



MEMORANDUM

Business & Finance Services

William V. Husfelt III, Superintendent | Jim Loyed, Chief Financial Officer

TO: Prospective Proposers

FROM: Dan Fuller, GM of Purchasing, Contracting & Materials Mgmt

DATE: February 5, 2019

RE: RFP #19-04 – Employee Benefits Consulting Services
ADDENDUM NO. 1

Addendum for RFP #19-04 – Employee Benefits Consulting Services, is amended in the following particulars and in these particulars only. All provisions of the original documents shall remain in force, except as specifically modified or changed herein or by other Addendum issued by Bay District Schools. This Addendum is hereby made part of the proposal documents.

This Addendum addresses questions from Proposers and clarification. All proposers are responsible for receiving and reading Addendums. All Addendums will be posted at <http://www.bay.k12.fl.us/bids>.

Q&A's:

Q 1. Will exhibits be forthcoming?

Answer No. Reference to exhibits was a typo and should have been deleted prior to posting.

Q 2. Who is the current consultant?

Answer Fisher, Brown, Bottrell Insurance, Inc. Destin FL.

Q 3. How many years has your current consultant been working with the school district?

Answer Five years.

Q 4. Is your current consultant also the agent or broker of record for any of the employer paid or employee paid benefits such as on the health & prescriptions plan's stop-loss insurance or supplemental voluntary group life?

Answer No.

Q 5. Would the school district like to see fees for services as an amount Per Employee Per Month (PEPM) for the different benefits and/or services?

Answer Yes.

Q 6. Are Voluntary Benefits included in the services requested and does The School District know whether commissions, bonuses or other forms of compensation are being paid by

the insurance carrier or not?

Answer Voluntary benefits are included in the benefits package offered to employees. The District is not aware of commissions paid to the consultant.

Q 7. Does the school district know the current consultant's total fees and compensation for all benefits (group life, voluntary life, dental, vision, ASO fees for medical and dental, wellness and any other supplemental voluntary employee paid benefits)?

Answer Contract states the District will pay \$75,000 annually in quarterly increments of \$18,750.

Q 8. What is the current total annual fees and compensation paid by the school district and insurance carriers to your current agent? Would the District consider using commissions to cover any of the cost of providing consulting fees at a future date?

Answer Contract states the District will pay \$75,000 annually in quarterly increments of \$18,750. The District is not aware if the contractor is receiving additional commissions.

Q 9. Would the school district consider having a separate consultant who specializes in self-funding and stop-loss for your health & prescription plan?

Answer It could be considered by the committee.

Q 10. Under Section 6 - Scope of Services and Specifications - response
Page 17 of 24: Are you looking for us to answer in writing, provide documentation or are you just outlining what your expectations are for the consultant? Are you requesting sample reports to be included for committee's review?

Answer Yes, answer in writing the ability to meet the District expectations. Sample reports are desired but not required.

Q 11. Are group life, disability, voluntary life, voluntary disability & worksite benefits included in the scope of work?
If so, does the consultant earn commissions from that those benefit lines or are those net of commission?

Answer Yes, included in the SOW. The District is not aware of any commissions paid to the consultant.

Q 12. Does the scope of work include hosting & management of the benefit administration/online enrollment system?

Answer The committee would take that into consideration if available.

Q 13. Is consultation for the school board health clinic is within the scope of work?

Answer Yes.

Q 14. Section 6. – 6.1A. – The ten times annually to meet with the Director and Benefits Committee – are all the meetings to be in person or may some be facilitated by phone/WebEx conference?

Answer All meetings have been in person in the past. The committee is open to discussion and review to new possibilities if it is in the Districts best interests.

Q 15. Section 6. – 6.1.I. – what is the acronym ECSD stand for?

Answer Error in RFP draft. Should read SBBC. School Board of Bay County.

Q 16. Would the District entertain language that clarifies that the successful bidder may rely on the data provided by the District and is not responsible for data clean-up or inaccurate data?

Answer Yes.

Q 17. Would the County entertain language that sets out a limitation of liability on asserted negligence or breach of contract, without limiting gross negligence or willful misconduct, to a mutually agreed amount?

Answer Yes.

Q 18. Would the County entertain language that clarifies that the indemnity is solely triggered when a claim from a non-party arises against the County that is due to the successful bidder's fault?

Answer Yes.

Q 19. Would the District entertain language clarifying that the insurance could be edited?

Answer Yes, the committee is open to discussion.

Q 20. Would the District be interested in alternate pricing structures in addition to the requested cost proposal that would lead to cost/fee savings?

Answer Yes.

Q 21. The RFP mentions Medicare Part D studies in Section 6. – 6.1G. – In reading the annual financial report it seems that the County provides a pre-Medicare implicit

subsidy to retirees by blending the premium rates with active employees. Can you confirm that a Medicare part D attestation is not required?

Answer Yes.

Q 22. Please provide a copy of the most recent GASB 75 OPEB valuation report.

Answer See attached.

Q 23. Please provide a copy of the most recent annual actuarial report to be filed with the Department of Insurance.

Answer See attached.

Q 24. Are any retirees included in these services? If so, please provide the number of retirees to be included?

Answer Bay District retirees are eligible to retain health, dental, life and vision coverage after retirement. Current participation numbers are as follows: Health – 282, Dental – 679, Vision – 577.

Q 25. Does the current Benefits Consultant meet the local office preference of section 3.16; if so, at what level?

Answer Yes, local office in excess of 6 months and holds business license in Bay County.

Q 26. How important is it to the District that the Benefits Consultant work out of a local office?

Answer It can be discussed based on best interests of the District.

Q 27. What is the fee structure in place with the current Benefits Consultant? Can you provide a copy of the existing contract?

Answer Contract states the District will pay \$75,000 annually in quarterly increments of \$18,750. The District is not aware if the contractor is receiving additional commissions.

Q 28. The RFP specifies “the benefits package that includes medical, dental, vision, life insurance, a flexible spending plan tax sheltered annuity (TSA) and a District employee wellness center. Please clarify the following:

- a. Are there any additional supplemental benefits, such as long-term disability, short-term disability, cancer, accident, etc. that would be**

- included in these services? If so, what is the expected compensation for these services? Does the District expect consultative services of the TSA be provided or administrative services of the TSA be provided?
- b. What services are expected regarding the employee wellness center?

Answer Additional supplemental benefits are available (LTD, STD, Accident, Cancer, Critical Illness). The District pays consultant based upon contract fee and no additional commissions should be paid. The District is open to discussion of capability to provide TSA or administrative services in the best interest of the District however this is not part of the services to be requested. The consultant is expected to provide expert advice to all District benefits programs related to insurance and wellness.

Q 29. Is the current online enrollment/benefit administration system in place Benefit Connector?

- a. Is it meeting the needs of the District satisfactorily?
- b. Would the District like to see a new system implemented?
- c. Does it handle both online, year round enrollment (new hires, annual enrollment and CIS) and benefit administration interface with carriers?
 - i. Is it used by all Active employees?
 - ii. Is it used by Retirees?
 - iii. If not, please identify which employee/retiree groups it does not serve?

Answer The District does currently utilize Benefit Connector which is the online enrollment system operated by Triune Technologies. A. Yes, it does serve our current needs and we have been utilizing this system since October 2010. B. We would entertain the possibility of other systems that serve our requirements or offer cost saving opportunities. C. Yes, current system handles new hire situation, open enrollment and qualifying event situations. Yes, it is integrated with the various carriers. Weekly files are sent to carriers with coverage additions or changes. All benefit eligible groups are contained in the enrollment platform.

Q 30. Please identify your benefit plan year and describe your current enrollment process and timeframe?

Answer Plan year is January to December. Open enrollment is held during the month of November and can be performed in person or online. New hires have thirty (30) calendar days from date of hire to make new hire elections. Coverage starts date of hire.

Q 31. Does the current Benefits Consultant cover the cost of:

- a. The online enrollment/ben admin system?
- b. The production and delivery of communication booklets/materials to actives and/or retirees?
- c. FSA administration or other services, i.e. ACA reporting?

Answer No.

Q 32. Is it the expectation of the District that the awarded Benefits Consultant would cover the costs of the items listed in question #31?

Answer No.

Q 33. In addition to Health Care Reform, what other compliance services is the District seeking?

Answer Consultation and advice to meet compliance requirements. As requested file appropriate documentation.

