CONTRACT, LEASE, AGREEMENT CONTROL FORM

Date: 06/24/2020

Contract/Lease Control #: C08-1608-RM

Procurement#: NA

Contract/Lease Type: AGREEMENT

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

Owner/Lessor: OKALOOSA COUNTY

Effective Date: 10/01/2019

Expiration Date: 09/30/2021

Description of: PROSHARE PLUS ACCOUNTY DEPARTMENT

Department: KB

Department Monitor: BIRD

Monitor's Telephone #: 850-689-5977

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

Closed:

Cc: BCC RECORDS

Kelly Bird C08-1608-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.

BLUE CROSS & BLUE SHIELD OF FLORIDA, INC.

By: _____

Name: Joseph C. Gregor, Esq.

Title: Vice President, Commercial Segments

Date: June 2, 2020

OKALOOSA COUNTY BOARD OF COUNTY COMMISSIONERS

By: _____

Name: John Hofstad
Printed

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**

1. **Pooling Level: $230,000 Per Individual**
2. **Pooling Charges: 5.48% of earned premium**

EXHIBIT B

CONTRACT & LEASE AGREEMENT CONTROL FORM

Date: ~~2/27/2008~~ 8/21/15

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

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: 9/30/16 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:

CONTRACT # C08-1608-RM
BLUE CROSS & BLUE SHIELD
PROSHARE PLUS ACCT AGREEMENT
EXPIRES: 9/30/2011

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: CA-1608-KM Tracking Number: 3469-19

Procurement/Contractor/Lessee Name: BC/BS Grant Funded: YES___ NO___

Purpose: Proshare Agreement

Date/Term: 9-30-19

Amount: _____

Department: KM

Dept. Monitor Name: Gibson

1. [X] GREATER THAN $100,000
2. [ ] GREATER THAN $50,000
3. [ ] $50,000 OR LESS

Purchasing Review

Procurement or Contract/Lease requirements are met:

Date: 7-31-19

Purchasing Manager or designee — Jeff Hyde, DeRita Mason, Victoria Taravella

2CFR Compliance Review ***(if required)***

Approved as written: NA Grant Name: _____

Date: _____

Grants Coordinator — Danielle Garcia

Risk Management Review

Approved as written: Go ahead and email outcome

Date: 7-31-19

Risk Manager or designee — Laura Porter or Krystal King

County Attorney Review

Approved as written: Approved without legal review

Date: _____

County Attorney — Gregory T. Stewart, Lynn Hoshihara, Kerry Parsons or Designee

Following Okaloosa County approval:

Clerk Finance

Document has been received:

Date: _____

Finance Manager or designee

Revised November 3, 2017

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 CROSS & BLUE SHIELD OF FLORIDA, INC.

By: _____

Name: Joseph C. Gregor, Esq.

Title: Vice President, Commercial Segments

Date: 6/9/17

OKALOOSA COUNTY, FLORIDA

By: _____

Name: Charles K. Windes, Jr., Chairman
Printed

Title: Chairman

Date: AUG 0 6 2019

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD # B CRESTVIEW,FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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 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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05193 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1010.55

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1352.61

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1568.31

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05192 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$449.10	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05193 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1010.55
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$898.25

Florida Blue
An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	$601.13	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1352.61
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1202.30

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$696.98	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1568.31
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1394.02

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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.

Florida Blue

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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**
HMO:	**Not Applicable**

E. Rate Comments:

Florida Blue

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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. 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. Windes, Jr.	CHARLES K. WINDES, CHAIRMAN

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

Florida Blue

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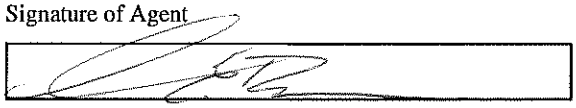
Blue Cross and Blue Shield Association

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.

