziito io ii iu	icated bolow.			
Included		_									
Produc	t Ac	cept E	Decline								
			Menta	al & Nervous	s Disord	der					
\times			Alcoh	ol and drug	depend	dency					
×			Mamı	nograms W	aiver of	Deductible & Co	insurance	e			
Enteral Formulas											
Single Plan Blue Packages											
Health Plan	n Name					Rx Option (ind	icate copa	ayments)			
HSA Comp	atible Pla	ns 05193 -	NSTD			BlueScript G I	n-Network	CDED + \$15/\$60	/\$100C - I	NSTD	
Benefit Pe	eriod :	01/01/20	19 - 12/31/2019			Coinsurance					
Deductibl	e:					In-Network / Pa	articipatin	g	80%	20%	
Per Persor	ı	\$5,000 /	\$10,000			Out-of-Networl	k/Non-Pai	ticipating	60%	40%	
Per Family		\$5,000 /	\$10,000			Office Visit C	opay:				
Pre-Existin	g	N/A				Family Physici	an		DED	+ 20%	
Rates						All Other Provi	ders		DED	+ 20%	
Employee	N/A	Employ	/ee/Spouse	N/A	Empl	oyee/Child(ren)	N/A	Family	N/A]	
Spouse	N/A	Child(re	en)	N/A	Spor	use/Child(ren)	N/A	Employee + 1	\$1010.55	5	



Health Plan Name			Rx Option (inc	Rx Option (indicate copayments)					
Predictable Cost Pla	n 05781 - NSTD		BlueScript Rx	BlueScript Rx OOP Int \$15/\$60/\$80C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance	:					
Deductible :	1		In-Network / P	In-Network / Participating 70% / 30%					
Per Person	\$1,500 / \$4,500		Out-of-Networ	k/Non-Participating	50% / 50%				
Per Family	\$4,500 / \$13,500		Office Visit C	Сорау:					
Pre-Existing	N/A		Family Physic	ian	\$30				
Rates			All Other Prov	iders	\$55				
Employee N/A	Employee/Spouse	N/A E	Employee/Child(ren)	N/A Family	N/A				
Spouse N/A	Child(ren)	N/A	Spouse/Child(ren)	ouse/Child(ren) N/A Employee + 1 \$1352.61					
Single P	lan	Blue Pack	ages						
Health Plan Name			Rx Option (inc	Rx Option (indicate copayments)					
Predictable Cost Pla	n 05770 - NSTD		BlueScript Ry	BlueScript Rx OOP Int \$15/\$50/\$80C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance						
Benefit Period : Deductible :	01/01/2019 - 12/31/2019):	80% / 20%				
	01/01/2019 - 12/31/2019 \$750 / \$1,500		Coinsurance In-Network / F):					
Deductible :			Coinsurance In-Network / F	e: Participating rk/Non-Participating	80% / 20%				
Deductible : Per Person	\$750 / \$1,500		Coinsurance In-Network / F	e: Participating rk/Non-Participating Copay:	80% / 20%				
Deductible : Per Person Per Family	\$750 / \$1,500 \$2,250 / \$4,500		Coinsurance In-Network / F Out-of-Network Office Visit (e: Participating rk/Non-Participating Copay:	80% / 20%				
Deductible: Per Person Per Family Pre-Existing	\$750 / \$1,500 \$2,250 / \$4,500	N/A I	Coinsurance In-Network / F Out-of-Network Office Visit (e: Participating rk/Non-Participating Copay:	80% / 20% 50% / 50% \$30				



	an 🔀								
Health Plan Name				Rx Option (ind	licate copayments)				
HSA Compatible Pla	ns 05192 - NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	:				
Deductible :				In-Network / Participating 80% / 20%					
Per Person	\$2,500 / \$5,000			Out-of-Networ	k/Non-Participating	60% / 40%			
Per Family	Not Applicable / Not Applic	able		Office Visit C	орау:				
Pre-Existing	N/A			Family Physici	an	DED + 20%			
Rates				All Other Provi	ders	DED + 20 %			
Employee \$449.10	Employee/Spouse	N/A	Emple	loyee/Child(ren) N/A Family N/A					
Spouse N/A	Child(ren)	N/A	Spou	ıse/Child(ren)	N/A Employee +	1 N/A			
Single Pl	an X	Blue Pac	ckages						
Health Plan Name				Rx Option (indicate copayments)					
HSA Compatible Pla	ns 05193 - NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	1				
Deductible :		,		In-Network / P	articipating	80% / 20%			
Per Person	\$5,000 / \$10,000			Out-of-Networ	k/Non-Participating	60% / 40%			
Per Family	\$5,000 / \$10,000			Office Visit C	Сорау:				
Pre-Existing	N/A			Family Physician DED + 20%					
Rates				All Other Providers DED + 20%					
Employee N/A	Employee/Spouse	N/A	Empl	oyee/Child(ren)	N/A Family	\$1010.55			
Spouse N/A	Child(ren)	N/A	1 _	use/Child(ren)	N/A Employee +	1 \$898.25			



Single Pl	an X	Blue Pack	ages	;					
Health Plan Name				Rx Option (ind	icate copa	ayments)			
Predictable Cost Plan	n 05781 - NSTD			BlueScript Rx	OOP Int \$	615/\$60/\$80C - N	NSTD		
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance					
Deductible :		·-····		In-Network / Pa	70% / 30%				
Per Person	\$1,500 / \$4,500			Out-of-Networl	50% / 50%				
Per Family	\$4,500 / \$13,500			Office Visit C	opay:				
Pre-Existing	N/A	N/A					\$30		
Rates				All Other Provi	ders		\$55		
Employee \$601.13	Employee/Spouse	N/A	Emp	loyee/Child(ren)	N/A	Family	\$1352.61		
Spouse N/A	Child(ren)	N/A	Spo	use/Child(ren)	N/A	Employee + 1	\$1202.30		
Single Plan Blue Packages									
Health Plan Name				Rx Option (indicate copayments) BlueScript Rx OOP Int \$15/\$50/\$80C - NSTD					
Predictable Cost Pla	n 05770 - NSTD			BlueScript Rx	OOP Int	\$15/\$50/\$80C - I	NSTD		
Benefit Period :	01/01/2019 - 12/31/2019			Coinsurance	:	•	p		
Deductible :				In-Network / P	articipatir	g	80% / 20%		
Per Person	\$750 / \$1,500			Out-of-Networ	50% / 50%				
Per Family	\$2,250 / \$4,500			Office Visit Copay:					
Pre-Existing	N/A			Family Physic	\$30				
Rates				All Other Provi	iders		\$70		
Employee \$696.98	Employee/Spouse	N/A	Emp	loyee/Child(ren)	N/A	Family	\$1568.31		
Spouse N/A	Child(ren)	N/A	Spc	ouse/Child(ren)	N/A	Employee + 1	\$1394.02		
•	ter Policy for a complete des								
IV. Health Savings	s Account (HSA), Health Re	imburseme	ent A	rrangement (HR	A) or Fle	xible Spending	g Account (FSA)		
A. Are you choos	sing Florida Blue's integrated	HSA, HRA	or FS	A preferred admi	nistrator a	arrangement?	Yes X No		
(if left blank, t	he response is assumed to b	e No.)							
B. If Yes is selec	ted above, which type of acc	ounts are yo	ou ch	oosing	HSA	HRA	☐ FSA		
NOTE: Applic	ant must have elected an HS	A compatibl	le pla	in to be able to of	fer an HS	A with preferre	d administrator.		
V. Rate Inform	ation						<u></u>		
A. Premium/Prep	ayment fee are payable mon						1st		
B. Regular Billin Employee can	g - Employee applications sh cellations must be submitted	ould be sub within 30 da	mitte ays o	d thirty (30) days f the Effective Da	prior to p te of the l	roposed Effecti Termination.	ve Date.		



EMPLOYER APPLICATION (True Group Application)

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

D.	Funding Arrangements:	Florida Blue:	NNUAL REFND NO SPEC STOP LOSS						
		НМО:	Not Applicable						
E.	Rate Comments:								



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
- B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.
- E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
- G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Charles H. which on

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITT	LE
Signature of Agent	Agent License Identification Number
<u> </u>	5014

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



	New Business	Renewa	l Business	Other							
I	. Group Information	Group	# (Florida Blu	e): 41954			(Florida I	Blue HM0	0): [
Α.	Name of Group: OKA	LOOSA	CO BOARD C)F CO COM	MIS	SIONER	S				
	Nature of Business: G	ENERAL	GOVERNMI	ENT, NEC				SIC Cod	de:	9199	
	Mailing Address: 5479	OLD BE	THEL RD #B	CRESTVIE	W, F	L 32536-	5512				
	Email Address: EGI	DOONOM	IYOKALOOS	A COM							
	List below Subsidiary or Affil				s are	to be eli	igible and	included	with	this	
	application. Name				Addre						
	VALUE CONTRACTOR OF THE PROPERTY OF THE PROPER										
В.	Applicant hereby applies for i	ssuance	of a Group Po	olicy (herein	refer	red to as	a Policy)	by Blue (Cross	and	
	Blue Shield of Florida, Inc., I Upon acceptance of this app	D/B/A Flo	rida Blue and	or Health O	ption	is, Inc., D Rhia HMC)/B/A Florid	da Blue F come na	HMO. et of t	he Policy issued	1 to
	the applicant named above.	лканоп в	y Fiorida Dide	and/or rior	iua L	JIGG FINIC), it will be	oomo pa	0, 0	ino i onoy locade	
c.	Prior Insurance Carrier: In	surance	HUMANA								
		нмо	NO GROUP I	NSURANCI	E						
D.	The Policy excludes expense	ا es for any	service or su	pply to diagr	nose	or treat a	any Condit	tion from	or in	connection	
	with an Insured's job or empinsurance) except for medic	lloyment (ally neces	e.g., any serv sarv services	rice or suppl : (not otherw	y wh ise e	ich is cov excluded)	/ered by W I for an ind	/orkers [.] C lividual w	Jomp ho is	not covered	
	by Workers' Compensation	and that Is	ack of coverag	ge did not re	sult	from any	intentiona	al action c	or om	ission by	
	that individual. The foregoin Compensation coverage and	g exclusio	on applies to a	an individual orogoes Wo	who	elects e: c' Compe	xemption f	rom Wor	kers' waila	ble to	
	compensation coverage and employees in the Group.	a to an in	aividuai who i	oregoes wo	ikeis	Compe	iiisalion cc	weraye a	avana	DIG TO	
E.	Workers Compensation Carr	ier is:	SELF INS	URED							
	Effective Date/Eligibility In		on							,	
 А.	Effective Date of this Policy s		10/01/20	000							
	Effective Date of this Change		licv shall be		/01/2	019					
	This Policy may be terminate	d by the a	pplicant or Fl	 orida Blue/F	lorid	 a Blue Hi	MO by givi	ing at lea	ıst 45	days prior	
	written notice to the other par	ty except	in the case of	f non-payme	ent of	Premiur	n.				
B.	Only eligible employees who shall be eligible for coverage					30 ho	urs each v	veek and	tneir	eligible depend	ents,
C.	Specify classification of enrol	upon me lees for w	hom coverag	e is being re	eques	sted, if ot	her than e	ligible en	nploy	ees as	
	described in B above.										
D.	New eligible employees may	be cover	ed effective or	n the		st of the			ter 3		days
	of employment, so long as th	e eligible	employee sub	omits an app				Florida B	lue H	IMO within	_
	30 days of the date the indivi							F-65 - 15		-	
E.	At least 65 % of the throughout the term of the Po	eligible ei dicv and t	mployees mus	st be enrolle st meet and	d un cont	der the P inue to m	olicy on th neet Florida	ie Effectiv a Blue/Fl	ve Da orida	ate and Blue HMO	
_	participation requirements. Florida Blue/Florida Blue HM	-									
F.	confirm eligibility for coverage	บ รกลแ กล e, includir	ave une rigiti to ig participation	n percentag	e crit	eria requ	ired by Flo	orida Blue	e/Flor	rida Blue HMO.	
	Applicant agrees to furnish a			, 0	_		-				
G.	Employer Contribution: Empl	oyee:	100 %	Dependent	s:	0	%				



