DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Request for Proposal
For
Group Medical and Prescription Benefits

RFP # 2016-01

Proposal Return Date and Time
Thursday, October 15, 2015 at 3:00 p.m.

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DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

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Introduction

SECTION I

INTRODUCTION

SCOPE OF REQUEST FOR PROPOSAL

The District School Board of Sumter County (the District) is requesting information for the following coverages/services as further described in this Request for Proposals (RFP):

Section IV of the RFP: Fully Insured Medical and Prescription Benefits.

Section V of the RFP: Medical and Prescription Claims Administration Services.
Claims Administration proposals should include network access for the proposed plans, medical claims management, utilization review services and the ability to use the District's choice of stop-loss insurance vendors.

Section VI of the RFP: Stop-Loss Insurance.
Proposers are advised that stop-loss proposals MUST indicate which administration network they require and proposals with complete programs (i.e. administration network and stop-loss) are preferred.

Section VII of the RFP: Agent/Broker Services.
Proposals are requested, but not required, to be submitted net of any agent or broker commissions. If an agent or broker is submitted with the proposal(s), the corresponding proposal forms (Section XII) must be completed.

Proposers have the ability to propose on one or all of the above requested coverages and services. Please see Section II, page 11 for Severability of Contracts.

PROFILE OF THE DISTRICT SCHOOL BOARD OF SUMTER COUNTY

Sumter County is located in the central part of the state of Florida. District offices are located in Bushnell, Florida, which is approximately 50 miles North of Tampa and 50 miles West of Orlando.

CURRENT PLAN OR PROGRAM INFORMATION

Medical and Rx Plans: The District currently fully insures its medical and prescription coverage. The current group medical benefits insurer is Florida Blue, which has provided the District's insurance since 2003.

The District is interested in proposals for plan designs that most closely match the District's current plan designs.

1. Florida Blue BlueOptions – Plan 03359
2. Florida Blue BlueOptions – Plan HSA 03160/03161
3. Florida Blue BlueCare – Plan 47

- The District's plans are not grandfathered.

- The District does not offer a Medicare Advantage plan.

- All proposals are expected to comply with a plan year of January 1, 2016 through December 31, 2016.

- The current group medical plan includes prescription drug coverage. Proposers are asked to review the prescription coverage in detail.

SEPARATION AND DISTRIBUTION

This RFP has been designed for transmittal as a complete document to interested parties. It is recommended that it not be separated; however, it may be reproduced in its entirety as additional distribution might dictate.

The District will utilize its website for distribution of RFP # 2016-01 – Group Medical and Prescription Benefits at:

http://www.sumter.k12.fl.us/finance

In addition, vendors may obtain an Excel version of the census and/or a Word version of the RFP Proposal Forms by submitting an e-mail request directly to:

Theresa Conley
Siver Insurance Consultants
tconley@siver.com

ROLE OF CONSULTANT

The District retains Siver Insurance Consultants as independent risk and insurance management consultants. Siver acts solely in its capacity as consultant. The consultant does not participate in commissions from any insurance company, agent or broker, nor does it accept any income from other than its clients.

DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Section II

General Conditions

SECTION II

GENERAL CONDITIONS

PROPOSAL SUBMISSION AND WITHDRAWAL

All proposal sheets and forms must be executed and submitted in a sealed envelope. Four (4) completed responses to this RFP (one (1) original and three (3) copies) and three (3) CD-ROM copy (with all documents in their original format, Word, Excel, etc.) shall be submitted to the Finance Department at the District School Board of Sumter County in sealed envelopes marked "RFP # 2016-01 – Group Medical and Prescription Benefits." Proposals not submitted on the attached forms may be rejected. All proposals are subject to the conditions specified herein. Those which do not comply with these conditions are subject to rejection. It is the sole responsibility of the proposer to deliver the proposal to the address contained herein on, or before, the closing hour and date indicated. The District will not be responsible for the inadvertent opening of a proposal not properly sealed, addressed or identified.