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD # B CRESTVIEW,FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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Blue Cross and Blue Shield Association

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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05193 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1010.55

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1352.61

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1568.31

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05192 - NSTD	BlueScript G In-Network DED + $15/$60/$100C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$449.10	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05193 - NSTD	BlueScript G In-Network DED + $15/$60/$100C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1010.55
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$898.25

Florida Blue
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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	$601.13	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1352.61
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1202.30

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$696.98	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1568.31
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1394.02

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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.

Florida Blue

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Blue Cross and Blue Shield Association

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**
HMO:	**Not Applicable**

E. Rate Comments:

Florida Blue

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. 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 06 2019	Charles K. Windes Jr	CHARLES K. WINDES, CHAIRMAN

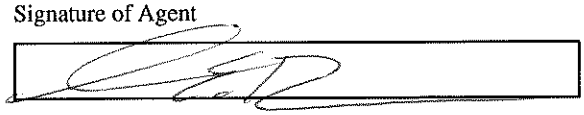
Date — Florida Blue and/or Florida Blue HMO Licensed Agent (Print)

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

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.

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD # B CRESTVIEW,FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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 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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05193 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1010.55

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1352.61

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1568.31

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05192 - NSTD	BlueScript G In-Network DED + $15/$60/$100C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$449.10	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05193 - NSTD	BlueScript G In-Network DED + $15/$60/$100C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1010.55
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$898.25

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	$601.13	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1352.61
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1202.30

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$696.98	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1568.31
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1394.02

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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.

Florida Blue

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Blue Cross and Blue Shield Association

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**
HMO:	**Not Applicable**

E. Rate Comments:

Florida Blue

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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. 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. Windes	CHARLES K. WINDES, CHAIRMAN

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

Florida Blue

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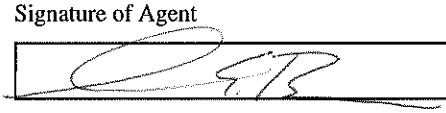
Blue Cross and Blue Shield Association

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.

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION (True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD # B CRESTVIEW,FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05193 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1010.55

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1352.61

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1568.31

Florida Blue
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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	HSA Compatible Plans 05192 - NSTD
Rx Option *(indicate copayments)*	BlueScript G In-Network DED + $15/$60/$100C - NSTD
Benefit Period :	01/01/2019 - 12/31/2019
Deductible :	
Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A
Coinsurance:	
In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%
Office Visit Copay:	
Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$449.10	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name	HSA Compatible Plans 05193 - NSTD
Rx Option *(indicate copayments)*	BlueScript G In-Network DED + $15/$60/$100C - NSTD
Benefit Period :	01/01/2019 - 12/31/2019
Deductible :	
Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A
Coinsurance:	
In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%
Office Visit Copay:	
Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	N/A	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1010.55
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$898.25

Florida Blue
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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

Employee	$601.13	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1352.61
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1202.30

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Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$696.98	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1568.31
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1394.02

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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.

Florida Blue

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Blue Cross and Blue Shield Association

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**
HMO:	**Not Applicable**

E. Rate Comments:

Florida Blue

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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. 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.

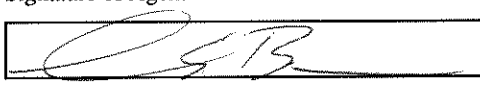
Date	Signature of Applicant	Print/Type Name & Title
AUG 0 6 2019	Charles K. Windes	CHARLES K. WINDES, CHAIRMAN
Date	Florida Blue and/or Florida Blue HMO Licensed Agent (Print)	

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

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.

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD #B CRESTVIEW, FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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 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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05192 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$774.15	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	$561.46	Child(ren)	$561.46	Spouse/Child(ren)	N/A	Employee + 1	N/A

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05193 - NSTD	BlueScript G In-Network DED + $15/$60/$100C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

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)	$561.46	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

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

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$1201.88	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1834.45
Spouse	$871.33	Child(ren)	$871.33	Spouse/Child(ren)	$871.33	Employee + 1	N/A

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No

(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA

NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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 Arrangements: Florida Blue: ANNUAL REFND NO SPEC STOP LOSS

HMO: Not Applicable

E. Rate Comments:

Florida Blue

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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. 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.