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.												
Included in Product		cept De	cline									
$ $ \boxtimes			Mental	& Nervous	Disor	der						
\boxtimes			Alcohol	l and drug	depen	dency						
×			Mamm	Mammograms Waiver of Deductible & Coinsurance								
Enteral Formulas												
Single Plan Blue Packages												
Health Plan N	lame			· ·		Rx Option (ina						
HSA Compati	ble Plai	ıs 05192 - NS	STD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD						
Benefit Peri	od :	01/01/2019	- 12/31/2019			Coinsurance:						
Deductible :	:					In-Network / Participating 80% / 20%						
Per Person		\$2,500 / \$5	,000			Out-of-Networ	k/Non-Pai	ticipating	60% /	40%		
Per Family		Not Applic	able / Not Applic	cable		Office Visit C	орау:					
Pre-Existing		N/A				Family Physician DED + 20%						
Rates						All Other Providers DED + 20%						
Employee \$7	74.15	Employee	e/Spouse	N/A	Emp	loyee/Child(ren)	N/A	Family	N/A			
Spouse \$5	61.46	Child(ren)	\$561.46 Spouse/Child(ren) N/A Employee + 1 N/A								



Single Pl	an 🔀	Blue Pac	kages						
Health Plan Name			Rx Option (inc	dicate copayments)					
HSA Compatible Pla	ns 05193 - NSTD		BlueScript G	BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance		80% / 20%				
Deductible :			In-Network / F	In-Network / Participating					
Per Person	\$5,000 / \$10,000		Out-of-Netwo	rk/Non-Participating	60% / 40%				
Per Family	\$5,000 / \$10,000		Office Visit (Copay:					
Pre-Existing	N/A		Family Physic	ian	DED + 20 %				
Rates			All Other Prov	riders	DED + 20%				
Employee N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A Family	\$1181.61				
Spouse N/A	Child(ren)	N/A	Spouse/Child(ren)	ouse/Child(ren) \$561.46 Employee + 1 N/A					
Single Pl	an 🔀	Blue Pac	ckages						
Health Plan Name			Rx Option (in	Rx Option (indicate copayments)					
Predictable Cost Pla	n 05781 - NSTD		BlueScript Rx	BlueScript Rx OOP Int \$15/\$60/\$80C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance	9:					
Deductible :			In-Network / F	Participating	70% / 30%				
Per Person	\$1,500 / \$4,500		Out-of-Netwo	rk/Non-Participating	50% / 50%				
Per Family	\$4,500 / \$13,500		Office Visit (Copay:					
Pre-Existing	N/A		Family Physic	Family Physician					
Rates			· All Other Prov	All Other Providers \$55					
Employee \$1036.20	Employee/Spouse	N/A	Employee/Child(ren)	N/A Family	\$1581.60				
Spouse \$751.51	Child(ren)	\$751.51	Spouse/Child(ren)	\$751.51 Employee +	1 N/A				



	Single Plan Blue Packages										
Heal	Ith Plan Name					Rx Option (ind	licate copa	ayments)			
Pred	ictable Cost Plan	n 05770 -	NSTD	******		BlueScript Rx	OOP Int \$	815/\$50/\$80C - N	STD		
L		-		-	1.0000	<u> </u>					
Ben	efit Period :	01/01/2	2019 - 12/31/2019			Coinsurance					
Ded	uctible :					In-Network / Pa	articipatin	g	80% /	20%	
Per Person \$750 / \$1,500						Out-of-Network	k/Non-Par	rticipating	50% /	50%	
Per	Per Family \$2,250 / \$4,500					Office Visit C	opay:				
Pre-	Existing	N/A				Family Physici	an		\$30		
Rates All Other							ders		\$70		
Emp	ployee \$1201.88 Employee/Spouse N/A Emp				oloyee/Child(ren)	N/A	Family	\$1834.45			
Spo	use \$871.33	Child	l(ren)	\$871.33 Spouse/Child(ren) \$871.33 Employee + 1					N/A		
See	See the Group Master Policy for a complete description of benefits.										
IV.	IV. Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA)										
Α.	Are vou choos	ina Flori	da Blue's integrated	HSA, HRA	or FS	SA preferred admir	nistrator a	rrangement?	Yes	X No	
			nse is assumed to be			·					
В.	•	·	e, which type of acco		ou ch	oosina F	HSA	HRA	☐ FS/	4	
ъ.			t have elected an HS			L					
17			Tiave elected air i io	M Compani	olo pie	ar to be able to on	10, 4,, 110,	T THE PROJECTION			
V. A.			ee are payable mont	thly on or b	efore	the due date which	h will be:		1st		
			oyee applications sh					oposed Effectiv			
٥.			s must be submitted								
C.	Date of Covera	age unle: da Blue/	for this Policy will no ss there is a change /Florida Blue HMO m providing notice to th	in benefits nay change	or a f	15% or more chan Rates that are to be	ige in the o e effective	composition of t after this initial	he group. twelve (12	2) month	
D.	Funding Arrang	gements	: Florida Blue: A	NNUAL RI	EFND	NO SPEC STOP	LOSS				
			нмо: п	lot Applical	ole						
E.	Rate Commen	ts:	1								



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
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- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
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Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Musher White or

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITTLE	
Signature of Agent	Agent License Identification Number
	5014

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



	ent Licensee of the			(True	Grou	p Appi	ication)		
Cross an	d Blue Shield Association									
	New Business		al Busines	L	Other					
I.	Group Information			Blue): 4195			`	Blue HMO):		
Α.	Name of Group:	OKALOOSA	CO BOAL	ED OF CO C	COMMI	SSIONEI	RS			
	Nature of Business:	GENERA	L GOVER	NMENT, NI	EC			SIC Code:	9199	
	Mailing Address:	5479 OLD B	ETHEL RI	#B CREST	VIEW,	FL 32536	-5512			
	Email Address:	EGIBSON@	MYOKALO	OOSA.COM	[
	List below Subsidiary					e to be e	ligible and	included with	this	
	application. Name		· ·		_ Addi	ess				
B.	Applicant hereby applie	s for issuance	e of a Grou	p Policy (he	rein refe	erred to a	s a Policy)	by Blue Cros	ss and	
	Blue Shield of Florida, Upon acceptance of the the applicant named a	Inc., D/B/A F is application	lorida Blue	and/or Heal	lth Optio	ns, Inc.,	D/B/A Flor	ida Blue HMC).	ued to
C.	Prior Insurance Carrie	r: Insurance	HUMAN	A						
		НМО	NO GRO	UP INSURA	NCE					
D.	The Policy excludes ex with an Insured's job or insurance) except for roby Workers' Compens that individual. The for Compensation coveragemployees in the Ground with the Ground statement of the Compensation coveragement of the Ground statement of the Compensation coveragement of the Compensation	or employmen medically nec ation and that regoing exclus ge and to an i	t (e.g., any essary serv t lack of cov sion applies	service or s rices (not ot rerage did n to an indivi	upply w herwise ot resuli idual wh	hich is co excluded t from an o elects o	overed by \ d) for an ind y intention exemption	Workers' Com dividual who i al action or or from Workers	ipensation is not covered mission by s'	
E.	Workers Compensation	n Carrier is:	SELF	INSURED						
II. E	Effective Date/Eligibil	ity Informa	tion							
A.	Effective Date of this Po	olicy shall be	10/	01/2000						
	Effective Date of this Cl	nange to the I	Policy shall	be	10/01/	2019				
	This Policy may be term written notice to the oth	ninated by the er party exce	applicant of the care	or Florida Bi se of non-pa	lue/Flori ayment o	of Premiu	ım.			
	Only eligible employees					30 h	ours each	week and the	ir eligible depe	endents,
C.	shall be eligible for cove Specify classification of	∍rage upon t⊓ I enrollees for	whom cov	erage is bei	ng reque	ested, if o	other than	eligible emplo	yees as	
	described in B above.									
D.	New eligible employees	s may be cove	ered effecti	ve on the		1st of the		after		days
	of employment, so long	as the eligibl	e employee	e submits ar	applica	tion to F	lorida Blue ments	/Florida Blue	HMO within	
E.	30 days of the date the At least 65 %	of the eligible	emplovees	must be er	rolled u	nder the	Policy on t	he Effective [Date and	
	throughout the term of the participation requirement	the Policy and	the Group	must meet	and cor	itinue to	meet Florid	da Blue/Florid	la Blue HMO	
F.	Florida Blue/Florida Blu confirm eligibility for co Applicant agrees to furn	ıe HMO shall verage, includ	ling particip	ght to audit to attion perce	the appl ntage ci	icant's pa iteria req	ayroll recor Juired by F	ds at any time lorida Blue/Fl	e to orida Blue HM	О.
G.	Employer Contribution:	-	100	% Deper	ndents:	0	%			



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.											
Included Produc		cept [Decline								
×			Mental	& Nervous I	Disord	der					
\boxtimes			Alcohol	Alcohol and drug dependency							
\mathbf{x}			Mamm	Mammograms Waiver of Deductible & Coinsurance							
×			Enteral	Formulas							
Single Plan Blue Packages											
Health Plan	n Name					Rx Option (indi					
HSA Comp	atible Pla	ns 05192 -	NSTD			BlueScript G I	n-Networl	k DED + \$15/\$60	/\$100C - NSTD		
Benefit Pe	eriod :	01/01/20)19 - 12/31/2019			Coinsurance:					
Deductibl	e:					In-Network / Participating 80% / 20%					
Per Persor	1	\$2,500 /	\$5,000			Out-of-Network/Non-Participating 60% / 40%					
Per Family	,	Not App	plicable / Not Applic	able		Office Visit C	орау:				
Pre-Existin	ıg	N/A				Family Physici	an		DED + 20%		
Rates						All Other Provi	ders		DED + 20%		
Employee	\$774.15	Emplo	yee/Spouse	N/A	Empl	oyee/Child(ren)	N/A	Family	N/A		
Spouse	\$561.46	Child(r	ren)	\$561.46	Spo	use/Child(ren)	N/A	Employee + 1	N/A		