Proposals properly labeled in sealed envelopes will be received at:

Physical and Mailing Address:

The District School Board of Sumter County, FL
Deborah Smith
Senior Director of Business & Institutional Services
2680 W CR 476, Building #2
Bushnell, FL 33513

Proposals are due by 3:00 p.m. on October 15, 2015.

Proposals, once received, become the property of the District, cannot be withdrawn, and will not be returned to the Proposers. Upon opening, proposals become subject to public disclosure in accordance with Chapter 119, Florida Statutes.

PROPOSAL OR PUBLIC OPENING

The proposal opening shall be public, at the address indicated on the Request for Proposal document, on the date and at the time specified. It is the proposer's responsibility to assure that the proposal is delivered at the proper time to the place of the opening. Proposals received after the date and time will be rejected and returned unopened to the offeror. Proposals by fax or telephone will not be accepted.

MINIMUM QUALIFICATIONS OF PROPOSER

No proposal will be accepted by the District where insurance coverage is proposed by a person or organization which is not rated at least a B+ by A.M. Best. We will also be reviewing the financial strength and financial outlook of each proposer.

Rating Firm	Minimum Rating
A. M. Best	B+

If a proposal is made by an organization not rated by A.M. Best, it will only be considered if the organization:

1. Has, as of the proposal return date specified in the RFP, been successfully operating for a minimum of five (5) consecutive years; and

2. Submits with its proposal, its last audited financial statement issued by a certified public accountant, dated no earlier than 18 months prior to the proposal date specified in this RFP.

ADDITIONAL INFORMATION/ADDENDA TO THIS RFP

Any questions concerning conditions and specifications shall be in writing for receipt no later than 2:00 p.m. on September 29, 2015. Questions will not be accepted after this time. Inquiries must reference the date of RFP opening and RFP number. Failure to comply with this condition will result in proposer waiving his right to dispute the RFP conditions and specifications.

All questions concerning this RFP must be submitted, in writing, to:

Theresa Conley
E-mail: tconley@siver.com

Written responses, in the form of addenda, will be provided via the District's website at:

http://www.sumter.k12.fl.us/finance

The District will issue responses to inquiries and any other corrections or amendments it deems necessary in written addenda issued prior to the Proposal Due Date. Proposers should not rely on any representations, statements or explanations other than those made in this RFP or in any addendum to this RFP. Where there appears to be a conflict between the RFP and any addenda issued, the last addendum issued will prevail.

It is the proposer's responsibility to be sure all addenda were received. The proposer should verify with the designated contact persons prior to submitting a proposal that all addenda have been received. Proposers are required to acknowledge the number of addenda received as part of their proposals.

CALENDAR OF EVENTS

Date:	Action:
September 15, 2015	Release Solicitation
September 29, 2015	Last Day for Submissions of Written Questions
ASAP	Addendum release if needed
October 15, 2015	Proposals Due / Bid Opening
Week of October 26, 2015	Evaluation Committee Meeting
Early November 2015	School Board Approval
January 1, 2016	Coverage Effective Date

INSURANCE REQUIREMENTS

The successful bidder shall furnish the District with proof of:

(1) Statutory Limits of Worker's Compensation in compliance with Chapter 440, Florida Statute.

(2) Employer's Liability Insurance in an amount not less than $1,000,000 per occurrence.

(3) Commercial General Liability Insurance, including Contractual Liability and Products and Completed Operations, in an amount equal to or greater than $1,000,000 per occurrence for any occurrence resulting in bodily injury or death, or personal injury or property damage to any one or group of persons, including any consequential damages that arise therefrom. If policy is on a "CLAIMS MADE" basis, contractor's insurance carrier will identify policy as such and indicate in writing the amount of claims paid by this policy and reserves outstanding. Policy aggregates must equal at least two (2) times the occurrence limit.

(4) Commercial Automobile Liability Insurance in an amount equal to or greater than $1,000,000 per occurrence for bodily injuries and/or death to any person or persons caused by passenger automobiles or commercial vehicles.