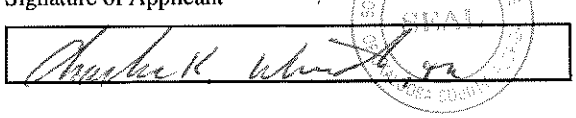
E. Applicant understands that if applying for an HSA-qualified High Deductible Health Plan and electing to grant Prior Carrier Credit under Florida law to enrolling Employees, then that plan may no longer qualify as an HSA-compatible plan.

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. WINDES, CHAIRMAN

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

Florida Blue

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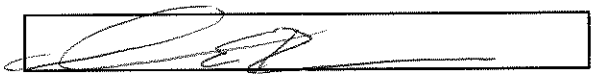
Blue Cross and Blue Shield Association

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.

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD #B CRESTVIEW, FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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Blue Cross and Blue Shield Association

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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05192 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$774.15	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	$561.46	Child(ren)	$561.46	Spouse/Child(ren)	N/A	Employee + 1	N/A

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	HSA Compatible Plans 05193 - NSTD
Rx Option *(indicate copayments)*	BlueScript G In-Network DED + $15/$60/$100C - NSTD
Benefit Period :	01/01/2019 - 12/31/2019
Deductible :	
Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A
Coinsurance:	
In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%
Office Visit Copay:	
Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

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)	$561.46	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name	Predictable Cost Plan 05781 - NSTD
Rx Option *(indicate copayments)*	BlueScript Rx OOP Int $15/$60/$80C - NSTD
Benefit Period :	01/01/2019 - 12/31/2019
Deductible :	
Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A
Coinsurance:	
In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%
Office Visit Copay:	
Family Physician	$30
All Other Providers	$55

Rates

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

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$1201.88	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1834.45
Spouse	$871.33	Child(ren)	$871.33	Spouse/Child(ren)	$871.33	Employee + 1	N/A

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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 Arrangements: Florida Blue: ANNUAL REFND NO SPEC STOP LOSS
HMO: Not Applicable

E. Rate Comments:

Florida Blue

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Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

VI. Applicant Responsibilities

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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.

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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.]

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. Windes, Jr.	CHARLES K. WINDES, CHAIRMAN

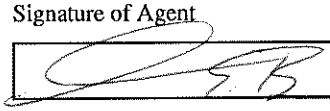
Date — Florida Blue and/or Florida Blue HMO Licensed Agent (Print)

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

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.

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD #B CRESTVIEW, FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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 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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05192 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$774.15	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	$561.46	Child(ren)	$561.46	Spouse/Child(ren)	N/A	Employee + 1	N/A

Florida Blue

An Independent Licensee of the
Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05193 - NSTD	BlueScript G In-Network DED + $15/$60/$100C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

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)	$561.46	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

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

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$1201.88	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1834.45
Spouse	$871.33	Child(ren)	$871.33	Spouse/Child(ren)	$871.33	Employee + 1	N/A

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No

(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA

NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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 Arrangements: Florida Blue: ANNUAL REFND NO SPEC STOP LOSS

HMO: Not Applicable

E. Rate Comments:

Florida Blue

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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 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. Windes	CHARLES K. WINDES, CHAIRMAN

SEAL

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

Florida Blue

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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.

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION (True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. Name of Group: OKALOOSA CO BOARD OF CO COMMISSIONERS

Nature of Business: GENERAL GOVERNMENT, NEC SIC Code: 9199

Mailing Address: 5479 OLD BETHEL RD #B CRESTVIEW, FL 32536-5512

Email Address: EGIBSON@MYOKALOOSA.COM

List below Subsidiary or Affiliated Companies whose employees are to be eligible and included with this application.