Health Plan Name			Rx Option (ind	Rx Option (indicate copayments)						
HSA Compatible Pla	ns 05193 - NSTD		BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD							
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance:							
Deductible :			In-Network / P	In-Network / Participating 80% / 20%						
Per Person	\$5,000 / \$10,000		Out-of-Networ	k/Non-Participating	60% / 40%					
Per Family	\$5,000 / \$10,000		Office Visit C	орау:						
Pre-Existing	N/A	**********	Family Physic	an	DED + 20 %					
Rates			All Other Provi	All Other Providers						
Employee N/A	Employee/Spouse	N/A E	mployee/Child(ren)							
Spouse N/A	Child(ren)	N/A Spouse/Child(ren) \$561.46 Employee + 1 N/A								
Single Pl	an [2	Single Plan Blue Packages								
House Fall Fall			Rx Option <i>(inc</i>	licate copayments)						
Predictable Cost Plan	n 05781 - NSTD			dicate copayments) OOP Int \$15/\$60/\$80C -	NSTD					
Predictable Cost Plan Benefit Period : Deductible :	01/01/2019 - 12/31/2019			OOP Int \$15/\$60/\$80C -	NSTD 70% / 30%					
Benefit Period :			BlueScript Rx Coinsurance In-Network / F	OOP Int \$15/\$60/\$80C -						
Benefit Period : Deductible :	01/01/2019 - 12/31/2019		BlueScript Rx Coinsurance In-Network / F	OOP Int \$15/\$60/\$80C - c: Participating	70% / 30%					
Benefit Period : Deductible : Per Person	01/01/2019 - 12/31/2019 \$1,500 / \$4,500		BlueScript Rx Coinsurance In-Network / F Out-of-Network	OOP Int \$15/\$60/\$80C - c: Participating rk/Non-Participating Copay:	70% / 30%					
Benefit Period : Deductible : Per Person Per Family	01/01/2019 - 12/31/2019 \$1,500 / \$4,500 \$4,500 / \$13,500		Coinsurance In-Network / F Out-of-Network Office Visit C	OOP Int \$15/\$60/\$80C - c: Participating rk/Non-Participating Copay:	70% / 30% 50% / 50%					
Benefit Period : Deductible : Per Person Per Family Pre-Existing	01/01/2019 - 12/31/2019 \$1,500 / \$4,500 \$4,500 / \$13,500 N/A	N/A E	Coinsurance In-Network / F Out-of-Networ Office Visit C	OOP Int \$15/\$60/\$80C - c: Participating rk/Non-Participating Copay:	70% / 30% 50% / 50% \$30					



	X s	ingle Plan			Blue Pac	kage	5					
Heal	th Plan	Name					Rx Option (inc	licate cop	ayments)			
Pred	ictable (Cost Plan (05770 -	NSTD			BlueScript Rx	OOP Int S	\$15/\$50/\$80C - N	ISTD		
Ben	efit Pe	riod :	01/01/2	2019 - 12/31/2019			Coinsurance	:				
Ded	uctible) :					In-Network / P	In-Network / Participating				
Per	Person		\$750 /	\$1,500			Out-of-Networ	k/Non-Pa	rticipating	50% / 50%		
Per	Per Family \$2,250 / \$4,500					Office Visit C	Сорау:					
Pre-	Pre-Existing N/A					Family Physic	ian		\$30			
Rate	Rates						All Other Prov	iders		\$70		
Emp	loyee \$1201.88 Employee/Spouse N/A Emp				Emp	loyee/Child(ren)	N/A	Family	\$1834.45			
Spo	use	se \$871.33 Child(ren) \$871.33 Spouse/Child(re				use/Child(ren)	\$871.33	Employee + 1	N/A			
See the Group Master Policy for a complete description of benefits.												
IV.	IV. Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA)											
Α.	Are yo	u choosin	g Florid	da Blue's integrated	HSA, HRA	or FS	A preferred admi	nistrator a	arrangement?	Yes X No		
	(if left	blank, the	respo	nse is assumed to b	e No.)							
В.	If Yes	is selected	d abov	e, which type of acc	ounts are y	ou ch	posing	HSA	HRA	FSA		
	NOTE	: Applicar	t must	have elected an HS	SA compatib	ole pla	in to be able to of	fer an HS	A with preferred	d administrator.		
v.	Rate	Informat	tion									
A.	Premiu	ım/Prepay	ment f	ee are payable mon	thly on or b	efore	the due date whic	ch will be:		1st		
В.				oyee applications st s must be submitted						ve Date.		
C.	Date of	of Coverag	e unles a Blue/	for this Policy will no ss there is a change Florida Blue HMO n providing notice to th	in benefits nay change	or a 1 the R	5% or more char ates that are to b	nge in the e effective	composition of after this initial	the group. I twelve (12) month		
D.	Fundir	ng Arrange	ments	: Florida Blue:	ue: ANNUAL REFND NO SPEC STOP LOSS							
				HMO:	lot Applicab	le						
E.	Rate C	Comments	:									



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
- B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.
- E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
- G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Charles K, Winter In

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITTL	E
Signature of Agent	Agent License Identification Number
C S B	5014

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



ſ	New Business	Renewa	l Business	Othe	er				
I,	— . Group Information	n Group	# (Florida Blu	ıe): 41954		(1	Florida	Blue HMO):	
A.	Name of Group:	OKALOOSA	CO BOARD (OF CO COM	иміs	SIONERS			
	Nature of Business:	GENERAL	GOVERNM	ENT, NEC				SIC Code:	9199
	Mailing Address:	5479 OLD BE	THEL RD #B	CRESTVIE	EW, F	L 32536-551	12		
	Email Address:	EGIBSON@M	IYOKALOOS	SA.COM					
	List below Subsidiary of application.			se employee			ole and	included with	this
	Name				Addre	ess			-
B.	Applicant hereby applie	s for issuance	of a Group Po	olicy (herein	refe	rred to as a	Policy)	by Blue Cros	s and
	Blue Shield of Florida, Upon acceptance of th	is application b	rida Blue and v Florida Blue	/or Health C e and/or Flo	Optior orida E	ns, Inc., D/B. Blue HMO, i	/A Flori t will be	da Blue HMC come part of). the Policy issued to
	the applicant named al	bove.							
C.	Prior Insurance Carrier	r: Insurance	HUMANA						
		НМО	NO GROUP	INSURANC	E				
D.	The Policy excludes ex with an Insured's job o insurance) except for r by Workers' Compensathat individual. The for Compensation coveragemployees in the Group	r employment (medically neces ation and that I egoing exclusion ge and to an in-	e.g., any services ack of covera on applies to	rice or supp s (not otherv ge did not re an individua	oly wh wise e esult al who	ich is cover excluded) fo from any int elects exer	ed by V r an inc tentiona mption f	Vorkers' Com lividual who i: al action or on from Workers	pensation s not covered nission by '
E.	Workers Compensation	Carrier is:	SELF INS	URED					
II. I	Effective Date/Eligibil	ity Informatio	on						
Α.	Effective Date of this Po	olicy shall be	10/01/2	000					
	Effective Date of this Ch	nange to the Po	olicy shall be	10	0/01/2	2019			
	This Policy may be term written notice to the other	ninated by the a er party except	pplicant or Fi in the case o	orida Blue/f f non-paym	Florid ent o	f Premium.			
B.	Only eligible employees				L	30 hours	s each v	week and the	r eligible dependents,
C.	shall be eligible for cove Specify classification of	enrollees for w	hom coverag	e or this For e is being r	eque:	sted, if other	r than e	ligible emplo	yees as
	described in B above.								
D.	New eligible employees					1st of the mo		after	
	of employment, so long 30 days of the date the							Fiorida Blue I	HIVIO WITHIN
Ε.	At least 65 % d	of the eligible e	mplovees mu	st be enrolle	ed un	der the Poli	cy on th	ne Effective D	ate and
	throughout the term of t	he Policy and t nts.	he Group mu	st meet and	d cont	inue to mee	t Florid	a Blue/Florida	a Blue HMO
F.	Florida Blue/Florida Blu- confirm eligibility for cov Applicant agrees to furr	/erage, includir	ıg participatio	o audit the a n percentag	applic ge crit	cant's payrol teria require	n record d by Flo	us at any time orida Blue/Flo	rio orida Blue HMO.
G.	Employer Contribution:	Employee:	100 %	Dependen	nts:	0 %			



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.											
Included in	Accept Decline										
×		Mental & Nervous	s Disor	der							
×		Alcohol and drug	Alcohol and drug dependency								
		Mammograms Waiver of Deductible & Coinsurance									
		Enteral Formulas									
Single Plan Blue Packages											
Health Plan Name	3			Rx Option (ina							
HSA Compatible I	Plans 05192 - NSTD			BlueScript G I	n-Network	x DED + \$15/\$60	/\$100C - N	NSTD			
Benefit Period	01/01/2019 - 12/	31/2019		Coinsurance:							
Deductible :				In-Network / Participating 80% / 20%							
Per Person	\$2,500 / \$5,000			Out-of-Network/Non-Participating 60% / 40%							
Per Family	Not Applicable /	Not Applicable		Office Visit C	орау:						
Pre-Existing	N/A			Family Physici	ian		DED -	+ 20%			
Rates	Rates All Other Providers DED + 20%										
Employee \$774.1	5 Employee/Spou	ise N/A	Emp	loyee/Child(ren)	N/A	Family	N/A				
Spouse \$561.4	Child(ren)	\$561.46	Spo	use/Child(ren)	N/A	Employee + 1	N/A				



Single Pla	an X Blue H	-ackage	S					
Health Plan Name			Rx Option (indicate copayments)					
HSA Compatible Pla	ns 05193 - NSTD		BlueScript G I	n-Network DED + \$15/\$6	0/\$100C - NSTD			
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance:					
Deductible :			In-Network / P	80% / 20%				
Per Person	\$5,000 / \$10,000	Out-of-Networ	k/Non-Participating	60% / 40%				
Per Family	\$5,000 / \$10,000		Office Visit C	Сорау:				
Pre-Existing	N/A	Family Physic	ian	DED + 20%				
Rates		All Other Prov	DED + 20%					
Employee N/A	Employee/Spouse N/A	Emp	oloyee/Child(ren) N/A Family \$1181.61					
Spouse N/A	Child(ren) N/A	A Spouse/Child(ren) \$561.46 Employee + 1 N/A						
Single Pl	an 🔀 Blue	Package	s					
Health Plan Name			Rx Option <i>(indicate copayments)</i>					
Predictable Cost Plan	n 05781 - NSTD		BlueScript Rx OOP Int \$15/\$60/\$80C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		Coinsurance):				
Deductible :			In-Network / F	Participating	70% / 30%			
Per Person	\$1,500 / \$4,500		Out-of-Netwo	rk/Non-Participating	50% / 50%			
Per Family	\$4,500 / \$13,500		Office Visit (Сорау:				
Pre-Existing	N/A		Family Physic	\$30				
Rates			All Other Providers \$55					
Employee \$1036.20	Employee/Spouse N/A	Em	oloyee/Child(ren)	N/A Family	\$1581.60			
Spouse \$751.51	Child(ren) \$751.5	Sp Sp	ouse/Child(ren)	\$751.51 Employee +	1 N/A			