(5) Professional (errors and omissions) liability policy in the amount of not less than $2,000,000 covering employees or representatives who provide services to the County.

(6) A fidelity bond in the amount of not less than $1,000,000 covering those employees or representatives who handle or have possession of monies of the Plan. – Self-Insured only

(7) Additional Insured Endorsement: The District shall be named as an additional insured on all policies (except Workers Compensation and Professional Liability) that are required by these specifications.

(8) Cancellation Notice: All policies in effect shall contain cancellation endorsements providing sixty (60) days written notice of such cancellation, non-renewal and/or reduction in coverage limits prior to the effective date of such cancellation, non-renewal and/or reduction.

(9) Cyber Liability: Such insurance shall be on a form acceptable to the District and shall cover, at a minimum, the following:

- Data Loss and System Damage Liability
- Security Liability
- Privacy Liability
- Privacy/Security Breach Response Coverage, including Notification Expenses

Such Cyber Liability coverage must be provided on an Occurrence Form or, if on a Claims Made Form, the retroactive date must be no later than the first date of this Contract and such claims-made coverage must respond to all claims reported within three years following the period for which coverage is required and which would have been covered had the coverage been on an occurrence basis. The minimum limits (inclusive of any amounts provided by an umbrella or excess policy) shall be: $ 1,000,000 Each Claim/Annual Aggregate.

LATE PROPOSALS, LATE MODIFICATIONS AND LATE WITHDRAWALS

Proposals received after the Proposal Due Date and time are late and will not be considered. Modifications received after the Proposal Due Date are also late and will not be considered. Letters of withdrawal received after the Proposal Due Date or after contract award, whichever is applicable, are late and will not be considered.

COSTS INCURRED BY PROPOSERS

All expenses involved with the preparation and submission of proposals to the District, or any work performed in connection therewith shall be borne by the proposer(s). No payment will be made for any responses received, nor for any other effort required of or made by the proposer(s) prior to commencement of work as defined by a contract approved by the District.

ORAL PRESENTATION

The District may require proposers to give oral presentations (or interviews) in support of their proposals or to exhibit or otherwise demonstrate the information contained therein.

EXCEPTION TO THE RFP

Proposers may take exceptions to any of the terms of this RFP unless the RFP specifically states where exceptions may not be taken. Should a proposer take exception where none is permitted, the proposal may be rejected as non-responsive. All exceptions taken must be specific, and the proposer must indicate clearly what alternative is being offered to allow the District a meaningful opportunity to evaluate and rank proposals.

Where exceptions are permitted, the District shall determine the acceptability of the proposed exceptions and the proposals will be evaluated based on the proposals as

submitted. The District, after completing evaluations, may accept or reject the exceptions. Where exceptions are rejected, the District may request that the proposer furnish the services or goods as described herein, or negotiate an acceptable alternative.

PROPRIETARY INFORMATION

Please note: Proposers are requested to ensure that boilerplate language in both headers and footers (and any other places) on all proposal pages are accurate and do not assert proprietary and confidential information if not purposefully asserted.

Pursuant to chapter 119, Florida Statutes, proposals received as a result of this RFP will not become public record until thirty (30) days after the date of opening or until posting of a recommendation for award, whichever occurs first. Thereafter, all proposal documents or other materials submitted by all Proposers in response to this RFP will be open for inspection by any person and in accordance with Chapter 119, Florida Statutes. To the extent a Proposer asserts any portion of its proposal is confidential or exempt from disclosure under Florida's public records laws, the Proposer must expressly identify all portions of the proposal asserted to be confidential and exempt, along with specific citations of the Florida Statutes establishing the confidentiality or exemption. Failure to identify the portions of the proposal claimed to be exempt or the specific statutory authority establishing the exemption shall be deemed a waiver by the Proposer that any unidentified portion of the proposal is confidential or exempt from disclosure under Chapter 119, Florida Statutes.