Name	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. 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

II. 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 10/01/2019

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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

D. New eligible employees may be covered effective on the 1st of the month after 30 days of employment, so long as the eligible employee submits an application to Florida Blue/Florida Blue HMO within 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

Florida Blue

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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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name: **HSA Compatible Plans 05192 - NSTD**

Rx Option *(indicate copayments)*: **BlueScript G In-Network DED + $15/$60/$100C - NSTD**

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$2,500 / $5,000
Per Family	Not Applicable / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

Employee	$774.15	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	$561.46	Child(ren)	$561.46	Spouse/Child(ren)	N/A	Employee + 1	N/A

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
HSA Compatible Plans 05193 - NSTD	BlueScript G In-Network DED + $15/$60/$100C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$5,000 / $10,000
Per Family	$5,000 / $10,000
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	60% / 40%

Office Visit Copay:

Family Physician	DED + 20%
All Other Providers	DED + 20%

Rates

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)	$561.46	Employee + 1	N/A

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05781 - NSTD	BlueScript Rx OOP Int $15/$60/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$1,500 / $4,500
Per Family	$4,500 / $13,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	70% / 30%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$55

Rates

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

Florida Blue

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EMPLOYER APPLICATION
(True Group Application)

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
Predictable Cost Plan 05770 - NSTD	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2019 - 12/31/2019

Deductible :

Per Person	$750 / $1,500
Per Family	$2,250 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$30
All Other Providers	$70

Rates

Employee	$1201.88	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1834.45
Spouse	$871.33	Child(ren)	$871.33	Spouse/Child(ren)	$871.33	Employee + 1	N/A

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No

(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA

NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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 Arrangements: Florida Blue: ANNUAL REFND NO SPEC STOP LOSS

HMO: Not Applicable

E. Rate Comments:

Florida Blue

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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 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. WINDES, CHAIRMAN

SEAL

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

Florida Blue

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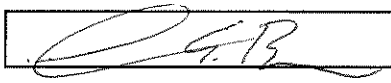
Blue Cross and Blue Shield Association

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.

CONTRACT, LEASE, AGREEMENT CONTROL FORM

Date: 08-03-2017

Contract/Lease Control #: C08-1608-RM

Bid #: NA

Contract/Lease Type: AGREEMENT

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: RM

Department Monitor: PORTOR

Monitor's Telephone #: 850-689-5977

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.

By: _____

Name: Joseph C. Gregor, Esq.

Title: Vice President, Commercial Segments

Date: 6/9/17

OKALOOSA COUNTY BOARD OF COUNTY COMMISSIONERS

By: _____

BOARD OF COUNTY COMMISSIONERS OF OKALOOSA COUNTY, FLORIDA SEAL

Name: Carolyn N. Ketchel
Printed

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	$861.53	$806.12	$760.49
Employee Family	$1,314.96	$1,230.41	$1,160.76
	Division Group B	Division Group B	Division Group B
Employee Only	$499.61	$467.65	$441.18
Employee Spouse	$999.26	$935.34	$882.40
Employee Family	$1,124.20	$1,052.28	$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 ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 41954 (Florida Blue HMO):

A. 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

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. 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

II. 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, shall be eligible for coverage upon the Effective Date of this Policy.

C. Specify classification of enrollees for whom coverage is being requested, if other than eligible employees as described in B above.

Eligibility - Full Time Employees - 1st of the Month 30 Days. Dept Heads - 1st of the Month following DOH
Eligibility - 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 misconduct 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 30 days of the date the individual first meets the applicable eligibility requirements.