	\mathbf{X}^{s}	Single Plar	1		Blue Pac	ckage	S				
Heal	th Plar	n Name					Rx Option (ind	licate copa	ayments)		
Pred	Predictable Cost Plan 05770 - NSTD							OOP Int \$	615/\$50/\$80C - N	NSTD	
Bene	Benefit Period : 01/01/2019 - 12/31/2019						Coinsurance:				
Ded	Deductible:						In-Network / P	80% / 20	%		
Perl	r Person \$750 / \$1,500			Out-of-Networ	k/Non-Pai	ticipating	50% / 50	%			
Perl	er Family \$2,250 / \$4,500					Office Visit C	орау:				
Pre-	Existin	g	N/A				Family Physici	ian		\$30	
Rate	s						All Other Provi	iders		\$70	
Emp	loyee	\$1201.88	Emplo	yee/Spouse	N/A	Emp	loyee/Child(ren)	N/A	Family	\$1834.45	
Spor	use	\$871.33	Child(ren)	\$871.33	Spo	ouse/Child(ren)	\$871.33	Employee + 1	N/A	
See	the Gr	oup Maste	r Policy	for a complete de	scription of I	oenefi	ls.				
IV.	Health	Savings .	Accoun	t (HSA), Health R	eimbursem	ent A	rrangement (HR	A) or Flex	dble Spending	Account (FS	SA)
Α.	•		-	a Blue's integrated		or FS	A preferred admi	nistrator a	rrangement?	Yes 🗙	No
	(if lef	t blank, the	respon	se is assumed to l	oe No.)						
B.	If Yes	s is selecte	d above	, which type of acc	counts are y	ou ch	oosing	HSA	HRA	FSA	
	NOT	E: Applica	nt must	have elected an H	SA compatil	ole pla	n to be able to of	fer an HS/	A with preferred	d administrato	r.
v.	Rate	Informa	tion								
A.				e are payable mor						1st	
B.				yee applications s must be submitted						ve Date.	
C.	Date Howe	of Coveraç ver, Florid d of covera	ge unles a Blue/F	or this Policy will n s there is a change Florida Blue HMO r roviding notice to t	e in benefits nav change	or a 1 the R	5% or more chan ates that are to be	ige in the e e effective	composition of after this initia	the group. I twelve (12) n	nonth
D.	Fundi	ng Arrange	ements:	Florida Blue:	ANNUAL R	EFND	NO SPEC STOP	LOSS			
				HMO:	Not Applical	ole					
E.	Rate	Comments	»: [<u> </u>			



EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
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- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.
- E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
- G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

MRAI

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Cherla K. Wind

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITTLE	
Signature of Agent	Agent License Identification Number
	5014

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



Г	New Business	X Renewa	Business	Other					
I,	— . Group Information		# (Florida Blue): 41954		(Florid	a Blue HMO):		
Α.	Name of Group:	OKALOOSA	CO BOARD OF	со сомм	SSION	ERS			
	Nature of Business:	GENERAL	GOVERNMEN	NT, NEC			SIC Code:	9199	$\overline{}$
	Mailing Address:	Mailing Address: 5479 OLD BETHEL RD #B CRESTVIEW, FL 32536-5512							
	Email Address:	ECIDEONOM	WOKAT OOSA	COM					Ħ
	List below Subsidiary		YOKALOOSA npanies whose		re to be	eligible an	d included with	this	
	application. Name		•		ress				
В.	Applicant hereby applie	s for issuance	of a Group Poli	cy (herein ref	erred to	as a Policy	/) by Blue Cros	s and	
	Blue Shield of Florida, Upon acceptance of th	Inc., D/B/A Flo	rida Blue and/o	r Health Option	ons, Inc	., D/B/A Flo	orida Blue HMC), the Policy issued to	
	Upon acceptance of the the applicant named a	is application b bove.	y Florida Blue a	and/or Fionda	. Diue m	iiviO, it wiii i	Jecome part of	the rolley issued to	
C.	Prior Insurance Carrie	r: Insurance	HUMANA				· · · · · · · · · · · · · · · · · · ·		
		нмо	NO GROUP IN	SURANCE				,	Ī
_	The Policy excludes ex	L			o or tro	at any Con	dition from or in	connection	
D.	with an Insured's job o	penses for any r emplovment (service or supp e.a., anv servic	e or supply w	hich is	covered by	Workers' Com	pensation	
	insurance) except for r	nedically neces	sary services (not otherwise	exclud	ed) for an li	ndividual who i:	s not covered	
	by Workers' Compens	ation and that la	ack of coverage	did not resu	It from a	any intentio	nal action or on	nission by	
	that individual. The for Compensation coverage	egoing exclusions	in applies to an dividual who for	inaiviauai wi eaoes Worke	io elect irs' Con	s exemplior noensation	coverage avail	able to	
	employees in the Grou		AIVIGUAI WIIO IOI	ogooo monte	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,portoditor.	00,0,mg= m		
E.	Workers Compensation	Carrier is:	SELF INSU	RED					٦
II. I	Effective Date/Eligibil	ity Informatio)n						_
A.	Effective Date of this Po	olicy shall be	10/01/200	0					
	Effective Date of this Ch	nange to the Po	licy shall be	10/01	/2019				
	This Policy may be term	inated by the a	pplicant or Flor	ida Blue/Flor	da Blue	ı e HMO by g	iving at least 4	5 days prior	
	written notice to the oth	er party except	in the case of r	on-payment	of Pren	nium.			
В.	Only eligible employees				30	hours each	n week and the	ir eligible dependents	5,
C.	shall be eligible for cove Specify classification of	erage upon the enrollees for w	hom coverage	is being requ	ested, i	f other than	eligible emplo	yees as	
	described in B above.								
D.	New eligible employees	may be cover	ed effective on	the T	1st of t	he month	after	30 da	ays
υ.	of employment, so long						I .		
	30 days of the date the	individual first r	neets the appli	cable eligibilit	y requii	ements.			
E.	At least 65 % o	of the eligible er	nployees must	be enrolled u	nder th	e Policy on	the Effective D	ate and	
	throughout the term of t	nts.	•						
F.	Florida Blue/Florida Blu	e HMO shall ha	ve the right to	audit the app	icant's	payroll reco	ords at any time	eto orida Blua UMO	
	confirm eligibility for cov Applicant agrees to furr			percentage c	пепа г	equirea by I	-ionua biue/ri0	лиа вие пио.	
G.	Employer Contribution:	*		Dependents:	0	7%			



EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Bene	fit Offerin	gs:(Optional) Applica	ant has been	advise	ed of the following	benefit of	fferings mandate	d	
by the Federal a	nd/or State	Law. Applicant's de	cision to acce	ept or o	decline these ben	efits is ind	licated below.		
Included in	Accort	Dooling							
Product	Accept								
		Mental & Nervous Disorder							
×		Alco	hol and drug	depen	dency				
×		Man Man	nmograms Wa	aiver c	of Deductible & Co	oinsurance	e		
×		Ente	eral Formulas						
Sing	gle Plan		X Blue Pac	ckages					
Health Plan Na	ame				Rx Option (ind				
HSA Compatib	le Plans 05	192 - NSTD			BlueScript G I	n-Networl	k DED + \$15/\$60/	\$100C - N	STD
Benefit Perio	d: 01/	01/2019 - 12/31/2019			Coinsurance	# #	•		
Deductible :	<u>. </u>				In-Network / P	articipatin	g	80% /	20%
Per Person	\$2,	500 / \$5,000			Out-of-Networ	k/Non-Pai	rticipating	60% /	40%
Per Family	No	t Applicable / Not Ap	plicable		Office Visit C	орау:			
Pre-Existing	N/A	1			Family Physici	lan		DED -	+ 20%
Rates					All Other Provi	iders		DED +	+ 20%
Employee \$77	4.15 E	nployee/Spouse	N/A	Emp	loyee/Child(ren)	N/A	Family	N/A	
Spouse \$56	51.46 C	hild(ren)	\$561.46	Spo	ouse/Child(ren)	N/A	Employee + 1	N/A	

1:59:11 PM



Health Plan Name		,		Rx Option (inc	licate copayments)				
HSA Compatible Pla	ns 05193 - NSTD			BlueScript G In-Network DED + \$15/\$60/\$100C - NSTD					
Benefit Period :	01/01/2019 - 12/31/2019		c	Coinsurance:					
Deductible :				In-Network / F	articipating	80% / 20%			
Per Person	Person \$5,000 / \$10,000				Out-of-Network/Non-Participating 60% / 40%				
Per Family	\$5,000 / \$10,000			Office Visit (Сорау:				
Pre-Existing	N/A			Family Physic	ian	DED + 20 %			
Rates			ı	All Other Prov	iders	DED + 20%			
Employee N/A	Employee/Spouse	N/A	Employ	ree/Child(ren)	N/A Family	\$1181.61			
Spouse N/A	Child(ren)	N/A	Spouse	e/Child(ren)	\$561.46 Employee +	1 N/A			
Single Pl	lan [X Blue Pac		Rx Option (in	dicate copayments)				
		X Blue Pac			dicate copayments) OOP Int \$15/\$60/\$80C	- NSTD			
Health Plan Name Predictable Cost Pla					OOP Int \$15/\$60/\$80C	- NSTD			
Health Plan Name Predictable Cost Pla Benefit Period:	n 05781 - NSTD			BlueScript Rx	OOP Int \$15/\$60/\$80C	- NSTD 70% / 30%			
Health Plan Name	n 05781 - NSTD			BlueScript Rx Coinsurance In-Network / I	OOP Int \$15/\$60/\$80C				
Health Plan Name Predictable Cost Pla Benefit Period : Deductible :	n 05781 - NSTD 01/01/2019 - 12/31/2019			BlueScript Rx Coinsurance In-Network / I	OOP Int \$15/\$60/\$80C	70% / 30%			
Health Plan Name Predictable Cost Pla Benefit Period: Deductible: Per Person	n 05781 - NSTD 01/01/2019 - 12/31/2019 \$1,500 / \$4,500			BlueScript Rx Coinsurance In-Network / I Out-of-Netwo	OOP Int \$15/\$60/\$80C - Participating rk/Non-Participating Copay:	70% / 30%			
Health Plan Name Predictable Cost Pla Benefit Period: Deductible: Per Person Per Family Pre-Existing	n 05781 - NSTD 01/01/2019 - 12/31/2019 \$1,500 / \$4,500 \$4,500 / \$13,500			BlueScript Rx Coinsurance In-Network / I Out-of-Netwo	OOP Int \$15/\$60/\$80C Participating rk/Non-Participating Copay:	70% / 30% 50% / 50%			
Health Plan Name Predictable Cost Pla Benefit Period: Deductible: Per Person Per Family	n 05781 - NSTD 01/01/2019 - 12/31/2019 \$1,500 / \$4,500 \$4,500 / \$13,500 N/A			BlueScript Rx Coinsurance In-Network / F Out-of-Netwo Office Visit (OOP Int \$15/\$60/\$80C Participating rk/Non-Participating Copay:	70% / 30% 50% / 50% \$30			