Should a public records request for proposal documents or other materials submitted by a Proposer be submitted, the Sumter County School District will notify the contact person identified in the proposal of the request in writing. The notice provided will indicate that requested materials will be produced unless, within ten (10) calendar days of the date of the written notification, the Proposer initiates an action in a court of competent jurisdiction to obtain an injunction or protective order prohibiting the release of the requested materials. The Proposer will name the party requesting the materials as a defendant and will not name the Sumter County School District as a party to the action. The Proposer agrees to hold the Sumter County School District harmless from any award to a plaintiff for damages, costs, or attorney's fees based on nondisclosure of information asserted to be confidential and exempt. Failure to timely initiate the action will be deemed a waiver by the Proposer that the requested information is confidential and exempt. The Proposer agrees to waive any cause of action it may have against the Sumter County School District for the release of materials pursuant to a public records request except those based on the intentional or grossly negligent conduct of an employee of the Sumter County School District. Any submission by a Proposer in response to this RFP shall be deemed as Proposer's consent to the foregoing conditions.

WAIVER/REJECTION OF PROPOSALS

All reasonably responsive proposals will be considered. However, the District reserves the right to waive formalities or informalities in proposals, to reject, with or without cause, any or all proposals or portions of proposals, or to interview or not interview individual proposers, and to accept any proposal(s) or portions of proposals deemed to be in the best interest(s) of the District.

NEGOTIATIONS OF PROPOSALS

Based on the written proposals, pursuant to Florida Statute 112.08, the District may elect to enter into negotiations with one or more of the proposers. The District reserves the right to negotiate with proposer finalist(s) on alternative medical and EAP plan designs.

RULES, REGULATIONS AND LICENSING REQUIREMENT

The proposer shall comply with all laws, ordinances and regulations applicable to the services contemplated herein, including those applicable to conflict of interest and collusion. Proposers are presumed to be familiar with all Federal, State and local laws, ordinances, codes and regulations that may in any way affect the services offered. Each Proposer is responsible for full and complete compliance with all laws, rules, and regulations that may be applicable.

INVESTIGATION OF ALLEGED WRONGDOINGS, LITIGATION/ SETTLEMENTS/FINES/PENALTIES

The District specifically requests that responders to this document indicate in writing any investigations of wrongdoings, litigation and/or settlements, and fines or penalties (anywhere in the U.S) involving the Contractor and specific Contractors listed as projected to provide services to the District. You may be required to respond to questions on this subject matter.

CONDUCT OF PROPOSERS

All submitters or individuals acting on behalf of submitters are hereby prohibited from lobbying or otherwise attempting to persuade or influence any member of the Sumter County School District or any member of the Insurance Selection Committee at any time during the course of the solicitation process. Failure to comply with this procedure will result in rejection/disqualification of said submittal without exception.

All submitters or individuals acting on behalf of submitters are further prohibited from contacting or otherwise attempting to communicate with any member of the Insurance Selection Committee regarding the pending solicitation or its outcome until after the Committee has arrived at a recommendation of the most qualified submitters. Until such recommendation is disclosed, any contact with the Insurance Selection Committee shall be channeled through the District's Finance Director. Failure to comply with this procedure will result in rejection/disqualification of said submittal without exception.

EVALUATION CRITERIA FOR MEDICAL AND PRESCRIPTION COVERAGE
(Applies to both Fully Insured and Claims Administration Services)

The following is the evaluation criteria below for the medical and prescription benefits. If more than one (1) firm is designated qualified enough to be considered as a finalist, finalist interviews may be considered. The District may also conduct simultaneous negotiations with vendors regarding qualifications, quality, price and plan alternatives, prior to recommending to the District award of the contract to the vendor believed to provide the most responsive and responsible proposal that is most advantageous to the District.