E. 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.

F. 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 %

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

Florida Blue

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 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 & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☒ Single Plan ☐ Blue Packages

Health Plan Name		Rx Option *(indicate copayments)*	
BlueOptions Physician Copay Plan 03559 - Cust		**BlueScript Rx OOP Int $15/$50/$80C - NSTD**	
Benefit Period :	**01/01/2015 - 12/31/2015**	**Coinsurance:**	
Deductible :		In-Network / Participating	**80% / 20%**
Per Person	**$500 / $750**	Out-of-Network/Non-Participating	**60% / 40%**
Per Family	**$1,500 / $2,250**	**Office Visit Copay:**	
Pre-Existing	**N/A**	Family Physician	**$20**
Rates		All Other Providers	**$40**

Employee	**$812.76**	Employee/Spouse	**N/A**	Employee/Child(ren)	**N/A**	Family	**$1240.53**
Spouse	**$589.23**	Child(ren)	**$589.23**	Spouse/Child(ren)	**$589.23**	Employee + 1	**N/A**

Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueOptions Network Advantage Plans 03769 - Cust	BlueScript Rx OOP Int $15/$50/$80C - NSTD

Benefit Period : 01/01/2015 - 12/31/2015

Deductible :

Per Person	$500 / $1,500
Per Family	$1,500 / $4,500
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	50% / 50%

Office Visit Copay:

Family Physician	$25
All Other Providers	$60

Rates

Employee	$760.49	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1160.76
Spouse	$551.55	Child(ren)	$551.55	Spouse/Child(ren)	$551.55	Employee + 1	N/A

See the Group Master Policy for a complete description of benefits.

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? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

B. If Yes is selected above, which type of accounts are you choosing ☐ HSA ☐ HRA ☐ FSA
NOTE: Applicant must have elected an HSA compatible plan to be able to offer an HSA with preferred administrator.

V. Rate Information

A. Premium/Prepayment fee are payable monthly on or before the due date which will be: 1st

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 Arrangements: Florida Blue: ANNUAL REFND NO SPEC STOP LOSS
HMO: Not Applicable

E. Rate Comments:

Florida Blue

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. 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

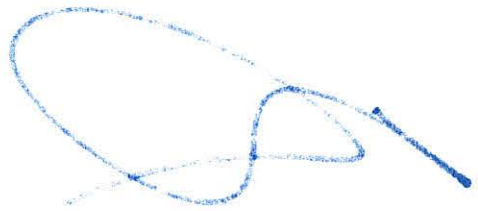
Issuance of the Policy by Florida Blue/Florida Blue HMO will be deemed acceptance of this application.

Date	Signature of Applicant	Print/Type Name & Title
8-18-15	Nathan D. Boyles, Chairman	Nathan D. Boyles, Chairman

Date	Florida Blue and/or Florida Blue HMO Licensed Agent (Print)
8/5/15	Dennis E. Barnes

Signature of Agent	Agent License Identification Number
	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**
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

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
Spouse Only	$589.23	$551.55
Child Only	$589.23	$551.55
Spouse Child	$589.23	$551.55
	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
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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
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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-~~PMI-87~~ RMA

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~~ 2009 2010 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

Contract/Lease Number: C12-1976-RM, C08-1681-RM, C09-1743-RM, C08-1608-RM, Tracking Number: 737-13

Contractor/Lessee Name: Symetra, BCBS, Lockard & Wilkens, BCBS ProShare, Grant Funded: YES ✓ NO ___

Purpose: Insurance Renewals for 2014

Date/Term: 9/30/2014

Amount: per rates

Department: Risk Management

Dept. Monitor Name: Gary Real

1. ☑ GREATER THAN $50,000
2. ☐ GREATER THAN $25,000
3. ☐ $25,000 OR LESS

Document has been reviewed and includes any attachments or exhibits.