Q 34. Is your current Benefits Consultant providing the same services as listed in the Scope of Services of this RFP and is the District satisfied with the services being provided?

Answer Yes, they are providing the same services at this time. The District defers answering part two of the question.

Q 35. Are there key drivers to this RFP other than what you have outlined, such as significant benefit changes or major benefit initiatives?

Answer No.

Q 36. Please confirm the plan year and contract years for all types of insurance intended in the services for this RFP.

Answer Calendar year for all types.

Q 37. Is it expected the awarded Benefits Consultant file the Medicare Part D and the GASB 45 (OPEB) or only provide the necessary information and the annual actuarial analysis?

Answer Not currently performed by the consultant however District would entertain this possibility.

Q 38. Please provide the current agreement and annual cost of the incumbent insurance consultant as well as any other relationships involved with the benefits plan including stop loss, ancillary coverages and enrollment system?

Answer Consultant \$75,000 annually, Enrollment System \$168,000 annually, Stop Loss \$1.4 million

Q 39 Please have Florida Blue confirm all compensation that they are paying to all consultants and/or agents associated with Bay Schools' benefit program.

Answer Contract states the District will pay \$75,000 annually in quarterly increments of \$18,750. The District is not aware if the contractor is receiving additional commissions.

Q40. Who collects commissions from the Voluntary Plans offered and are they included as part of the consulting fees?

Answer Contract states the District will pay \$75,000 annually in quarterly increments of \$18,750. The District is not aware if the contractor is receiving additional commissions.

Q41. The RFP contained no details on the plans offered. Please provide benefit summaries of all available plan offerings and state which ones are self-funded or fully insured.

Answer Benefit Summaries are attached. Health is self insured. Other products are fully insured.

Q42. Who is the current Stop Loss carrier and how many different carriers have you had in the past five years?

Answer US Fire Insurance Company is our current Stop Loss carrier. Four (4) carriers.

Q43. The School Board's website makes mention of an online enrollment system. Is the system provided by the current consultant? Is it paid for by the School Board and would any administration be part of the Scope of Work?

Answer Online enrollment system is not provided by current consultant. The District has contracted with Triune Technologies (Benefit Connector) for this service. Cost of this is paid by the District.

Q44. Section 3.9 Indemnification: The School Board asks that the contractor be responsible for any and all claims. Would the School Board be willing to accept that indemnification be limited to losses and damages as a result of our negligence and covered under the terms of our general liability policy; any wrongful acts solely in rendering or failing to render professional services and covered under our professional liability policy; or, any claim alleging a security failure, privacy event or wrongful act and covered under our cyber liability policy (misappropriation of trade secret or, infringement of patent are exclusions in our cyber policy)?

Answer The selection committee is open to discussion.

Q45. Section 3.14 – Insurance Requirements: Vendor’s insurers are not required to provide advance notice of cancellation/non-renewal via the terms of the policies, so Vendor cannot agree to provide 15 days prior notice to its clients. Rather, any canceled or non-renewed policy will be replaced with no coverage gap and a current Certificate of Insurance will be provided to the School Board. Is this acceptable to the School Board?

Answer The selection committee is open to discussion as long as terms are solidified within the final contract.

Q46. Section 3.15 Security: We work with a number school districts within the state of Florida and this provision has been waived or modified as we do not have direct access to students nor do we visit schools as part of the services performed.

Answer The RFP language for the Jessica Lumsford Act is boilerplate T&C. It is not anticipated that the consultant would be on school grounds except for District Offices. It is not anticipated that the consultant would have any contact with students without escort by District personnel.

Q47. Section 6.1 Scope of Work: The contract term is for one year with up to 4 additional renewals. Given the fact that a large amount of the requested work is performed in the prior year, would the School Board consider a two or three year initial contract with one year renewals which may provide improved pricing?

Answer No. The District is restricted by law to not commit beyond funding. Therefore, the District is limited to one year contract and renewable if funding is provided.

Q48. Section 6.1 Scope of Work - Item A, Analyze Current Benefit Design & Funding Arrangements: This section asked for unlimited actuarial support at no additional fee. This level of service potentially could be very broad and costly depending on the need. Can you be more specific in the types of actuarial services that you use in addition to the ones listed under Item G of this section?

Answer Only actuarial services listed are anticipated. Any additional actuarial information needed could be negotiated separately.

Q49. Page 20, Item 3 Monthly Trust Fund Report: Is the School Board’s Health Plan set up as a Trust? Please provide a copy of the Trust documents.

Answer No. Not applicable.

Q50. Section 6.1 Scope of Work – Item H: This section request that the consultant provide RFP services for self-insured medical plan, Stop Loss, Pharmacy and other services. Since these types of services usually occur once every few years, we routinely price these on an as needed basis. Would the School Board consider the pricing of these services on an as needed basis thereby reducing the School Board’s annual costs for core services?

Answer Yes the committee would consider it.

Due to delay in releasing this addendum, the RFP proposal due date will shift 24 hours to the right making the new due time 2:00 PM Feb 15 2019.

No other changes.

Proposers are asked to acknowledge receipt of this Addendum by signing in the space provided and return either separately or with their proposal response, no later than the opening date of February 15, 2019.

Firm/Signature of Proposer

Printed Name

Address

Telephone Number

City, State, Zip Code

e-mail address

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

Coverage for: Family | Plan Type: PPO

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at the previous web address or call 1-800-352-2583 to request a copy.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: <u>Deductible</u> / Independent Diagnostic Testing Center: <u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com/tools-resources/pharmacy/me	Generic drugs	<u>Deductible</u> + \$10 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$25 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	<u>Deductible</u> + \$30 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$75 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	<u>Deductible</u> + \$50 <u>Copay</u> per Prescription at retail,	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
dication-guide		<u>Deductible</u> + \$125 <u>Copay</u> per Prescription by mail		
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	<u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 40% <u>Coinsurance</u> / Hospital: <u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
	<u>Urgent care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> + 20% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40% <u>Coinsurance</u>	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	-----none-----

For more information about limitations and exceptions, see the [plan](#) or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	-----none-----
	Inpatient services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
	Childbirth/delivery facility services	<u>Deductible</u> + 20% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40% <u>Coinsurance</u>	-----none-----
If you need help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Coverage limited to 20 visits.
	<u>Rehabilitation services</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered
	<u>Skilled nursing care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Coverage limited to 60 days.
	<u>Durable medical equipment</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	<u>Hospice services</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	-----none-----
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the [plan](http://www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx) or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult)• <u>Habilitation services</u>	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Pediatric dental check-up• Pediatric eye exam	<ul style="list-style-type: none">• Pediatric glasses• Private-duty nursing• Routine eye care (Adult)• Routine foot care unless for treatment of diabetes• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Chiropractic care - Limited to 35 visits	<ul style="list-style-type: none">• Most coverage provided outside the United States. See www.floridablue.com.	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet Minimum Value Standards? [Yes / No]

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

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

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,000
- Specialist Coinsurance 20%
- Hospital (facility) Coinsurance 20%
- Other No Charge \$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,590

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$5,580

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

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

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

Florida Blue (including FEP members):

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

Florida Combined Life:

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

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

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

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

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

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

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

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

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

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

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

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-Ñpă ăĉĒÝ ĆáŌă æĉáÈĒă: 1) 3852-253-008-ăáæÙÉ: ÅĐÇ ßăÉ ÊĒİİĒ ÇĐßÑ ĆááÙÉĭ YĂă İİăĉĒ ĆăăŌÇŪİÉ ĆááÙæİÉ ÊĒæÇÝÑ áß ÈĉáăĭÇă. ÇĒŌă ÈÑpă 1 .ÇĒŌă ÈÑpă 1-008-333-7222 .0778-559-008

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

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

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

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

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000 000 [1-800-352-2583](tel:1-800-352-2583) (TTY: [1-800-955-8770](tel:1-800-955-8770)). FEP: 000 000 [1-800-333-2227](tel:1-800-333-2227)

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

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

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

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

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

Coverage for: Individual | Plan Type: PPO

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bay.k12.fl.us/hr/Benefits/CertificateofInsurance.aspx For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at the previous web address or call 1-800-352-2583 to request a copy.