	Criterion
1.	**Cost -** Although cost will be a major consideration in evaluating proposals, it will not be the only consideration. Cost will include (but not be limited to) disclosure of rates/premiums, service costs, administration fees, network discounts, retention and claims cost, pooling costs, any cost guarantees (if applicable) and other cost components.
2.	**Coverage -** The ability to administer the benefits as is, or as close as practical. The amounts and breadth of coverage and extent of deductibles, co-payments, coinsurance, restrictions or exclusions. For prescription benefits, this will also include the formulary list.
3.	**Providers –** The number and types of providers, e.g. the number of hospitals and number of physicians under contract and the number of contracted physicians who will accept new patients and the match-up between current top providers and network providers proposed. For pharmacies, the extensiveness of the pharmacy network and pharmacy mail order.
4.	**Service/Customer Service -** The administration capabilities and experience of proposers. This includes such items as enrollment assistance, service responsiveness, communication with District staff on program administration, quality of billings, Internet website, attendance at District monthly committee and other meetings/events and willingness to engage in at-risk performance guarantees. In addition, this also includes the District's onsite insurance representative. The capabilities of the online electronic enrollment system will also be reviewed.
5.	**Reporting Services –** Monthly and annual reports of paid claims, quality of experience reports, timeliness of reports on a monthly basis, developing adhoc reports, extent and quality of reports on wellness/disease management, etc.
6.	**Wellness and Disease Management Programs** - This includes maintaining the momentum of the current wellness programs in place. In addition, such items as breadth of wellness and disease management program and predictive modeling capabilities, health risk assessment, biometric screenings and self-help tools, health coaching, Internet website, attendance at wellness meetings/events. Experience in developing and administering programs, including use of incentives and other methods to encourage participation.
7.	**Stability -** Financial stability of the proposer, A.M. Best rating and/or NCQA ratings (if applicable), the number of years in business, etc.
8.	**References –** The input received from references contacted by the District and/or the relevant experience such references display.
9.	**Interviews -** For those chosen to be interviewed by the District (if interviews are conducted), the quality of the interview and the information provided about the proposal and expectations for service to the District.

EVALUATION CRITERIA FOR STOP-LOSS INSURANCE

The following is the evaluation criteria below for the stop loss insurance in situations where the successful administrator of the medical claims administration services is directly proposed with two or more stop-loss proposals. If more than one firm is designated qualified enough to be considered as a finalist, the committee will consider finalist interviews. The District may also conduct simultaneous negotiations with vendors regarding qualifications, quality and price, prior to recommending to the District award of the contract to the vendor believed to provide the most responsive and responsible proposal that is most advantageous to the District.

	Criterion
1.	**Cost -** Although cost will be a major consideration in evaluating proposals, it will not be the only consideration. Cost will include (but not be limited to) disclosure premium and cost guarantees and other cost components, including claims disclosure requirements and the increased specific deductibles for individuals ("lasers").
2.	**Coverage -** The ability to administer the benefits as is. The amounts and breadth of coverage and extent of restrictions or exclusions.
3.	**Service/Customer Service -** The administration capabilities and experience of proposers. This includes such items as service responsiveness, stop-loss claims filing (if applicable), communication with District staff on program administration, quality of billings, etc. Willingness to provide reports, as needed, to the District.
4.	**Stability -** Financial stability of the proposer, A.M. Best rating, the number of years in business, etc.
5.	**References –** The input received from references contacted and the relevant experience such references display.
6.	**Interviews –** For those chosen to be interviewed by the District (if interviews are conducted), the quality of the interview and the information provided about the proposal and expectations for service to the District.

EVALUATION CRITERIA FOR AGENT/BROKER (IF APPLICABLE)

The proposal review committee will evaluate proposals agent/broker services based on the described criteria and points which follow to determine which general insurance agent is the first choice. However, the basic decision to utilize a general agent versus use of a company agent (direct) will be made by simple committee vote independently from the below. An agent may be considered only if the winning and/or shortlisted insurer or administrator names such agent in their RFP response.