Heal	lth Plar	n Name					Rx Option (ind	licate copa	ayments)		
			05770 - NSTD		WW				615/\$50/\$80C - N	ISTD	
Ben	efit Pe	eriod :	01/01/2019 - 1	2/31/2019			Coinsurance				
Ded	uctibl	e:				In-Network / Participating 80% / 20%			20%		
Perl	Person	rson \$750 / \$1,500			Out-of-Networl	k/Non-Pai	ticipating	50%/	50%		
Per	Family		\$2,250 / \$4,500				Office Visit C	opay:			
Pre-	Existin	ıg	N/A				Family Physici	an		\$30	
Rate	es						All Other Provi	ders		\$70	
Emp	oloyee	\$1201.88	Employee/Sp	ouse	N/A	Emp	oloyee/Child(ren)	N/A	Family	\$1834.45	
_	use Ī				ouse/Child(ren)	\$871.33	Employee + 1	N/A			
Spor	~~~	3			1	1					
•	L.	oup Maste	er Policy for a co	mplete des	scription of I	benefi	ts.				
See	the Gr						its. Arrangement (HR <i>i</i>	A) or Flex	ible Spending	Account ((FSA)
See	the Gr	Savings	Account (HSA)	, Health R	eimbursem	nent A				Account ((FSA)
See IV.	the Gr Health Are y	Savings	Account (HSA)	, Health R e	eimbursem i HSA, HRA	nent A	Arrangement (HR				
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EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
- B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.
- E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that falling to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]
- G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date

Signature of Applicant

Print/Type Name & Title

AUG 0 6 2019

Charles H. What In ,

CHARLES K. WINDES, CHAIRMAN

Date

Florida Blue and/or Florida Blue HMO Licensed Agent (Print)



EMPLOYER APPLICATION (True Group Application)

DENNIS BARNES / JAMES LITTLE	
Signature of Agent	Agent License Identification Number
43	5014

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.

CONTRACT, LEASE, AGREEMENT CONTROL FORM

Date:

<u>08-03-2017</u>

Contract/Lease Control #: _C08-1608-RM

Bid #:

<u>NA</u>

Contract/Lease Type:

<u>AGREEMENT</u>

Award To/Lessee:

BLUE CROSS & BLUE SHIELD OF FLORIDA

Owner/Lessor:

OKALOOSA COUNTY

Effective Date:

10/01/2007

Expiration Date:

09/30/2017

Description of

Contract/Lease:

PROSHARE PLUS ACCOUNTING DEPARTMENT

Department:

<u>RM</u>

Department Monitor:

<u>PORTOR</u>

Monitor's Telephone #:

<u>850-689-5977</u>

Monitor's FAX # or E-mail:

LPORTOR@CO.OKALOOSA.FL.US

Closed:

Cc:

Finance Department Contracts & Grants Office

BlueCross BlueShield Of Florida, Inc.

Annual Accounting & Retention Agreement

This is an agreement (hereinafter "Agreement") between Blue Cross Blue Shield of Florida, Inc. (hereinafter referred to as "Florida Blue"), located at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 and Okaloosa County Board of County Commissioners, (hereinafter "the Group") located at 5479 Old Bethel Road #B, Crestview, FL 32536.

WHEREAS, the Group requests Florida Blue to provide a Point-of-Service insurance program, (hereinafter jointly referred to as GHP "the Group Health Plan") to its employees and their covered dependents (hereinafter "Group Member(s)"); and

WHEREAS, each of the parties to this Agreement seeks to set forth in writing the terms and conditions of their Agreement,

NOW THEREFORE, for good and valuable consideration, the parties agree to these terms and conditions:

I. TERM

The term of this Agreement shall begin on October 1, 2015, (the Effective Date) and shall end on September 30, 2017, (the Termination Date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

II. BENEFIT PLAN

Florida Blue will pay benefits to all eligible Group Members in accordance with the provisions of this agreement and the GHP.

III. PREMIUM PAYMENTS

The Premium Rates, Prepayment Fees and Supplemental Charges for the GHP are payable in advance to Florida Blue at the address set forth above. The premiums for the program are set forth in Exhibit A.

Contract # C08-1608-RM
BLUE CROSS & BLUE SHIELD
PROSHARE PLUS AGREEMENT
EXPIRES: 09/30/2017

IV. ACCOUNTING FOR OCTOBER 1, 2015 THROUGH SEPTEMBER 30, 2017

- A) Within one hundred twenty days of September 30, 2017 of this Agreement, Florida Blue shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, 100% of this excess will be returned to the Group, less any prior period deficit. However, if the group cancels prior to January 31, 2018, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by Florida Blue.
- E) Florida Blue will guarantee \$350,000 for the current Pro-Share Term, October 1, 2015 through September 30, 2017.

V. TERMINATION

This agreement may be terminate at any anniversary of the effective date by either party by giving the other party at least forty-five (45) days prior written notice of such termination.

VI. MODIFICATION OF RATES

Rates for the first twelve (12) months of this Agreement will remain in effect, as set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by Florida Blue. Thereafter, all rates set forth in Exhibit A of this Agreement or subsequent contract periods are subject to change by Florida Blue at any time following at least forty-five (45) days prior written notice to the Group.

The renewal rates effective on October 1, 2015 and October 1, 2016, will each be set forth and presented to the group on a revised Exhibit A.

All other provisions of this Agreement shall remain in effect without modification.

VII. LATE PAYMENT/CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to Florida Blue up to ten (10) days after such due date without a late payment charge. Payments received by Florida Blue eleven (11) to thirty-one (31) days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to Florida Blue immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to Florida Blue within thirty-one (31) days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by Florida Blue that were incurred after the termination date.

All payments due for charges during the Agreement period must be received by Florida Blue in order for the Group to share in any excess.

VIII. RENEWAL

This Agreement does not automatically renew or extend upon completion of the term of the Agreement. A revised Exhibit A for subsequent periods after the initial period showing renewal rates, administrative charge and pooling charge for such subsequent period will be provided to the Group after renewal for each subsequent period within the term of the Agreement. Any revised Exhibit A does not represent a renewal or extension of the original term of the Agreement.

IX. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

X. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XI. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XII. GOVERNING LAW

This Agreement, and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XIII. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

XIV. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that Florida Blue may make changes necessary to comply with State and Federal laws upon sixty days' notice to the Group.

XV. ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and Florida Blue. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVI. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XVII. PROVIDER NETWORKS

Florida Blue's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BLUE CROSS & BLUE SHIELD OF FLORIDA, INC.

Ву:	RICC
Name:	Joseph C. Gregor, Esq.
Title:	Vice President, Commercial Segments
Date:	6/8/17
OKALOO	SA COUNTY BOARD OF COUNTY COMMISSIONERS
Ву:	Causey N to the Old (SEAL)
Name: Printed	Carolyn N. Ketchel
Title:	Chairman, Board of County Commissioners
Date:	1 August 2017

Exhibit A

Accounting & Retention Agreement Okaloosa County Board of County Commissioners Group Number 41954

October 1, 2015 through September 30, 2016

A)	Premium Rates	Blue Options 03559	Blue Options 03769

Division Group A Division Group A

Employee Only \$812.76 \$760.49 Employee Family \$1,240.53 \$1,160.76

Division Group B Division Group B

 Employee Only
 \$471.33
 \$441.18

 Employee Spouse
 \$942.70
 \$882.40

 Employee Family
 \$1,060.57
 \$992.72

B) Administrative Charge

15.00% of Earned Premium
3.51% of Earned Premium for HCR Fees

C) Pooled Claim Charge

5.10% of Earned Premium

Pooling Level \$195,000 per Individual

03559 Division Group A: 021, 022, 023, 024, R26, R27, R36, R44, R45, C21, C22, C23

03559 Division Group B: R28, R32, R33, R34, R35

03769 Division Group A: 002, 011, 013, 015, R02, R03, R11, R16, R48, R50, C02, C11, C13, C15

03769 Division Group B: 005, R05, R15, R17, R56

Exhibit A

Accounting & Retention Agreement Okaloosa County Board of County Commissioners Group Number 41954

October 1, 2016 through September 30, 2017

A) Premium Rates	Blue Options 03559	Blue Options 03769	Blue Options 05770
	Division Group A	Division Group A	Division Group A
Employee Only Employee Family	\$861.53 \$1,314.96	\$806.12 \$1,230.41	\$760.49 \$1,160.76
Employee Only Employee Spouse Employee Family	Division Group B \$499.61 \$999.26 \$1,124.20	Division Group B \$467.65 \$935.34 \$1,052.28	Division Group B \$441.18 \$882.40 \$992.72

B) Administrative Charge

14.29% of Earned Premium

C) Pooled Claim Charge

5.57% of Earned Premium

Pooling Level \$175,000 per Individual

03559 Division Group A: 021, 023, 024, R27, R36, R44, R45, C21, C23

03559 Division Group B: R32, R33, R34, R35

03769 Division Group A: 002, 013, 015, R02, R03, R16, R48, R50, C02, C13, C15

03769 Division Group B: 005, R05, R15, R56

05770 Division Group A: 025, 026, 027, R25, R59, R60, R61, R62, C25, C26, C27

05770 Division Group B: 028, R57, R58, R63

Florida Blue 💩 🗑

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION

(True Group Application)

	New Business				
	I. Group Information Group # (Florida Blue): 41954 (Florida Blue HMO):				
Α	Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS .				
	Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199				
	Mailing Address: 601A NORTH PEARL STREET, SUITE 204 CRESTVIEW,FL 32536				
	Email Address: LPORTER@CO.OKALOOSA,FL,US				
	List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application. Name Address				
	Address				
B.	Applicant hereby applies for issuance of a Group Policy (herein referred to as a Policy) by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue and/or Health Options, Inc., D/B/A Florida Blue HMO. Upon acceptance of this application by Florida Blue and/or Florida Blue HMO, it will become part of the Policy issued to the applicant named above.				
C.	Prior Insurance Carrier: Insurance HUMANA				
	HMO NO GROUP INSURANCE				
D.	D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.				
E,	Workers Compensation Carrier is: SELF INSURED				
П.	Effective Date/Eligibility Information				
A.	Effective Date of this Policy shall be 10/01/2000				
	Effective Date of this Change to the Policy shall be 10/01/2015				
	This Policy may be terminated by the applicant or Florida Blue/Florida Blue HMO by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.				
B.	Only eligible employees who regularly work a minimum of 30 hours each week and their eligible dependents,				
C.	shall be eligible for coverage upon the Effective Date of this Policy. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as				
լեյիլ	described in B above. sibility - Full Time Employees - 1st of the Month 30 Days. Dept Heads - 1st of the Month following DOH sibility - Termination is as of the end of month, the benefits are termed as of the end of month. With the exception of termination due to conduct or mischievous conduct, then termination of benefits is as of the date of termination.				
D,	New eligible employees may be covered effective on the 1st of the month after See Spec Ins days				
	of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within				
E, F,	30 days of the date the individual first meets the applicable eligibility requirements. At least 65 % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet Florida Blue/Florida Blue HMO participation requirements. Florida Blue/Florida Blue HMO shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by Florida Blue/Florida Blue HMO. Applicant agrees to furnish any such request.				
G.	Employer Contribution: Employee: 100 % Dependents: 0 %				