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

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: <u>Deductible</u> / Independent Diagnostic Testing Center: <u>Deductible</u> +20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com/tols-resources/pharmacy/medication-guide	Generic drugs	<u>Deductible</u> + \$10 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$25 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	<u>Deductible</u> + \$30 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$75 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	<u>Deductible</u> + \$50 <u>Copay</u> per Prescription at retail, <u>Deductible</u> + \$125 <u>Copay</u> per Prescription by mail	In-Network <u>Deductible</u> + 50% <u>Coinsurance</u>	Up to 30 day supply for retail, 90 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	<u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 40% <u>Coinsurance</u> / Hospital: <u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
If you need immediate medical attention	<u>Emergency room care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
	<u>Urgent care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: <u>Deductible</u> + 20% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40% <u>Coinsurance</u>	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	-----none-----
	Inpatient services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)

For more information about limitations and exceptions, see the [plan](http://www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx) or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

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

For more information about limitations and exceptions, see the [plan](#) or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (Adult)• <u>Habilitation services</u>	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Pediatric dental check-up• Pediatric eye exam	<ul style="list-style-type: none">• Pediatric glasses• Private-duty nursing• Routine eye care (Adult)• Routine foot care unless for treatment of diabetes• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none">• Chiropractic care - Limited to 35 visits	<ul style="list-style-type: none">• Most coverage provided outside the United States. See www.floridablue.com.	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet Minimum Value Standards? [Yes / No]

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

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

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

About these Coverage Examples:



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

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

- The plan's overall deductible \$2,500
- Specialist Coinsurance 20%
- Hospital (facility) Coinsurance 20%
- Other No Charge \$0

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

Total Example Cost	\$12,800
In this example, Peg would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,390

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

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

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

Total Example Cost	\$7,400
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,760

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

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

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

Total Example Cost	\$1,900
In this example, Mia would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

Florida Blue (including FEP members):

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

Florida Combined Life:

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

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

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

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

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

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

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

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

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

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

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

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-Ñpã àÇÉÝ ÇáÕã æÇáÈËã: 1) 3852-253-008-ääáæÙÉ: ÅÐÇ ßäÉ ÊÊÏÏÈ ÇÐßÑ ÇááÙÉ; ÝÅä ÏïãÇÉ ÇáãÓÇÚÏÉ ÇááÙæíÉ ÊÊæÇÝÑ áß ÈÇáãìÇä. ÇÊÕá ÈÑpã 1 .ÇÊÕá ÈÑpã 1-008-333-7222 .0778-559-008

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

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

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

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

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000 000 [1-800-352-2583](tel:1-800-352-2583) (TTY: [1-800-955-8770](tel:1-800-955-8770)). FEP: 000 000 [1-800-333-2227](tel:1-800-333-2227)

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

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

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

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojjı' hodíłnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígıı éı kojı' hodíłnih 1-800-333-2227.

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

Coverage for: Individual and/or Family | **Plan Type:** PPO



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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage,

www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at the previous web address or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network</u> : \$2,000 Per Person. <u>Out-of-Network</u> : \$4,500 Per Person.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Yes. <u>In-Network</u> : \$6,350 Per Person/ \$12,700 Family. <u>Out-Of-Network</u> : \$20,000 Per Person/ \$20,000 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	\$50 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	No Charge	50% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: <u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	\$200 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied. Tests performed in hospitals may have higher cost-share.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com/tools-resources/pharmacy/me	Generic drugs	\$10 <u>Copay</u> per Prescription at retail, \$25 <u>Copay</u> per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	20% <u>Coinsurance</u>	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	<u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dication-guide				
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: <u>Deductible</u> + 30% <u>Coinsurance</u> / Hospital Option 1: \$300 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 30% <u>Coinsurance</u>	Ambulatory Surgical Center: <u>Deductible</u> + 50% <u>Coinsurance</u> / Hospital: <u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	————none————
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>Copay</u> per Visit	\$200 <u>Copay</u> per Visit	————none————
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	————none————
	<u>Urgent care</u>	\$60 <u>Copay</u> per Visit	<u>Deductible</u> + \$60 <u>Copay</u> per Visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Option 1: \$1,500 <u>Copay</u> per Admission	<u>Deductible</u> + 50% <u>Coinsurance</u>	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost-share.
	Physician/surgeon fees	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	50% <u>Coinsurance</u>	————none————
	Inpatient services	No Charge	<u>Physician Services</u> : No Charge/ Hospital: 50% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	\$50 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>In-Network Deductible</u> + 30% <u>Coinsurance</u>	————none————
	Childbirth/delivery facility	Option 1: \$1,500 <u>Copay</u>	<u>Deductible</u> + 50%	Option 2 hospitals may have a higher cost-

For more information about limitations and exceptions, see the [plan](#) or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services	per Admission	Coinsurance	share.
If you need help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 10 visits.
	<u>Rehabilitation services</u>	\$50 <u>Copay</u> per Visit	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 25 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered
	<u>Skilled nursing care</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Coverage limited to 60 days.
	<u>Durable medical equipment</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	<u>Hospice services</u>	<u>Deductible</u> + 30% <u>Coinsurance</u>	<u>Deductible</u> + 50% <u>Coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • <u>Habilitation services</u> • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-preferred brand drugs • Pediatric dental check-up • Pediatric eye exam 	<ul style="list-style-type: none"> • Pediatric glasses • Private-duty nursing • Routine eye care (Adult) • Routine foot care unless for treatment of diabetes • Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

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

- Chiropractic care - Limited to 25 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet Minimum Value Standards? [Yes / No]

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

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist Copayment</u>	\$50
■ Hospital (facility) <u>Copayment</u>	\$1,500
■ Other <u>No Charge</u>	\$0

This **EXAMPLE** event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$200
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,760

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist Copayment</u>	\$50
■ Hospital (facility) <u>Copayment</u>	\$1,500
■ Other <u>Coinsurance</u>	30%

This **EXAMPLE** event includes services like:

Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$1,100
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,860

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist Copayment</u>	\$50
■ Hospital (facility) <u>Copayment</u>	\$1,500
■ Other <u>Copayment</u>	\$200

This **EXAMPLE** event includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,100
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

Florida Blue (including FEP members):

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

Florida Combined Life:

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

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

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

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

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

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

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

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

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

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

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

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

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

Coverage for: Individual and/or Family | **Plan Type:** PPO

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at the previous web address or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network: \$500 Per Person/\$1,500 Family. Out-of-Network: Combined with In-Network.</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care.</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. <u>\$300 Out-of-Network Per Admission Deductible.</u> There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. <u>In-Network: \$2,000 Per Person/\$6,000 Family. Out-Of-Network: Combined with In-Network.</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium, balance-billed charges, and health care this plan doesn't cover.</u>	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>Copay</u> per Visit	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Specialist</u> visit	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares.
	<u>Preventive care/screening/immunization</u>	\$20 <u>Copay</u> per Visit	40% <u>Coinsurance</u>	Physician administered drugs may have higher cost shares. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Clinical Lab: 20% <u>Coinsurance</u> / Independent Diagnostic Testing Center: <u>Deductible</u> + 20% <u>Coinsurance</u>	Independent Clinical Lab: 40% <u>Coinsurance</u> / Independent Diagnostic Testing Center: <u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share.
	Imaging (CT/PET scans, MRIs)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Tests performed in hospitals may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.floridablue.com/tols-resources/pharmacy/me	Generic drugs	<u>Deductible</u> + 20% <u>Coinsurance</u> at retail, \$14 <u>Copay</u> per Prescription by mail	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	Up to 31 day supply for retail. 93 day supply for mail order. See Medication guide for more information.
	Preferred brand drugs	<u>Deductible</u> + 20% <u>Coinsurance</u> at retail, \$28 <u>Copay</u> per Prescription by mail	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	Up to 31 day supply for retail, 93 day supply for mail order.
	Non-preferred brand drugs	<u>Deductible</u> + 20% <u>Coinsurance</u> at retail, \$28 <u>Copay</u> per	<u>In-Network Deductible</u> + 20% <u>Coinsurance</u>	Up to 31 day supply for retail, 93 day supply for mail order.