Purchasing Review

Procurement requirements are met:

Purchasing Director or designee Date: 9/23/13

Risk Management Review

Approved as written:

Risk Manager or designee Date: 9/23/13

County Attorney Review

Approved as written:

County Attorney see attached faxed from Mr. Dowd. Date: 9/23/13

Following Okaloosa County approval:

Contracts & Grants

Document has been received:

Contracts & Grants Manager Date: 12/31/13

CONTRACT & LEASE INTERNAL COORDINATION SHEET

Contract/Lease Number: C12-1976-Rm, C08-1685-Rm, C08-1603-Rm, C08-1608-Rm, Blue Medicare C14-2126-Rm
Tracking Number: 247/13
Contractor/Lessee Name: Symetra, BCBS, Oakland Walker, BCBS Prostar,
Grant Funded: YES ✓ NO

Purpose: Insurance Renewals for 2014

Date/Term: 9/30/2014

Amount: per rates

Department: Risk Management

Dept. Monitor Name: Gary Neal

1. [✓] GREATER THAN $50,000
2. [ ] GREATER THAN $25,000
3. [ ] $25,000 OR LESS

Document has been reviewed and includes any attachment's or exhibits.

Purchasing Review

Procurement requirements are met.

Purchasing Director or designee

Date: 9/23/13

Risk Management Review

Approved as written.

Risk Manager or designee

Date: 9/23/13

County Attorney Review

Approved as written to legal sufficiency.

County Attorney

Date: 9/23/13

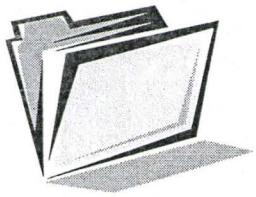
Following Okaloosa County approval.

Contracts & Grants

Document has been received.

Contracts & Grants Manager

Date



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

(850) 651-7200, ext 4381

MEMORANDUM

From ~~TO:~~ ~~Jack Allen~~, Jo Kublik
Purchasing ~~Manager~~

TO ~~FROM:~~ ~~Brenda L. Bailey~~, Gary Real RM
~~Contracts & Grants Manager~~

C08-1608-RM
Blue Cross / Blue Shield
Proshare

DATE: ~~September 26, 2013~~ 10/4/13

RE: **BCC Meeting Date: August 6, 2013**

The Okaloosa County Board of Commissioners has approved the attached document(s) on the date specified above. The documents are being returned for the following 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
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.

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.

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. 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	Name (typed) DON R. AMUNDS
Vice President and Chief Underwriting Officer	Title CHAIRMAN
Date 11/26/13	Date 9-18-13

Sent to J.T 5.25

EXHIBIT D

CONTRACT & LEASE INTERNAL COORDINATION SHEET

Contract/Lease Number: C08-1628 RM Tracking Number: 290-11

Contractor/Lessee Name: Blue Cross Blue Shield

Purpose: Proshare Plus Agreement

Date/Term: 9/30/2013 / Accounting Period

Amount: _____

Department: RM

Dept. Monitor Name: J. Taylor

1. ☑ GREATER THAN $50,000
2. ☐ GREATER THAN $25,001
3. ☐ $25,000 OR LESS

Purchasing Review

Procurement requirements are met: _____ Date: 5/9/11

Contracts & Lease Coordinator

Risk Management Review

Approved as written: _____ Date: 5/9/11

Risk Management Director

County Attorney Review

Approved as written: _____ Date: 5/24/11

County Attorney

Following Okaloosa County approval:

Contract & Grant

Document has been received: _____ Date: _____

Contracts & Grants Manager

5-24-11

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**	
By		**By**	
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:

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 CROSS AND BLUE SHIELD OF FLORIDA, INC.		**OKALOOSA COUNTY BOARD OF COUNTY COMMISSIONERS**
By		**By**
Name	William Coats	**Name** James Campbell (Typed)
Title	Vice President and Chief Underwriting Officer	**Title** Chairman
Date	12/19/07	**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				
Employee Only	$521.52 ~~$522.89~~	$303.48		$379.39
Employee & One		$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	$150,000 Per Individual
Charge	2.6 % Of Earned Premium