	Criterion
1.	**Cost -** Although cost will be a major consideration in evaluating proposals, it will not be the only consideration. Cost will be all remuneration to the agent including (but not be limited to) commission, fees and/or other compensation.
2.	**Background and Experience –** The size of the insurance agency, the experience in providing insurance for public entities and school districts, the personnel and qualifications (particularly of the agent who will serve the District), number of years as an agent/agency, the breadth of experience in medical benefits.
3.	**Service/Customer Service –** Agreement to the Scope of Services included in the RFP. This also includes such items as enrollment assistance, service responsiveness, communication with District staff on program administration, quality of billings and experience reports, Internet website, attendance at District meetings/events, willingness to engage in at-risk performance guarantees, wellness/disease management services, etc.
4.	**References –** The input received from references contacted by the District and/or the relevant experience such references display.
5.	**Interviews –** For those short-listed to be interviewed by the District (if interviews are conducted), the quality of the interview and the information provided about the proposal and expectations for service to the District.

CONFLICT OF INTEREST

The award hereunder is subject to the provisions of Chapter 112, Florida Statutes. All proposers must disclose with their proposal the name of any officer, director, or agent who is also an employee of the District. Further, all proposers must disclose the name of any employee who owns, directly or indirectly, an interest in the proposer's firm or any of its branches. The proposer shall not compensate, in any manner, directly or indirectly, any officer, agent, or employee of the District for any act or service that he/she may do, or perform for, or on behalf of any officer, agent or employee of the proposer. No officer, agent, or employee of the District shall have any interest, directly or indirectly, in any contract or purchase made, or authorized to be made by anyone for, or on behalf of the District. The proposer shall have no interest and shall not acquire any interest that shall conflict in any manner or degree with the performance of the services required under this RFP.

LEGAL REQUIREMENTS

Applicable provision of all Federal, State, county and local laws, and of all ordinances, rules, and regulations shall govern development, submittal and evaluation of all proposals received in response hereto and shall govern any and all claims and disputes which may arise between person(s) submitting a response to RFP hereto and the District by and through its officers, employees and authorized representatives, or any other person, natural or otherwise; and lack of knowledge by any bidder shall not constitute a cognizable defense against the legal effect thereof.

PUBLIC ENTITY CRIMES STATEMENT

Proposers are hereby notified about Section 287.133(2)(a), Florida Statutes, which requires that:

"A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in s. 287.017 for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list."

ANTI-DISCRIMINATION CLAUSE

The non-discrimination clause contained in Section 202, Executive Order 11246, as amended by Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex or national origin, and the implementing rules and regulations provided by the Secretary of Labor are incorporated herein.

RETENTION OF RECORDS

Contractor agrees to retain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertaining to any contract resulting from this RFP for a period of five (5) years. Copies of all records shall be made available to the District upon request. All invoices and documentation must be clear and legible for audit purposes. Documents must be retained by contractor within the State of Florida at an address to be provided, in writing, to the District within 30 days of the contract execution. Any records not available at the time of an audit will be deemed unavailable for audit purposes. The contractor will cooperate with the District to facilitate the duplication and transfer of any said records or documents during the required retention period. The contractor shall inform the District of the location of all records pertaining to the contract resulting from this RFP and shall notify the District by certified mail within ten (10) days if/when the records have been moved to a new location.

DISCRIMINATORY VENDOR'S LIST

Any entity or affiliate who has been placed on the Discriminatory Vendors List may not submit a proposal to provide goods or services to a public entity, may not be awarded a contract or perform work as a contractor, supplier, subcontractor, or consultant under contract with any public entity and may not transact business with any public entity.

STATE LICENSING REQUIREMENT

All entities defined under Chapters 607, 608, 617 or 620, Florida Statutes, seeking to do business with the District shall be on file and in good standing with the State of Florida's Department of State.

The offeror shall have, prior to making this offer, met the license, certification, and any other requirements of the state, county, city and/or other agency of authority with jurisdiction in such matters and should provide copies of documentation which evidence such qualifications with the response to this solicitation; and, that the offeror shall provide follow-up evidence that the contractor maintains such credentials throughout the period of the agreement.