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dication-guide		Prescription by mail		
	<u>Specialty drugs</u>	<u>Specialty drugs</u> are subject to the cost share based on applicable drug tier.	<u>Specialty drugs</u> are subject to the cost share based on the applicable drug tier.	Up to 31 day supply for retail, 93 day supply for mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	————none————
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	————none————
If you need immediate medical attention	<u>Emergency room care</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	————none————
	<u>Emergency medical transportation</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 20% <u>Coinsurance</u>	————none————
	<u>Urgent care</u>	\$20 <u>Copay</u> per Visit	<u>Deductible</u> + \$20 <u>Copay</u> per Visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Deductible</u> + 20% <u>Coinsurance</u>	Per Admission <u>Deductible</u> + <u>Deductible</u> + 40% <u>Coinsurance</u>	Not Covered
	Physician/surgeon fees	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	40% <u>Coinsurance</u>	————none————
	Inpatient services	No Charge	<u>Physician Services</u> : No Charge/ Hospital: 40% <u>Coinsurance</u>	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	<u>Deductible</u> + 20% <u>Coinsurance</u>	<u>Deductible</u> + 40% <u>Coinsurance</u>	————none————
	Childbirth/delivery facility	<u>Deductible</u> + 20%	Per Admission <u>Deductible</u> +	————none————

For more information about limitations and exceptions, see the [plan](#) or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	services	<u>Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Coverage limited to 20 visits.
	<u>Rehabilitation services</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost-share. Prior Authorization may be required. Your benefits/services may be denied.
	<u>Habilitation services</u>	Not Covered	Not Covered	Not Covered
	<u>Skilled nursing care</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Coverage limited to 60 days.
	<u>Durable medical equipment</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of <u>DME</u> due to use/age.
	<u>Hospice services</u>	<u>Deductible + 20% Coinsurance</u>	<u>Deductible + 40% Coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • <u>Habilitation services</u> 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Pediatric dental check-up • Pediatric eye exam 	<ul style="list-style-type: none"> • Pediatric glasses • Private-duty nursing • Routine eye care (Adult) • Routine foot care unless for treatment of diabetes • Weight loss programs

For more information about limitations and exceptions, see the plan or policy document at www.bay.k12.fl.us/hr/Benefits/CertificatesofInsurance.aspx

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

- Chiropractic care - Limited to 35 visits
- Most coverage provided outside the United States. See www.floridablue.com.
- Non-emergency care when traveling outside the U.S.

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet Minimum Value Standards? [Yes / No]

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

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

About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist Coinsurance</u>	20%
■ <u>Hospital (facility) Coinsurance</u>	20%
■ <u>Other Coinsurance</u>	20%

This **EXAMPLE** event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,090

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist Coinsurance</u>	20%
■ <u>Hospital (facility) Coinsurance</u>	20%
■ <u>Other Coinsurance</u>	20%

This **EXAMPLE** event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$1,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,960

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$500
■ <u>Specialist Coinsurance</u>	20%
■ <u>Hospital (facility) Coinsurance</u>	20%
■ <u>Other Coinsurance</u>	20%

This **EXAMPLE** event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

Florida Blue (including FEP members):

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

Florida Combined Life:

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

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

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019

1-800-537-7697 (TDD)

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

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

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

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

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

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

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

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

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

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

-Ñpă ăĉĒÝ ĆáŌă æĉăÈĒă: 1) 3852-253-008-ăăáæÙÉ: ÅĐÇ ßăÉ ÊĒİİĒ ÇĐßÑ ĆááÙÉĭ YĂă İİăĉĒ ĆăăŌĉŪİĒ ĆááÙæİÉ ÊĒæĉÝÑ áß Èĉăăİĉă. ĆĒŌă ÈÑpă 1 .ĆĒŌă ÈÑpă 1-008-333-7222 .0778-559-008

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

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

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

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

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

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

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

Baa ákonínzin: Diné bizaad bee yáníłti'go, saad bee áká anáwo', t'áá jíík'eh, ná hóló. Kojjı' hodíłnih 1-800-352-2583 (TTY: 1-800-955-8770). FEP ígıı éı kojjı' hodíłnih 1-800-333-2227.

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David L. Shaub, FSA
Direct Line: (615) 665-5309
Fax: (615) 665-1650
Email: David.Shaub@findley.com

August 17, 2018

Tracy Smith
Risk Manager
Bay County School Board
1311 Balboa Avenue
Panama City, FL 32401

Dear Tracy:

The attached report summarizes the results of an actuarial valuation as of June 30, 2018 for Bay County School Board Postemployment Benefits Other than Pensions. We trust this report will be helpful in the formulation of policy with respect to the operation and financing of the plan.

The opportunity to serve Bay County School Board is appreciated, and we will be pleased to supplement this report in any way, as you request.

The actuarial valuation summarized in this report has been performed utilizing generally accepted actuarial principles and is based on actuarial assumptions, each of which is considered to be reasonable taking into account the experience of the plan and which, in combination, represent a best estimate of the anticipated experience of the plan.

Sincerely,

David L. Shaub, FSA
Managing Consultant

Chris Johnson
Actuarial Analyst



Bay County School Board Postemployment Benefits Other than Pensions

GASB Statement No. 74 and No.75
Actuarial Report

June 30, 2018

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Certification

Legislative background

Statement No. 43 of the Governmental Accounting Standards Board was amended by Statement No. 74 of the Governmental Accounting Standards Board. Statement No. 74 became effective for the plan's financial statements for the fiscal year beginning after June 15, 2016. Statement No. 74 establishes financial reporting standards for state and local government OPEB plans that are administered through trusts or equivalent arrangements. The purpose of this report is to provide pertinent GASB Statement No. 74 information relating to the Bay County School Board Postemployment Benefits Other than Pensions for the fiscal year ending June 30, 2018 and June 30, 2019.

The Governmental Accounting Standards Board amended Statement No. 45 with Statement No. 75; the effective date for Statement No. 75 is for the fiscal year beginning after June 15, 2017. Statement No. 75 of the Governmental Accounting Standards Board requires the determination of the OPEB expense for the fiscal year beginning July 1, 2017. Statement No. 75 provides a new approach in calculating the pension expense which differs significantly from Statement No. 45 methodology. The purpose of this report is to provide pertinent GASB Statement No. 75 information relating to the Bay County School Board Postemployment Benefits Other than Pensions for the fiscal year ending June 30, 2018 and June 30, 2019 financial statements.

Purpose and use

This report has been prepared exclusively for the Bay County School Board. Actuarial computations under Statements No. 74 and No. 75 are for purposes of fulfilling employer and other post-employment benefit plan governmental accounting requirements, and may not be appropriate for other purposes. The calculations reported herein have been made on a basis consistent with our understanding of the statements. Findley is not responsible for consequences resulting from the use of any part of this report without prior authorization or approval. This report provides actuarial advice and does not constitute legal, accounting, tax or investment advice. Determinations for other purposes, such as funding, bond ratings, or judging benefit security, may be significantly different from the results shown in this report.

Actuarial findings in this report are based on actuarial assumptions selected by Bay County School Board which reflect expected plan experience. Although the deviation of the actual future plan experience and the expected experience inherently creates some uncertainty with the results, in our opinion the actuarial assumptions reasonably reflect the expected future experience of the plan. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the plan's funded status); and changes in plan provisions or applicable law. All of these factors can result in the risk of volatility in the Net OPEB Liability over time.

Data

The calculations shown in this report have been prepared using employee data and plan documentation furnished by Bay County School Board as of July 1, 2018. While we have not audited the data, we have reviewed it for reasonableness and internal consistency, and to the best of our knowledge, there are no material limitations to the data provided. Summaries of the census data and plan provisions can be found in the Basis for Valuation section of this report.

Subsequent events

We are unaware of any subsequent event after July 1, 2018 which would have a material effect on the results presented in this report.

Assumptions, methods, and procedures

The results presented in this report comply with the assumptions, methods, and procedures under the Statements No. 74 and No. 75. For Statement 74, the results are based on the July 1, 2018 actuarial valuation date with measurement dates of June 30, 2018 and June 30, 2019, and reporting dates of June 30, 2018 and June 30, 2019. For Statement 75, the results are based on the June 30, 2018 actuarial valuation with measurement dates of June 30, 2018 and June 30, 2019, and reporting dates of June 30, 2018 and June 30, 2019. All actuarial assumptions are set by the plan sponsor. Statements No. 74 and No. 75 mandate the use of the Entry Age Normal actuarial funding method for the purposes of those statements. For a description of the June 30, 2017 assumptions, methods, and procedures, please refer to the June 30, 2017 GASB report.

Changes in plan provisions, actuarial assumptions, and actuarial methods

The following changes were made to the actuarial assumptions and methods effective July 1, 2018.