BLUE CROSS & BLUE SHIELD PROSHARE PLUS AGREEMENT **CONTRACT # C08-1608-RM**



An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION (True Group Application)

III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benef by the Federal ar	fit Offerings nd/or State La	:(Optional) Appl aw. Applicant's	licant has been decision to acc	advis ept or	ed of the following decline these ber	g benefit offerings mand nefits is indicated below	dated	
Iлcluded in Product	Accept	Decline						
×		M	ental & Nervous	s Diso	rder			
×		Al-	Alcohol and drug dependency					
×		M:	Mammograms Waiver of Deductible & Coinsurance					
×		Er	Enteral Formulas					
Single	e Plan		Blue Pa	ckage	s			<u></u>
Health Plan Nan	ne				Rx Option (inc	licate copayments)		
BlueOptions Phy	sician Copay	Plan 03559 - Ct	ıst		BlueScript Rx	OOP Int \$15/\$50/\$80C -	- NSTD	
Benefit Period	01/01/2	2015 - 12/31/20	15		Coinsurance	:		
Deductible :					In-Network / P	articipating	80% /	20%
Per Person	\$500 /	\$750			Out-of-Networ	k/Non-Participating	60%/	40%
Per Family	\$1,500	/ \$2,250			Office Visit C	Copay:		
Pre-Existing	N/A				Family Physic	ian	\$20	
Rates					All Other Provi	ders	\$40	
Employee \$812.	.76 Emple	oyee/Spouse	N/A	Emp	loyee/Child(ren)	N/A Family	\$1240.53	
Spouse \$589.	23 Child	(ren)	\$589.23	Spo	use/Child(ren)	\$589.23 Employee +	1 N/A	



An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION (True Group Application)

Sin	gle Plan		Blue Packa	ages		
Health Plan N	ame			Rx Option	(indicate copayments)	
BlueQptions N	etwork Adva	ıntage Plans 03769 -	Cust	BlueScript	Rx OOP Int \$15/\$50/\$8	30C - NSTD
Benefit Peri	od : 01/0	1/2015 - 12/31/201	5	Coinsurar	ice:	
Deductible :				In-Network	/ Participating	80% / 20%
Per Person	\$500	/ \$1,500	W	Out-of-Netv	work/Non-Participating	50% / 50%
Per Family	\$1,50	00 / \$4,500	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Office Visi	it Copay:	<u> </u>
Pre-Existing	N/A	+ - · · · · · · · · · · · · · · · · · ·		Family Phy	sician	\$25
Rates				All Other Pr	oviders**	\$60
Employee \$70	0.49 Em	ployee/Spouse	N/A E	mployee/Child(re	n) N/A Family	\$1160.76
Spouse \$55	1.55 Chi	ld(ren)	\$551.55	Spouse/Child(ren)		
See the Group	Master Poli	cy for a complete d	escription of ben	efits.		
IV. Health Sa	vings Acco	unt (HSA), Health l	Reimbursemen	t Arrangement (F	HRA) or Flexible Sper	nding Account (FSA)
A. Are you	hoosing Flo	rida Blue's integrate	ed HSA, HRA or	FSA preferred ad	lministrator arrangeme	ent? Yes 🔀 No
(if left bla	ink, the resp	onse is assumed to	be No.)			
B. If Yes is	selected abo	ve, which type of a	ccounts are you	choosing	☐HSA ☐HI	RA TSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.						
V. Rate In	ormation					
		fee are payable mo	onthly on or befo	re the due date w	hich will be:	1st
B. Regular I Employee	B. Regular Billing - Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.					
C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, Florida Blue/Florida Blue HMO may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.						
D. Funding A	rrangement	s: Florida Blue:	ANNUAL REFN	D NO SPEC STO	P LOSS	
		НМО:	Not Applicable			
E. Rate Com	ments:					
		}				



An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION (True Group Application)

VI. Applicant Responsibilities

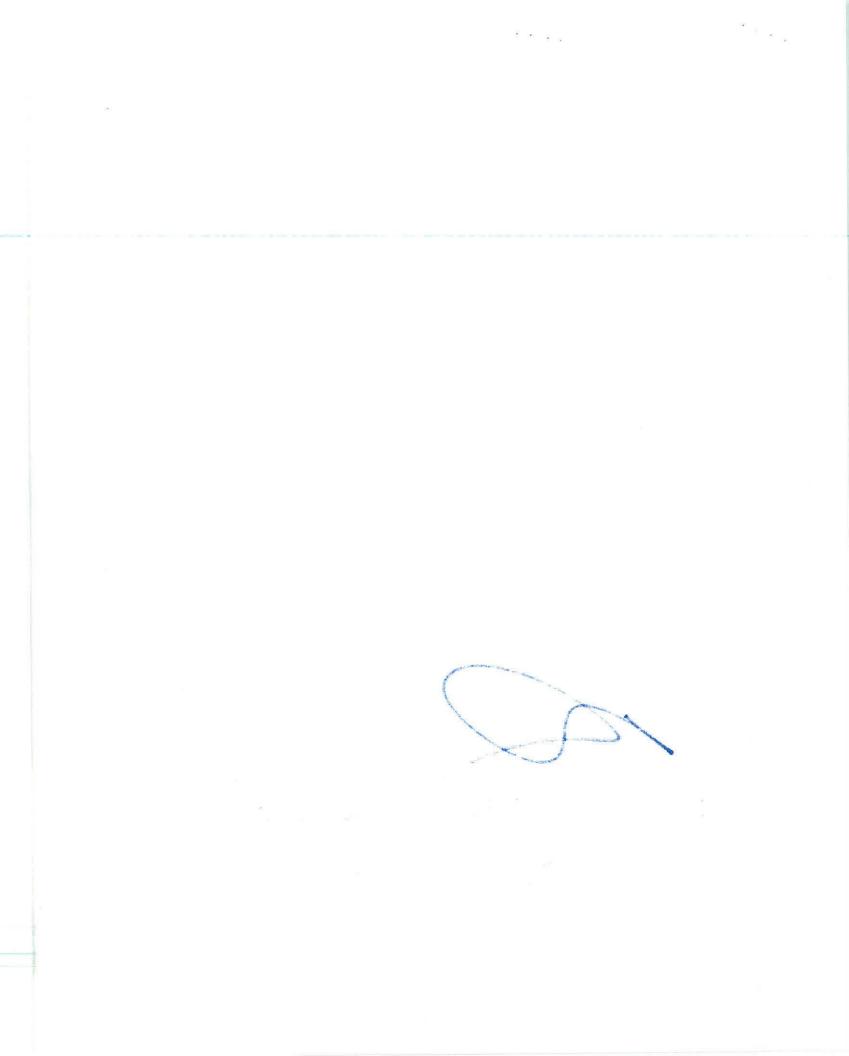
- A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.
- B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
- C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.
- D. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.
- E. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including information, of the employee as the administrator may require in order to establish and protected health maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
8-18-15		Nathan D. Boyles, Chairman
D-4-	Nathan D. Boyles, Chairman	r a
Date	Florida Blue and/or Florida Blue HMO Licensed Agent (Pri	int)
3/3/15	-CG. R	Dennis E. BArnes
	Signature of Agent	Agent License Identification Number
	57	A013980

Health and vision insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association.



BlueCross BlueShield Of Florida, Inc.

Annual Accounting & Retention Agreement

This is an agreement (hereinafter "Agreement") between BlueCross BlueShield of Florida, Inc. (hereinafter referred to as "BCBSF"), located at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 and Okaloosa County Board of County Commissioners, (hereinafter "the Group") located at 601A North Pearl Street, Suite 204, Crestview, FL 32536.

WHEREAS, the Group requests BCBSF to provide a PPO Program, (hereinafter "the Program") to its employees/members (herein "Group Member(s)"), and

WHEREAS, Blue Cross and Blue Shield of Florida, Inc., has agreed to provide the insurance part of the Program, and

WHEREAS, each of the parties to this Agreement seeks to set forth, in writing, the terms and conditions of their Agreement,

NOW THEREFORE, for good and valuable consideration, the parties agree as follows:

I. TERM

The term of this Agreement shall begin on October 1, 2008, (the Effective Date) and shall end on September 30, 2017, (the Termination Date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

II. BENEFIT PLAN

BCBSF agrees to administer the Group's health benefit plans (hereinafter referred to as the "Benefit Contracts"), which are hereby incorporated by reference into this Agreement.

III. PREMIUM PAYMENTS

The premium rates, prepayment fees and supplemental charges for the Program are payable in advance to BCBSF at the address set forth above. The premium rates will be set forth in Exhibit A once the premium rates are agreed upon by the parties.

CONTRACT # C08-1608-RM
BLUE CROSS & BLUE SHIELD
PROSHARE PLUS AGREEMENT
EXPIRES: 9/30/2016

IV. ACCOUNTING FOR OCTOBER 1, 2008 THROUGH SEPTEMBER 30, 2011

- A) Within one hundred twenty days of September 30, 2011 of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the \$150,000 pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, 50% of this excess will be returned to the Group. However, if the group cancels prior to January 31, 2012, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be carried forward to the next period's accounting.

V. ACCOUNTING FOR OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2013

- A) Within one hundred twenty days of September 30, 2013 of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the \$150,000 pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, 100% of this excess will be returned to the Group, less any prior period deficit. However, if the group cancels prior to January 31, 2014, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by BCBSF.

VI. ACCOUNTING FOR OCTOBER 1, 2013 THROUGH SEPTEMBER 30, 2015

- A) Within one hundred twenty days of September 30, 2015 of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the \$150,000 pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, 100% of this excess will be returned to the Group, less any prior period deficit. However, if the group cancels prior to January 31, 2016, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by BCBSF.

VII. ACCOUNTING FOR OCTOBER 1, 2015 THROUGH SEPTEMBER 30, 2017

- A) Within one hundred twenty days of September 30, 2017 of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, 100% of this excess will be returned to the Group, less any prior period deficit. However, if the group cancels prior to January 31, 2018, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by BCBSF.

E) If the Group issues a bid at any time after the date they sign this Agreement and prior to the termination date of this agreement, any excess premium available will not be returned to the Group. A bid will be defined as, but not be limited to, a competitive bid as described in section 112.08 of the Florida Statutes.

VIII. TERMINATION

Either party may terminate this Agreement at any anniversary of the effective date, by giving the other party at least forty-five days prior written notice of such termination.

IX. MODIFICATION OF RATES

Rates for the first twelve months of this Agreement will remain in effect, as will be set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by BCBSF.

Thereafter, all rates set forth in Exhibit A of this Agreement are subject to change by BCBSF at any time following at least forty-five days prior written notice to the Group.