1. The discount rate is 2.98% based on the S&P Municipal Bond 20 Year High Grade Rate Index as of June 30, 2018, compared to the prior Statement No. 45 discount rate of 4.5%.
2. The mortality rates were updated using mortality improvement scale MP-2017, compared to MP2015.
3. The health care cost trend rate was updated to 8.0% degrading uniformly to 5.0% over a 10 year period.

Summaries of the plan provisions, actuarial assumptions and methods can be found in the basis for valuation section of this report.

Professional qualifications

This report has been prepared under the supervision of David L. Shaub, FSA, a member of the American Academy of Actuaries, a Fellow of the Society of Actuaries, and a consulting actuary with Findley, who has met the Qualification Standards of the American Academy of Actuaries to render the actuarial opinions herein. To the best of our knowledge this report has been prepared in accordance with generally accepted actuarial standards and our understanding of Government Accounting Standards Board Statements No. 74 and No. 75, including the overall appropriateness of the analysis, assumptions, and results and conforms to appropriate Standards of Practice as promulgated from time to time by the Actuarial Standards Board, which standards form the basis for the actuarial report. We are not aware of any direct or material indirect financial interest or relationship that could create, or appear to create, a conflict of interest that would impair the objectivity of our work. The undersigned is available to provide supplemental information or explanation.

David L. Shaub, FSA
Managing Consultant

Date

Basis of Valuation

Summary of provisions of the plan

Plan year

Twelve-month period beginning on July 1 and ending June 30th

Retirement eligibility

- Employees hired prior to July 1, 2011 require the completion of 6 year of service to eligible for benefits.
- Employees hired after July 1, 2011 require the completion of 8 years of service to be eligible for benefits.

Dependent coverage

Dependent coverage was assumed if the active or retired participant currently has chosen couple or family coverage. Surviving spouses are eligible for coverage under the plan.

Summary of actuarial assumptions

Sample Values per 1,000 Lives

Attained Age

20 35 50 60

Mortality rates

RP 2014 Total Dataset Mortality Table Projected with Scale MP-2017

Male (Pre-Commencement)	.385	.604	1.684	8.793
Male (Post-Commencement)	.385	.604	4.059	11.700
Female (Pre-Commencement)	.168	.328	1.089	3.900
Female (Post-Commencement)	.168	.328	2.735	8.492

The RP-2014 Total Dataset Mortality Table was projected back to 2006 with scale MP-2014 and then forward using scale MP-2017. Rates for year 2018 are illustrated here.

Disability rates

Estimated Experience	1.00	1.00	10.10	10.80
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Withdrawal rates

Estimated Experience (1st Year Select)	510.50	491.50	413.50	327.50
Estimated Experience (2nd Year Select)	140.80	137.40	123.00	105.90
Estimated Experience (Ultimate)	105.60	59.80	38.40	31.30

Retirement rates

Age	Percent
55	20%
56 - 58	5%
59 - 61	10%
62	25%
63 - 64	5%
65	100%

Discount rate

2.98% per annum

Salary increases

4.00% per annum

Expected long-term rate of return on plan assets

Not applicable

Plan participation

40% of future eligible retirees are assumed to elect medical coverage upon retirement.

Marital status

Actual spouse participation was based on the census data and males were assumed to be three years older than female spouses.

Medical claims cost

	Annual Cost
Retiree / Spouse	\$ 13,768

Age variance

Claims were adjusted downward 3.0% each year for aging from attained ages 65 to 55.

Healthcare cost trend rate

Medical: 8.00% graded uniformly down to 5.00% over 10 years

Administrative expenses

Administrative expenses for the medical plan were assumed to be in the per capita claims cost for both pre-65 and post-65 coverage.

Retiree contributions – medical plan

For valuation purposes, contributions have been limited to the per capita claims amount when applicable and are assumed to increase at the health care cost trend rate.

	Annual Contribution
Retiree	\$ 8,743
Spouse	\$ 9,247

Valuation date

July 1, 2018

Actuarial valuation method

Entry Age Normal - A method under which the actuarial value of the projected benefits of each individual included in the actuarial valuation is allocated on a level basis over the earnings of the individual between entry age and assumed exit age(s).

Asset valuation method

Not applicable

Funding policy

The benefits of the Bay County School Board Postemployment Benefits Other than Pensions are funded on a pay-as-you-go basis. The company funds on a cash basis as benefits are paid. No assets have been segregated and restricted to provide for postretirement benefits.

Coordination with Medicare

Benefits for retirees are deemed to be similar to those benefits provided for actives. The retiree medical plan is assumed to be the primary plan of benefits prior to age 65. It is assumed to pay benefits secondary to Medicare after attaining age 65 or after permanent disability.

Amortization period

For Statement 75 contribution calculations: 20 years (closed) beginning July 1, 2017

For Statement No. 75: Experience gains or losses are amortized over the average working lifetime of all participants which for the current period is 6.5 years. Plan amendments are recognized immediately. Investment gains or losses are amortized over a 5 year period. Changes in actuarial assumptions are amortized over the average working lifetime of all participants.

Legislative changes

The valuation results provided in this report reflect a best estimate of the potential impact of the Patient Protection and Affordable Care Act (PPACA). Consideration has been made for provisions of the law that are effective as of the valuation date as well as those provisions that will take effect in the future.

In particular, the anticipated future excise tax has been valued and deemed immaterial.

Summary of Participant Data

Data as of June 30, 2018

Number of Participants	
Actives (covered)	2,227
Actives (not covered)	0
Retirees (covered)	201
Disabled's (covered)	0
Retiree Spouses and Beneficiaries (Covered)	0

Actuarially determined contribution

	Fiscal year beginning July 1, 2018	Fiscal year beginning July 1, 2019
Total OPEB Liability	\$ 5,075,461	\$ 5,296,857
Plan Fiduciary Net Position	\$ -	\$ -
Net OPEB Liability	<u>\$ 5,075,461</u>	<u>\$ 5,296,857</u>
Years of Amortization	19	18
Amortization Payment	\$ 343,475	\$ 373,351
Normal Cost	\$ 517,021	\$ 542,872
Interest	<u>\$ 12,727</u>	<u>\$ 13,552</u>
Actuarially Determined Contribution	<u>\$ 873,223</u>	<u>\$ 929,775</u>

GASB Disclosure

GASB statement No. 75

This section presents specific information required under Statement No. 75 which is not included in other sections of this report. The information in this section is to satisfy the reporting for the plan sponsor. This section contains the following:

- Schedule of changes in OPEB liability
- OPEB expense
- OPEB Liability healthcare cost trend rate and discount rate sensitivity
- Deferred outflows and inflows of resources
- Schedule of changes in OPEB Liability and reconciliation between years
- Schedule of Contributions

Total OPEB Liability is the plan liability determined using assumptions listed in the Summary of Actuarial Assumptions.

Schedule of changes in net OPEB liability, deferrals, and OPEB Expense

	Increase (Decrease)					
	Total OPEB Liability (a)	Plan Net Position (b)	Net OPEB Liability (a) - (b)	Deferred Outflows of Resources	Deferred Inflows of Resources	OPEB Expense
Balances—at 06/30/2017	\$4,851,840	\$0	\$4,851,840	\$0	\$0	
Changes for the Year:						
Service cost	492,401		492,401			492,401
Interest	146,872		146,872			146,872
Benefit changes	0		0			
Experience losses (gains)	0		0	0	0	0
Changes of assumptions	0		0		0	0
Contributions--Employer		415,652	(415,652)			
Contributions--members		0	0			0
Net investment income		0	0			
Expected return on plan investments						0
Current expense of asset gain/loss						0
Non expensed asset (gain)/loss				0	0	
Refunds of contributions		0	0			
Benefits paid	(415,652)	(415,652)	0			
Administrative expenses		0	0			0
Recognition of Prior Post-measurement Contribution				0		
Post-measurement Contribution				0		
Other changes		0	0			
Amortization of or change in beginning balances				0	0	0
Net Changes	<u>223,621</u>	<u>0</u>	<u>223,621</u>	<u>0</u>	<u>0</u>	<u>639,273</u>
Balances—at 06/30/2018	<u>\$5,075,461</u>	<u>\$0</u>	<u>\$5,075,461</u>	<u>\$0</u>	<u>\$0</u>	<u>\$639,273</u>