The renewal rates effective on October 1, 2009, October 1, 2010, October 1, 2011, October 1, 2012, October 1, 2013, October 1, 2014, October 1, 2015 and October 1, 2016 will each be set forth and presented to the group on a revised Exhibit A. All other provisions of this Agreement shall remain in effect without modification.

X. LATE PAYMENT/CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to BCBSF up to ten days after such due date without a late payment charge. Payments received by BCBSF eleven to thirty-one days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to BCBSF immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to BCBSF within thirty-one days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by BCBSF that were incurred after the termination date.

XI. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

XII. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XIII. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XIV. GOVERNING LAW

This Agreement, and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XV. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

XVI. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that BCBSF may make changes necessary to comply with State and Federal laws upon sixty days notice to the Group.

XVII. ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and BCBSF. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVIII. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XIX. PROVIDER NETWORKS

BCBSF's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.	OKALOOSA COUNTY BOARD OF COUNTY COMMISSIONERS
Tilca	SEAL
Joseph C. Gregor, Esq.	Name (typed) Nathan D. Boyles
Vice President Commercial Segments	Title
	Chairman
Date 8/5/15	Date Aug. 18, 2015

Exhibit A

Accounting & Retention Agreement Okaloosa County Board of County Commissioners Group Number 41954 October 1, 2015 through September 30, 2016

	,	 OCP	c o a b	.,	occose.	

A) Premium Rates	Blue Options 03559	Blue Options 03769	
	Division Group A	Division Group A	
Employee Only Employee Family Spouse Only Child Only	\$812.76 \$1,240.53 \$589.23 \$589.23 \$589.23	\$760.49 \$1,160.76 \$551.55 \$551.55 \$551.55	
Employee Only Employee Spouse Employee Family	Division Group B \$471.33 \$942.70 \$1,060.57	Division Group B \$441.18 \$882.40 \$992.72	

B) Administrative Charge

15.00% of Earned Premium
3.51% of Earned Premium for HCR Fees

C) Pooled Claim Charge

5.10% of Earned Premium

Pooling Level \$195,000 per Individual

03559 Division Group A: 021, 022, 023, 024, R26, R27, R36, R44, R45, C21, C22, C23

03559 Division Group B: R28, R32, R33, R34, R35

03769 Division Group A: 002, 011, 013, 015, R02, R03, R11, R16, R48, R50, C02, C11, C13, C15

03769 Division Group B: 005, R05, R15, R17, R56

EXHIBIT B

CONTRACT & LEASE AGREEMENT CONTROL FORM

Date: 2/27/2008 8/14/09

Contract/Lease Control #: C08-1608-rm1-87

Bid #: N/A

Contract/Lease Type: AGREEMENT

Award to/Lessee: BLUE CROSS & BLUE SHIELD OF FLORIDA

Lessor:

Effective Date: 10/1/2007

Amount: \$500,000

Term/Expires: 9/30/2008 W/ANNUAL RENEWALS

Description of Contract/Lease: PROSHARES PLUS ACCOUNTING

AGREEMENT

Department Manager: RISK MANAGEMENT

Department Monitor: J. TAYLOR

Monitor's Telephone #: 689-5977

Monitor's Fax #: 689-5973

Date Closed:

RENEWED 8/5/2008 BY BCC WHEN THEY APPROVED AWARDING OF NEW HEALTH CARE CONTRACT AGAIN TO BCBS.

CONTRACT & LEASE INTERNAL COORDINATION SHEET

C12-1976-PM CO8-1681-RM, C09-1743-RM, C08-1608-RM, Contract/Lease Number: Sympton BCBS, Ladard Vhilliams, BCBS Prostore, Contractor/Lessee Name:	Tracking Number: 737-/3 Grant Funded: YESNO				
Purpose: Insurance Renewals for 2014					
Date/Term: 9/30/2014 1.	GREATER THAN \$50,000				
Amount: per rates 2.	GREATER THAN \$25,000				
Department: Risk Management 3.	\$25,000 OR LESS				
Dept. Monitor Name: Gary Real					
Document has been reviewed and includes any attachments	or exhibits,				
Purchasing Review					
Procurement requirements are met:					
In/all	Date: 9/23/13				
Purchasing Director or designee					
Risk Management Review					
Approved as writter: Risk Manager or designee	Date: <u>9/23/3</u>				
County Attorney Review					
Approved as written:					
See affected faxed from Date: 9/23/13					
County Attorney pm. Dowd	150.0.				
Following Okaloosa County appro	oval:				
Contracts & Grants					
Document has been received:					
Brevela Raile	Date: 12 3 1 1 3				
Contracts & Crant Man	Dule. 10 121112				

	RNAL COORDINATION SHEET
CIL-1970 KM (OS-1687 KM) CO. 1608	in, Bye medican C14-2126-RM
Synthia 15065 fallend flishings, 180135 Pros	Grant Funded: Yes NO
Purpose: Insurance Renewals for	2014
Date/Term: 9/30/2014	1. M GREATER THAN \$50,000
Amount per rates	2 [] GREATER THAN \$25,000
Department Hisk Mungement	3. [] \$25,000 OR (155
Dept. Monitor Name: Gary Real	
Document has been reviewed and includes a	ny attachments or exhibits.
Purcha	sing Review
Purchasing Director or designee	Date: 9/13/13
Risk Mana	gement Review
Approved as written: Risk Manager or designee	poter 1/2/3/12
County Attorney	ttorney Review Date: 9/23/3
Fallowing Okaloi	osa County approvai.
Contra	cts & Grants
Document has been received	
Contracts & Grants Manager	Oate ;



OFFICE OF CONTRACTS & GRANTS CLERK OF THE CIRCUIT COURT 1804 Lewis Turner Blvd, Suite 206

(850) 651-7200, ext 4381

MEMORANDUM

From	70:	Jack Allen, Jo Kublik Purchasing Manager (08-1608-RM
TO	-FROM:	Brenda L. Bailey, From Eary Real Contracts & Grants Manager RM Proshare Jack Allen, Purchasing Manager Contracts & Grants Manager RM Proshare
	DATE:	September 26, 2013. 10/4/13
	RE:	BCC Meeting Date: August 6, 2013
		a County Board of Commissioners has approved the attached on the date specified above. The documents are being returned for action:
		Please submit to other party for signatures. When fully executed please return one "original" to our office.
		If document is fully executed, please make final distribution including returning one "original" to our office.

CONTRACT # C08-1608-RM
BLUE CROSS & BLUE SHIELD
PROSHARE PLUS AGREEMENT
EXPIRES: 9/30/2015

BlueCross BlueShield Of Florida, Inc.

Annual Accounting & Retention Agreement

This is an agreement (hereinafter "Agreement") between BlueCross BlueShield of Florida, Inc. (hereinafter referred to as "BCBSF"), located at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 and Okaloosa County Board of County Commissioners, (hereinafter "the Group") located at 601A North Pearl Street, Suite 204, Crestview, FL 32536.

WHEREAS, the Group requests BCBSF to provide a PPO Program, (hereinafter "the Program") to its employees/members (herein "Group Member(s)"), and

WHEREAS, Blue Cross and Blue Shield of Florida, Inc., has agreed to provide the insurance part of the Program, and

WHEREAS, each of the parties to this Agreement seeks to set forth, in writing, the terms and conditions of their Agreement,

NOW THEREFORE, for good and valuable consideration, the parties agree as follows:

I. TERM

The term of this Agreement shall begin on October 1, 2008, (the Effective Date) and shall end on September 30, 2015, (the Termination Date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

II. BENEFIT PLAN

BCBSF agrees to administer the Group's health benefit plans (hereinafter referred to as the "Benefit Contracts"), which are hereby incorporated by reference into this Agreement.

III. PREMIUM PAYMENTS

The premium rates, prepayment fees and supplemental charges for the Program are payable in advance to BCBSF at the address set forth above. The premium rates will be set forth in Exhibit A once the premium rates are agreed upon by the parties.

IV. ACCOUNTING FOR OCTOBER 1, 2008 THROUGH SEPTEMBER 30, 2011

- A) Within one hundred twenty days of September 30, 2011 of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the \$150,000 pooling level)
 - c. Pooled Claim Charges
 - d. Administrative Charges
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, 50% of this excess will be returned to the Group. However, if the group cancels prior to January 31, 2012, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be carried forward to the next period's accounting.

V. ACCOUNTING FOR OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2013

- A) Within one hundred twenty days of September 30, 2013 of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such term's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium
 - b. Incurred Claims (less claims in excess of the \$150,000 pooling level)
 - c. Pooled Claim Charges
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- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by BCBSF.

E) If the Group issues a bid at any time after the date they sign this Agreement and prior to the termination date of this agreement, any excess premium available will not be returned to the Group. A bid will be defined as, but not be limited to, a competitive bid as described in section 112.08 of the Florida Statutes.

VI. ACCOUNTING FOR OCTOBER 1, 2013 THROUGH SEPTEMBER 30, 2015

- A) Within one hundred twenty days of September 30, 2015 of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such term's operations.
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- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charges and Administrative Charges, the deficit will be retained by BCBSF.
- **VII.** If the Group issues a bid at any time after the date they sign this Agreement and prior to the termination date of this agreement, any excess premium available will not be returned to the Group. A bid will be defined as, but not be limited to, a competitive bid as described in section 112.08 of the Florida Statutes.

VIII. TERMINATION

Either party may terminate this Agreement at any anniversary of the effective date, by giving the other party at least forty-five days prior written notice of such termination.

IX. MODIFICATION OF RATES

Rates for the first twelve months of this Agreement will remain in effect, as will be set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by BCBSF.

Thereafter, all rates set forth in Exhibit A of this Agreement are subject to change by BCBSF at any time following at least forty-five days prior written notice to the Group.

The renewal rates effective on October 1, 2009, October 1, 2010, October 1, 2011, October 1, 2012, October 1, 2013 and October 1, 2014 will each be set forth and presented to the group on a revised Exhibit A. All other provisions of this Agreement shall remain in effect without modification.

X. LATE PAYMENT/CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to BCBSF up to ten days after such due date without a late payment charge. Payments received by BCBSF eleven to thirty-one days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to BCBSF immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to BCBSF within thirty-one days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by BCBSF that were incurred after the termination date.

XI. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

XII. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XIII. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XIV. GOVERNING LAW

This Agreement, and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XV. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

XVI. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that BCBSF may make changes necessary to comply with State and Federal laws upon sixty days notice to the Group.

XVII. ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and BCBSF. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVIII. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XIX. PROVIDER NETWORKS

BCBSF's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

OKALOOSA COUNTY BOARD OF COUNTY COMMISSIONERS

James J. Condit

Vice President and Chief **Underwriting Officer**

Date

Name (typed)

Title

CHAIRMAN

Date



CONTRACT & LEA INTERNAL COORDINAT	
Contract/Lease Number: C08-1658 RM	Tracking Number: <u>290·11</u>
Contractor/Lessee Name: Blue Cross Blue Shre	
Purpose: Proshere Plus Agreement	
Purpose: Proshere Plus Agreement Date/Term: 9/30/2013 / Accounting Period	1. GREATER THAN \$50,000
Amount:	2. GREATER THAN \$25,001
Department:	3. \$25,000 OR LESS
Dept. Monitor Name: J. Jaylor	
Purchasing Revi	iew
Procurement requirements are met: Contracts & Lease Coordinator	Date: <u>5/9/11</u>
Risk Management R	Review
Approved as written: Risk Management Director	Date:
County Attorney Re	eview
Approved as written: County Attorney	Date: 5/24/11
Following Okaloosa County	approval:
Contract & Gran	nt
Document has been received:	
	Date:
Contracts & Grants Manager	

BlueCross BlueShield Of Florida, Inc. Health Options, Inc. Accounting & Retention Agreement

This is an agreement (hereinafter "Agreement") between BlueCross BlueShield of Florida, Inc. (hereinafter referred to as "BCBSF"), located at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 and Okaloosa County Board of County Commissioners, (hereinafter "the Group") located at 601A North Pearl Street, Suite 204, Crestview, Florida 32536.

WHEREAS, the Group requests BCBSF to provide a PPO Program, (hereinafter "the Program") to its employees/members (herein "Group Member(s)"), and

WHEREAS, BCBSF has agreed to provide the insurance part of the Program, and

WHEREAS, each of the parties to this Agreement seeks to set forth, in writing, the terms and conditions of their Agreement,

NOW THEREFORE, for good and valuable consideration, the parties agree as follows:

I. TERM

The term of this Agreement shall begin on October 1, 2008, (the Effective Date) and shall end on September 30, 2013, (the Termination Date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

II. BENEFIT PLAN

BCBSF agrees to administer the Group's health benefit plans (hereinafter referred to as the "Benefit Contracts"), which are hereby incorporated by reference into this Agreement.

III. PREMIUM PAYMENTS

The premium rates, prepayment fees and supplemental charges for the Program are payable in advance to BCBSF at the address set forth above. The premium rates will be set forth in Exhibit A once the premium rates are agreed upon by the parties.

IV. ACCOUNTING FOR OCTOBER 1, 2008 THROUGH SEPTEMBER 30, 2011

- A) Within one hundred twenty days of September 30, 2011, BCBSF shall prepare and furnish to the Group an accounting of such period's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium.
 - b. Incurred Claims (less claims in excess of the \$150,000 pooling level),
 - c. Pooled Claim Charge, and
 - d. Administrative Charge.
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charge and Administrative Charge, 50% of this excess will

- be returned to the Group. However, if the group cancels prior to January 31, 2012, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charge and Administrative Charge, the deficit will be carried forward to the next period's accounting.

V. ACCOUNTING FOR OCTOBER 1, 2011 THROUGH SEPTEMBER 30, 2013

- A) Within one hundred twenty days of September 30, 2013, BCBSF shall prepare and furnish to the Group an accounting of such period's operations.
- B) This accounting shall include operations under all coverages of the Program and shall set forth the following:
 - a. Earned Premium,
 - b. Incurred Claims (less claims in excess of the \$150,000 pooling level),
 - c. Pooled Claim Charge, and
 - d. Administrative Charge.
- C) If Earned Premium is greater than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charge and Administrative Charge, 100% of this excess will be returned to the Group, less any prior period deficit. However, if the group cancels prior to January 31, 2014, any such excess will not be available for return to the Group.
- D) If Earned Premium is less than the sum of Incurred Claims (less claims in excess of the \$150,000 pooling level), Pooled Claim Charge and Administrative Charge, the deficit will be retained by BCBSF.
- E) If the Group issues a bid at any time after the date they sign this Agreement and prior to the termination date of this agreement, any excess premium available will not be returned to the Group. A bid will be defined as, but not be limited to, a competitive bid as described in section 112.08 of the Florida Statutes.

VI. TERMINATION

Either party may terminate this Agreement at any anniversary of the effective date, by giving the other party at least forty-five days prior written notice of such termination.

VII. MODIFICATION OF RATES

Rates for the first twelve months of this Agreement will remain in effect, as will be set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by BCBSF.

Thereafter, all rates set forth in Exhibit A of this Agreement are subject to change by BCBSF at any time following at least forty-five days prior written notice to the Group.

The renewal rates effective on October 1, 2009, October 1, 2010, October 1, 2011 and October 1, 2012 will each be set forth and presented to the Group on a revised Exhibit A. All other provisions of this Agreement shall remain in effect without modification.

VIII. LATE PAYMENT/CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to BCBSF up to ten days after such due date without a late payment charge. Payments received by BCBSF eleven to thirty-one days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to BCBSF immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to BCBSF within thirty-one days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by BCBSF that were incurred after the termination date.

IX. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

X. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XI. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XII. GOVERNING LAW

This Agreement and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XIII. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

XIV. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that BCBSF may make changes necessary to comply with State and Federal laws upon sixty days notice to the Group.

XV.ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and BCBSF. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVI. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XVI. PROVIDER NETWORKS

BCBSF's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BlueCross BlueShield Of Florida, Inc.		Okaloosa County Board Of County Commissioners		
Ву	January Corlet	Ву	Jan	Canghell
Name	James Condit	Name (Typed)		
Title	Vice President and Chief Underwriting Officer	Title		
Date	May 26, 2011	Date		

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

ANNUAL ACCOUNTING & RETENTION AGREEMENT

This is an agreement (hereinafter "Agreement") between Blue Cross and Blue Shield of Florida, Inc. (hereinafter referred to as "BCBSF"), located at 4800 Deerwood Campus Parkway, Jacksonville, FL 32246 and the Okaloosa County Board Of County Commissioners (hereinafter "the Group"), located at 601A North Pearl Street, Suite 204, Crestview, FL 32536.

WHEREAS, the Group requests BCBSF to provide a PPO Program, (hereinafter "the Program") to its employees/members (hereinafter "Group Member(s)"); and

WHEREAS, BCBSF has agreed to provide the insurance part of the Program; and

WHEREAS, each of the parties to this Agreement seeks to set forth, in writing, the terms and conditions of their Agreement;

NOW THEREFORE, for good and valuable consideration, the parties agree as follows:

i. TERM

The term of this Agreement shall begin on October 1, 2007 (the effective date) and shall end on September 30, 2008 (the termination date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

II. BENEFIT PLAN

BCBSF agrees to administer the Group's health benefit plans (hereinafter referred to as the "Benefit Contracts"), which are hereby incorporated by reference into this Agreement.

III. PREMIUM PAYMENTS

The premium rates, prepayment fees, and supplemental charges for the Program are payable in advance to BCBSF at the address set forth above. The premium rates for the Program are set forth in Exhibit A.

IV. ANNUAL ACCOUNTING

Within one hundred twenty (120) days after each anniversary of this Agreement, BCBSF shall prepare and furnish to the Group an accounting of such year's operations.

This accounting shall include operations under all coverages of the program and shall set forth the following:

CONTRACT: PROSHARE PLUS ACCOUNTING AGREEMENT CONTRACT NO.: C08-1608-RM2-87 BLUE CROSS BLUE SHIELD

EXPIRES: 9/30/2009



CONTRACT: PROSHARE PLUS ACCOUNTING AGREEMENT CONTRACT NO.: C08-1608-RM1-87 BLUE CROSS & BLUE SHIELD

EXPIRES: 9/30/2008

- A) Earned premium,
- B) Incurred claims less claims in excess of the pooling level,
- C) Pooling charge, and
- D) Administrative charges, as set forth on Exhibit A.

If earned premium is greater than the sum of incurred claims less claims in excess of the pooling level, pooling charge and administrative charges, 50% of the excess will be returned to the Group.

If the Group cancels prior to any anniversary of the effective date, no excess premium will be returned for the prior policy year or the current policy year. Excess premium for each policy will be determined solely from the results of that year. Prior gains or deficits will not be carried forward to subsequent years.

If earned premium is less than the sum of incurred claims less claims in excess of the pooling level, pooling charge and administrative charges, the deficit will be retained by BCBSF.

V. TERMINATION

Either party may terminate this Agreement at any anniversary of the effective date by giving the other party at least forty-five (45) days prior written notice of such termination.

VI. MODIFICATION OF RATES

Rates for the term of this Agreement will remain in effect, as set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by BCBSF.

Thereafter, all rates set forth in Exhibit A of this Agreement are subject to change by BCBSF at any time following at least forty-five (45) days prior written notice to the Group. The modified rates, including renewal rates, will be set forth and presented to the Group on a revised Exhibit A. All other provisions of this Agreement shall remain in effect without modification.

VII. LATE PAYMENT CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to BCBSF up to ten (10) days after such due date without a late payment charge. Payments received by BCBSF eleven (11) to thirty-one (31) days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to BCBSF immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to BCBSF within thirty-one (31) days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any



reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by BCBSF that were incurred after the termination date.

VIII. RENEWAL

This Agreement shall automatically renew/extend for additional one year period(s), after the termination date, at the rates then in effect (the renewal rates), unless either party notifies the other party of its intent not to extend this Agreement at least forty-five (45) days prior to the applicable Anniversary Date. The renewal rates will be set forth and presented to the Group on a revised Exhibit A.

IX. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

X. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XI. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XII. GOVERNING LAW

This Agreement, and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XIII. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.



XIV. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that BCBSF may make changes necessary to comply with State and Federal laws upon sixty (60) days notice to the Group.

XV. ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and BCBSF. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVI. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XVII. PROVIDER NETWORKS

BCBSF's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BLUE CI FLORID	ROSS AND BLUE SHIELD OF A, INC.	COUNTY COMMISSIONERS		
Ву		Ву	Jan and the	
Name	William Coats	Name	James Campbell	
Title	Vice President and Chief Underwriting Officer	Title	(Typed) Chairman	
Date	12/9/07	Date	February 19,2008	



EXHIBIT A

ANNUAL ACCOUNTING & RETENTION AGREEMENT

OKALOOSA COUNTY BOARD OF COUNTY COMMISSIONERS GROUP # 41954

COVERING THE PERIOD OCTOBER 1, 2007 THROUGH SEPTEMBER 30, 2008

A. Premium Rates	1	2	3	4
BlueOptions 1749				
Employee Only	\$602.95	\$349.95		\$437.49
Employee & One	·	\$699.93	\$787 . 44	•
Employee & Family	\$920.30	\$787 .44	\$918.72	\$437.49
BlueOptions 1359	2			
Employee Only	8521.52\$522.89	\$303.48		\$379.39
Employee & One	de	\$606.99	\$682.87	·
Employee & Family	796.72 \$798.09	\$682.87	\$796.72	\$379.39

Column 1 = Active Employees; Retired Employees without Medicare

Column 2 = Retired Employees Only with Medicare; Retired Employee & One, both with Medicare; Retired Employee & Family, 1>65 with Medicare

Column 3 = Retired Employee & One and Retired Employee & Family, 1>65 with or without Medicare

Column 4 = Dependents of BlueMedicare Enrollees (over and under age 65)

B. Administrative Charges

16.26% Of Earned Premium

C. Pooling

Level Charge \$150,000 Per Individual 2.6 % Of Earned Premium