**Bay County School Board Postemployment Benefits Other than Pensions
July 1, 2018**

	Increase (Decrease)					
	Total OPEB Liability	Plan Net Position	Net OPEB Liability	Deferred Outflows of Resources	Deferred Inflows of Resources	OPEB Expense
	(a)	(b)	(a) - (b)			
Balances—at 06/30/2018	\$5,075,461	\$0	\$5,075,461	\$0	\$0	
Changes for the Year:						
Service cost	517,021		517,021			517,021
Interest	153,279		153,279			153,279
Benefit changes	0		0			
Experience losses (gains)	0		0	0	0	0
Changes of assumptions	0		0		0	0
Contributions—Employer		448,904	(448,904)			
Contributions—members		0	0			0
Net investment income		0	0			
Expected return on plan investments						0
Current expense of asset gain/loss						0
Non expensed asset (gain)/loss				0	0	
Refunds of contributions		0	0			
Benefits paid	(448,904)	(448,904)	0			
Administrative expenses		0	0			0
Recognition of Prior Post-measurement Contribution				0		
Post-measurement Contribution				0		
Other changes		0	0			
Amortization of or change in beginning balances				0	0	0
Net Changes	<u>221,396</u>	<u>0</u>	<u>221,396</u>	<u>0</u>	<u>0</u>	<u>670,300</u>
Balances—at 06/30/2019	<u>\$5,296,857</u>	<u>\$0</u>	<u>\$5,296,857</u>	<u>\$0</u>	<u>\$0</u>	<u>\$670,300</u>

Sensitivity of OPEB liability to changes in the healthcare cost trend rate

The following represents the net OPEB liability calculated using the stated health care cost trend assumption, as well as what the OPEB liability would be if it were calculated using a healthcare cost trend rate that is 1-percentage-point lower or 1-percentage-point higher than the assumed trend rate:

	1% Decrease	Current	1% Increase
	7% decreasing to 4% over 10 years	8% decreasing to 5% over 10 years	9% decreasing to 6% over 10 years
Net OPEB Liability			
June 30, 2018	\$4,579,224	\$5,075,461	\$5,654,543
June 30, 2019	\$4,717,509	\$5,296,857	\$5,977,134

Sensitivity of OPEB liability to changes in the discount rate

The following represents the net OEPB liability calculated using the stated discount rate, as well as what the net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower or 1-percentage-point higher than the current rate:

	1% Decrease	Current Rate	1% Increase
	1.98%	2.98%	3.98%
Net OPEB Liability			
June 30, 2018	\$5,264,226	\$5,075,461	\$4,877,035
June 30, 2019	\$5,504,673	\$5,296,857	\$5,079,638

OPEB expense & deferred outflows/inflows of resources

For the year ended June 30, 2018, the recognized OPEB expense will be \$639,273. At June 30 2018, the employer reported deferred outflows of resources and deferred inflows of resources in relation to OPEBs from the following sources:

	Original Amount	Date Established	Original Amortization Period (Years)	Recognized Annually in Expense	Deferred Outflows of Resources	Deferred Inflows of Resources
Experience losses (gains)	\$0	06/30/2018	6.5	\$0	\$0	\$0
Change of assumptions	0	06/30/2018	6.5	0	0	0
Total				<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

Changes of assumptions and experience losses (gains) are amortized over the average remaining service period of actives and inactive (no future service is assumed for inactive for this calculation).

Amounts reported as deferred outflows (inflows) of resources related to OPEBs will be recognized in pension expense as follows:

Years Ending June 30:

2019	0
2020	0
2021	0
2022	0
2023	0
Thereafter	0

Bay County School Board Postemployment Benefits Other than Pensions
July 1, 2018

Schedule of changes in the NOL and related ratios

	fiscal year ending June 30									
	<u>2018</u>	<u>2019 *</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2027</u>
Total OPEB Liability										
Service cost	\$492,401	\$517,021								
Interest	146,872	153,279								
Changes of benefit terms	0	0								
Differences between expected and actual experience	0	0								
Changes of assumptions	0	0								
Benefit Payments / Refunds	(415,652)	(448,904)								
Net Change in Total OPEB Liability	<u>223,621</u>	<u>221,396</u>								
Total OPEB Liability - beginning	<u>4,851,840</u>	<u>5,075,461</u>								
Total OPEB Liability - ending (a)	<u>\$5,075,461</u>	<u>\$5,296,857</u>								
Plan Fiduciary Net Position										
Contributions - employer	\$415,652	\$448,904								
Contributions - employee	0	0								
Net investment income	0	0								
Benefit Payments / Refunds	(415,652)	(448,904)								
Administrative expenses	0	0								
Other	0	0								
Net Change in Plan Fiduciary Net Position	<u>\$0</u>	<u>\$0</u>								
Plan Fiduciary Net Position - beginning	<u>0</u>	<u>0</u>								
Plan Fiduciary Net Position - ending (b)	<u>\$0</u>	<u>\$0</u>								
Net OPEB Liability - ending (a) - (b)	<u>\$5,075,461</u>	<u>\$5,296,857</u>								
Plan Fiduciary Net Position as a % of the Total OPEB Liability	0.0%	0.0%								
Covered-employee payroll	\$91,979,446	\$95,658,624								
Net OPEB Liability as a % of covered-employee payroll	5.5%	5.5%								

* Projected

** Not provided

Schedule of contributions

	fiscal year ending June 30									
	<u>2018</u>	<u>2019 *</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2026</u>	<u>2027</u>
Actuarially determined contribution	\$820,456	\$873,223								
Contributions in relation to the actuarially determined contribution	415,652	448,904								
Contribution deficiency (excess)	<u>\$404,804</u>	<u>\$424,319</u>								
Covered-employee payroll	\$91,979,446	\$95,658,624								
Contributions as a percentage of covered-employee payroll	0.5%	0.5%								

* Projected

** Not provided



OPEN ENROLLMENT 2019 Summary of Benefits

Your Vision Benefits

Bay District Schools

Humana[®]

[Humana.com](https://www.humana.com)

Bay District Schools

Vision care services	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Exam with dilation as necessary • Retinal imaging ¹	\$10 Up to \$39	Up to \$30 Not covered
Contact lens exam options ² • Standard contact lens fit and follow-up • Premium contact lens fit and follow-up	Up to \$55 10% off retail	Not covered Not covered
Frames ³	\$130 allowance 20% off balance over \$130	\$65 allowance
Standard plastic lenses ⁴ • Single vision • Bifocal • Trifocal • Lenticular	\$15 \$15 \$15 \$15	Up to \$25 Up to \$40 Up to \$60 Up to \$100
Covered lens options ⁴ • UV coating • Tint (solid and gradient) • Standard scratch-resistance • Standard polycarbonate - adults • Standard polycarbonate - children <19 • Standard anti-reflective coating • Premium anti-reflective coating - Tier 1 - Tier 2 - Tier 3 • Standard progressive (add-on to bifocal) • Premium progressive - Tier 1 - Tier 2 - Tier 3 - Tier 4 • Photochromatic / plastic transitions • Polarized	\$15 \$15 \$15 \$40 \$40 \$45 Premium anti-reflective coatings as follows: \$57 \$68 80% of charge \$15 Premium progressives as follows: \$110 \$120 \$135 \$90 copay, 80% of charge less \$120 allowance \$75 20% off retail	Not covered Not covered Not covered Not covered Not covered Not covered Premium anti-reflective coatings as follows: Not covered Not covered Not covered Up to \$40 Premium progressives as follows: Not covered Not covered Not covered Not covered Not covered Not covered
Contact lenses ⁵ (applies to materials only) • Conventional • Disposable • Medically necessary	\$130 allowance, 15% off balance over \$130 \$130 allowance \$0	\$104 allowance \$104 allowance \$200 allowance

Humana Vision 130

Vision care services

	If you use an IN-NETWORK provider (Member cost)	If you use an OUT-OF-NETWORK provider (Reimbursement)
Frequency		
• Examination	Once every 12 months	Once every 12 months
• Lenses or contact lenses	Once every 12 months	Once every 12 months
• Frame	Once every 12 months	Once every 24 months
Diabetic Eye Care: care and testing for diabetic members		
• Examination - Up to (2) services per year	\$0	Up to \$77
• Retinal Imaging - Up to (2) services per year	\$0	Up to \$50
• Extended Ophthalmoscopy - Up to (2) services per year	\$0	Up to \$15
• Gonioscopy - Up to (2) services per year	\$0	Up to \$15
• Scanning Laser - Up to (2) services per year	\$0	Up to \$33

Optional benefits

- ¹ Member costs may exceed \$39 with certain providers. Members may contact their participating provider to determine what costs or discounts are available.
- ² Standard contact lens exam fit and follow up costs and premium contact lens exam discounts up to 10% may vary by participating provider. Members may contact their participating provider to determine what costs or discounts are available.
- ³ Discounts may be available on all frames except when prohibited by the manufacturer.
- ⁴ Lens option costs may vary by provider. Members may contact their participating provider to determine if listed costs are available.
- ⁵ Plan covers contact lenses or frames, but not both, unless you have the Eye Glass and Contact Lens Rider.

Additional plan discounts

- Member may receive a 20% discount on items not covered by the plan at network Providers. Members may contact their participating provider to determine what costs or discounts are available. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. Certain brand name Vision Materials may not be eligible for a discount if the manufacturer imposes a no-discount practice. Frame, Lens, & Lens Option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, members receive 20% off the retail price.
- Members may also receive 15% off retail price or 5% off promotional price for LASIK or PRK from the US Laser Network, owned and operated by LCA Vision. Since LASIK or PRK vision correction is an elective procedure, performed by specialty trained providers, this discount may not always be available from a provider in your immediate location.

Limitations and Exclusions:

In addition to the limitations and exclusions listed in your "Vision Benefits" section, this policy does not provide benefits for the following:

1. Any expenses incurred while you qualify for any worker's compensation or occupational disease act or law, whether or not you applied for coverage.
2. Services:
 - That are free or that you would not be required to pay for if you did not have this insurance, unless charges are received from and reimbursable to the U.S. government or any of its agencies as required by law;
 - Furnished by, or payable under, any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); or
 - Furnished by any U.S. government-owned or operated hospital/institution/agency for any service connected with sickness or bodily injury.
3. Any loss caused or contributed by:
 - War or any act of war, whether declared or not;
 - Any act of international armed conflict; or
 - Any conflict involving armed forces of any international authority.
4. Any expense arising from the completion of forms.
5. Your failure to keep an appointment.
6. Any hospital, surgical or treatment facility, or for services of an anesthesiologist or anesthetist.
7. Prescription drugs or pre-medications, whether dispensed or prescribed.
8. Any service not specifically listed in the Schedule of Benefits.
9. Any service that we determine:
 - Is not a visual necessity;
 - Does not offer a favorable prognosis;
 - Does not have uniform professional endorsement; or
 - Is deemed to be experimental or investigational in nature.
10. Orthoptic or vision training.
11. Subnormal vision aids and associated testing.
12. Aniseikonic lenses.
13. Any service we consider cosmetic.
14. Any expense incurred before your effective date or after the date your coverage under this policy terminates.
15. Services provided by someone who ordinarily lives in your home or who is a family member.
16. Charges exceeding the reimbursement limit for the service.
17. Treatment resulting from any intentionally self-inflicted injury or bodily illness.
18. Plano lenses.
19. Medical or surgical treatment of eye, eyes, or supporting structures.
20. Replacement of lenses or frames furnished under this plan which are lost or broken, unless otherwise available under the plan.
21. Any examination or material required by an Employer as a condition of employment.
22. Non-prescription sunglasses.
23. Two pair of glasses in lieu of bifocals.
24. Services or materials provided by any other group benefit plans providing vision care.
25. Certain name brands when manufacturer imposes no discount.
26. Corrective vision treatment of an experimental nature.
27. Solutions and/or cleaning products for glasses or contact lenses.
28. Pathological treatment.
29. Non-prescription items.
30. Costs associated with securing materials.
31. Pre- and Post-operative services.
32. Orthokeratology.
33. Routine maintenance of materials.
34. Refitting or change in lens design after initial fitting, unless specifically allowed elsewhere in the certificate.
35. Artistically painted lenses.

Vision health impacts overall health

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis ¹.



¹ Thompson Media Inc.

Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

This is not a complete disclosure of the plan qualifications and limitations. Specific limitations and exclusions as contained in the Regulatory and Technical Information Guide will be provided by the agent. Please review this information before applying for coverage.

NOTICE: Your actual expenses for covered services may exceed the stated cost or reimbursement amount because actual provider charges may not be used to determine insurer and member payment obligations.





Choosing Humana Vision is good for your health

Besides checking for changes in your vision, your eye doctor can check for common eye conditions like glaucoma.

An eye exam can also uncover other health issues, such as high blood pressure and diabetes. If you have diabetes, most Humana Vision plans have additional coverage for the care and testing you need to help manage your condition.

Humana Vision makes good eye health easy and budget friendly

- Get an annual eye exam for \$10
- Choose from more than 70,000 eye doctors in more than 24,000 locations including LensCrafters®, Pearle Vision®, Target Optical®, Sears® Optical, JCPenney Optical and many other private practitioners

How you can save with Humana Vision

	Retail cost	Cost with Humana Vision	Potential savings
 Exam	\$70	\$10	\$60
 Frames	\$150	\$15	\$134
Single-vision lenses	\$70-120	\$15	\$55-105
Standard scratch-resistant coating	\$40	\$15	\$25
Standard UV coating	\$40	\$15	\$25
 Total	\$370-420	\$70	\$299-349

More than 80% off the total retail cost

Data is based on the Humana Vision 130 plan. Example is for illustration purposes only, and individual results may vary.

Humana

Humana.com



Humana Vision products insured by Humana Insurance Company, Humana Health Benefit Plan of Louisiana, The Dental Concern, Inc. or Humana Insurance Company of New York.

GCHJPWZEN 0816

How to view a copy of your vision identification (ID) card

What do I do if I need to visit my provider and I haven't received my Humana member ID card?

You will have access to view and print your vision ID card via the website.

Here's how

- Go to **Humana.com** and sign in/register for MyHumana. Have your Humana member ID card or Social Security number available.
- Click "Access your ID Card" under "Tools & Forms" in the lower right of your MyHumana home page or in the page's footer under "Tools & Resources."
- A new window will appear with links to the ID card or proof of coverage.
- Print if desired.

The screenshot shows the MyHumana website interface. At the top, there's a navigation bar with "MyHumana", "Go365", "Caregiving", "Welcome, Samantha", "My Profile", and "Contact Us". Below this is a search bar and a navigation menu with "Home", "Coverage, Claims & Spending", "My Health", and "Get Healthy". A prominent banner for "Go365 is here!" features a person walking and the Go365 logo. Below the banner, there are tabs for "Medical", "Dental", "Pharmacy", "Go365", and "More". The main content area displays "Samantha's Gold Plus HMO (Humana, Inc.)" with options to "View coverage details" and "View ID card". A "Medical claims" table lists three claims with dates, provider names, and amounts. Below the table are sections for "Deductibles & maximums" and "In your network". At the bottom of the main content area, there are three promotional cards: "Sign up for Medicare today", "Experience HumanaVitality", and "Just sleep on it". The footer contains a "Humana" logo, a grid of navigation links for "Account & Settings", "Health and wellness", "Tools & Resources", and "Member support", social media icons, and copyright information.

Call Member Services at
1-877-398-2980 for
assistance or more information

Provider Directory Humana.com



Get the most up-to-date information.

Follow these simple steps to find a Humana Vision provider:

1. Under “Find a doctor” on the home page, click on **“Search.”**

Find a doctor

Quickly locate a doctor, hospital, dentist, vision provider or pharmacy.

→ Search

2. Under **“Search Type,”** select “Vision” and click on “Go.”

Medical
Dental
✓ Vision
Pharmacy

→ Go

Select **“Vision coverage through your employer”** and click on **“Go.”**

Vision care

To start search, choose your plan.

- Vision coverage through your employer or purchased on your own
- Vision coverage through Medicare Supplemental Benefits (EyeMed)

→ Go

Cancel

Select **Humana Vision (Humana Insight Network)**

Select a plan

Please choose a vision plan. You will then be able to select from a list of available providers in your area.

Vision Plans

- **Humana Vision (Humana Insight Network)**
- Vision Care Plan (VCP)
- EyeMed Plan (Optimum, Focus, Advantage, Exam Plus)

Enter Zip code and select **Get Results**

Humana

Begin Your Search

ZIP Code *

What else is important? ▾

Get Results → Advanced Search ▾

* Required Field

Find a Provider

Find a network provider near you by searching below. To find a participating provider, complete either the full street address or the zip code, then click Search.

Always call ahead to confirm a provider's participation in your plan. Make sure to say you're a Humana Vision member to ensure you receive your maximum benefits. Not all providers participate in every plan. If you aren't yet enrolled in a Humana Vision plan, please keep in mind your actual network may vary from what appears on our locator.

Humana Vision members should log in to access the exact list of available providers. Even if a provider is displayed on this site, you should call ahead to confirm the provider still accepts your plan.

Eye exams available by Independent Doctors of Optometry at or next to LensCrafters, Pearle Vision, Sears Optical and Target Optical in most states. Doctors in some states are employed by the location. In California, optometrists are not employed by LensCrafters, Sears Optical

Humana®

Your search results will display.

MyHumana Mobile app

“Now we go where you go”

Access your health information anytime, anywhere

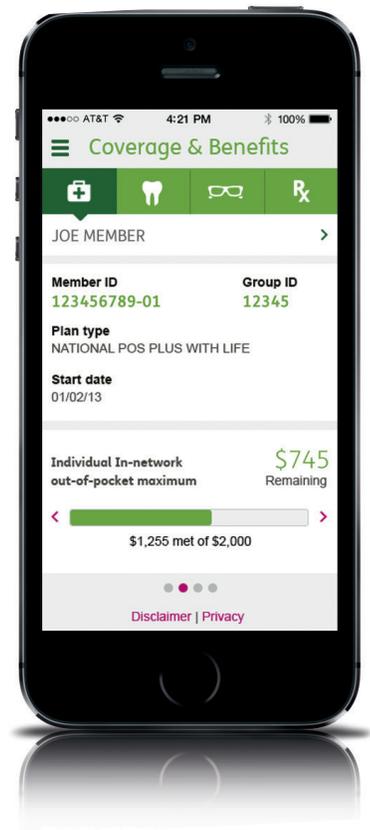
Whether you prefer downloading a mobile application, using your mobile device or receiving text messages, you have the ability to manage your healthcare needs virtually anywhere, anytime.

Use the MyHumana Mobile app and website to:

- View medical, dental, vision, and pharmacy claims
- View your plans and coverage details
- View your HumanaVitality® Dashboard†
- Receive medication reminders
- Research drug prices
- Locate providers in your network
- Refill your RightSource® prescriptions

Download the Mobile App:

Download the MyHumana Mobile app from your app store. Search “MyHumana” in the Google Play or App Store.



From your mobile device's browser:

You can visit MyHumana from your mobile device's browser. To get started, go to **Humana.com** and sign-in.

Text message alerts*

On the MyHumana Mobile app:

1. Register or Sign in
2. Click on the Menu icon
3. Select Text Alerts
4. Register and verify your Mobile #
5. Select the alerts you want to receive

On Humana.com:

1. Register or Sign in
2. Click on Account settings & preferences
3. Select Edit your preferences
4. Select Mobile from the tab
5. Register and verify your Mobile #
6. Select the alerts you want to receive

†Available to HumanaVitality members only.

*Message and data rates may apply.

Humana®

Humana.com

Humana Vision Lasik



Opening doors to better vision for thousands of people — with affordable Lasik¹ procedures

Network doctors can help you understand these new procedures and provide access to our network of Lasik providers.

You may also use independent Lasik provider-network doctors to receive a 10 percent discount from usual and customary prices and pay no more than \$1,800 per eye for conventional Lasik and \$2,300 per eye for custom Lasik.

¹Laser-assisted in-situ keratomileusis

²If qualified as a Lasik candidate by the network doctor

The Lasik program is a discount only for Humana Vision members and is not a covered benefit.

Reduced fees

Lasik procedures are available if you're nearsighted or have astigmatism and wear glasses or contacts.² We have contracted with many well-known facilities and eye doctors to offer these procedures at substantially reduced fees.

You can take advantage of these low fees when procedures are done by network providers. The network locations listed below offer the following prices (per eye):

	Custom**
TLC 1-888-358-3937	\$1,295 \$1,895*
LasikPlus 1-866-757-8082	\$1,895* LasikPlus free enhancements for life
QualSight LASIK 1-855-456-2020	\$1,320 \$1,995* with QualSight Lifetime Assurance Plan

*With IntraLase™

**Pricing varies by section, by procedure offered by the provider you choose, and by options in your area. Not all locations offer fixed pricing. Please call the provider for details.

Easy access to service

During your comprehensive eye health examination, your doctor can determine if you're a candidate for Lasik. If you qualify, the doctor can also make arrangements for the procedure with one of the centers that participates in this program.

Your Humana Vision ID card verifies your eligibility for Lasik discounts. You can find a list of providers online at [Humana.com](https://www.humana.com) or by calling a Customer Care specialist at **1-877-398-2980**.

This discount cannot be combined with any other discount or promotional offer. The Humana Vision Lasik program is not affiliated with any medical or health plan. All pricing listed is per eye.

Humana®

[Humana.com](https://www.humana.com)



It's an easy ordering process:

1

Members will go to contactsdirect.com

2

They'll select their lenses from a wide selection of top selling brands

3

In-network vision benefits instantly apply to their purchase price

4

Contact lenses will ship as soon as the prescription is verified- most even ship that same day

Members can now use their contact lens allowance online

We know that even though employees are busy, they always have a mobile device ready or a computer nearby. That's why they can order contact lenses online using ContactsDirect when they need to - without leaving their homes. And the best part is that they can use their in-network benefits to make sure they're getting the best price around.

Plus, members can be sure that they can find what they need because ContactsDirect stocks the best-selling brands. The site also offers a best-in-class user experience that allows users to view their eligibility and available allowance (with application directly in their shopping cart). All with fast, free shipping!

And don't worry, for members who still prefer to visit their eye doctor in person to purchase contacts lenses, nothing has changed. ContactsDirect is just one more way we're helping employees see life to the fullest.

73% of brokers agree that online, in-network options are of high value for their clients.**

Check out this new, online in-network benefit that you can offer to employees, visit us at www.contactsdirect.com

*ContactsDirect will abide by state laws that pertain to contact lens. **EyeMed internal research study, 2014

*** Members whose prescriptions are more than a year old will need an updated prescription to make an online or in-person purchase using their benefits.



Employees have a realistic way to try on glasses digitally:



Find frames
Thousands of styles rendered instantly in 3D



See from any angle
See how frames look from side to side



Share on Social Media
Get the opinions of family friends

In-network now means online

We're changing the way benefits work - because online purchases of prescription glasses is projected to increase by 15% over the next 10 years.¹ And now that Glasses.com is in our network, members can go online to buy glasses anytime, from anywhere. And the best part is that they can use their in-network benefits.

It's easy:

- Members can find a pair they love from thousands of name-brand frames
- Snap and send a picture of the prescription – or have Glasses.com call the provider for it
- Lenses available for most prescriptions (including progressives and multifocals)
- Orders fulfilled and shipped the following day – and it's free!
- All supported by the award winning² photorealistic and geometrically accurate 3D virtual "try-on" app for iPad and iPhone

Try glasses on at home

Risk Free



We'll send members frames they like in their prescription



They can wear them for 15 days



They can keep them – or send them back – all with free shipping

See how our vision is changing reality

Download the app or visit Glasses.com today

¹Estin & Co, 2013 estimates and analysis; Essilor International

²2014 Cannes Lions Festival, Bronze Award for "Creative Use of Technology"

Discrimination is Against the Law

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana Inc. and its subsidiaries do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Humana Inc. and its subsidiaries provide:

- Free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.
- Free language services to people whose primary language is not English when those services are necessary to provide meaningful access, such as translated documents or oral interpretation.

If you need these services, call 1-877-320-1235 or if you use a TTY, call 711.

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

Discrimination Grievances
P.O. Box 14618
Lexington, KY 40512 - 4618

If you need help filing a grievance, call 1-877-320-1235 or if you use a TTY, call 711.

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

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

Relationships are built on trust. Respect for an individual's privacy goes a long way toward building trust. Humana values our relationship with you, and we take your personal privacy seriously. Humana's Notice of Privacy Practices outlines how Humana may use or disclose your personal and health information. It also tells how we protect this information. The notice provides an explanation of your rights concerning your information, including how you can access this information and how to limit access to your information. In addition, it provides instructions on how to file a privacy complaint with Humana or to exercise any of your rights regarding your information.

If you'd like a copy of Humana's Notice of Privacy Practices, you can request a copy by:

- Visiting **Humana.com** and clicking the Privacy Practices link at the bottom of the home page
- E-mailing us at privacyoffice@humana.com
- Sending a written request to:
Humana Privacy Office
P.O. Box 1438
Louisville, KY 40202