A copy of a current certificate of authority from the Secretary of State authorizing your company to do business in the State of Florida; or other evidence of legal authority to do business in the state, county, city and/or any other agency of authority should be provided with your response to this solicitation; however, the District may allow this responsiveness issue to be cured after submission of the offer within a reasonable period of time and prior to any recommendation for award. Information concerning certification with the Secretary of State can be obtained at http://ccfcorp.dos.state.fl.us/index.html.

Failure to provide evidence of current licensure, certification or other evidence of legal authority to do business in the matters of this solicitation may render the offer non-responsive.

SEVERABILITY OF CONTRACTS

This RFP solicits proposals for multiple coverages/services. Each proposal received will be severable unless the Proposal Forms indicate that coverages/services are required to be purchased together. It is the Proposer's responsibility to explain such details on the Proposal Forms.

DRUG FREE WORK PLACE

Chapter 287.087, F.S., Procurement of Personal Property and Services. Whenever two or more offers which are equal with respect to price, quality, and service are received by the District for the purchase of commodities or contractual services, an offer received from a business that certifies that it complies fully with the requirements of the Drug-Free Workplace Program shall be given preference in the award process.

USE OF PROPOSAL FORMS

Proposers should complete the appropriate Proposal Form(s) included in Section IX through Section XII of this RFP. All blanks on the Proposal Forms should be completed. If a question or confirmation is not applicable, it should be answered with an "N/A." Proposal Forms need not be completed for coverages/services not being proposed.

Supplemental information may be attached to the Proposal Forms. Failure to fully complete the appropriate Proposal Forms may result in disqualification of your proposal.

If additional space for a response is required, attach an additional page to the page on which the question is stated. Clearly identify the number of the question to which the response is attached. Further, if additional Proposal Form pages are needed, photocopy or replicate as appropriate, and attach such additional pages to the page on which the question or chart is stated.

The signature on the Proposer's Warranty(ies) must be that of an officer, partner or a sole practitioner of the company making the proposal. The original proposal, and each copy submitted, should contain an original signature on the Proposer's Warranty contained in each Proposal Form.

IRREVOCABILITY OF PROPOSAL

Each Proposer agrees that proposals shall remain open until the effective date of coverage, January 1, 2016, not subject to revocation, and shall be subject to the District's acceptance.

CONTRACT AWARDS

The District anticipates entering into a contract with the Proposer or Proposers who submit the proposals judged by the District to be most advantageous.

The Proposer understands that this RFP does not constitute an agreement or a contract with the Proposer. An official contract or agreement is not binding until proposals are reviewed and accepted by the District and executed by all parties.

The District reserves the right to reject all proposals, to waive any informality, to negotiate with vendors, and to solicit and re-advertise for other proposals.

AGENT/BROKER SERVICES

Proposals are requested, but not required, to be submitted net of any agent or broker commissions.

Agents/Brokers shall recognize that the District will be scrutinizing the amount of remuneration in relation to the expected level of service to be received. The District wants to avoid payment of remuneration that may appear to be excessive. The District may be interested in negotiating such remuneration, especially when two or more agents have similar or identical lowest cost proposals. Proposing agents/brokers shall state if they are willing to negotiate such remuneration.

Please note that such agents making proposals must be designated by their choice of insurer(s) on the applicable Proposal Form(s). Whether an insurer is proposing with one such agent or multiple agents, all agents must be shown on the Proposal Form(s) submitted by such insurer, as these are the only agents that will be considered.

The Proposal Forms for all proposals must identify any agents or other intermediaries who are not employees of the insurers being proposed, and who will be receiving remuneration for the District's plan(s). The Proposal Forms must disclose the remuneration basis and estimated annual amounts. Any such agents that will be receiving remuneration in connection with proposals submitted in response to this RFP should complete the Proposal Forms contained in Section VIII.

The Proposal Forms must include details of the service to be provided by these agents who will be receiving remuneration. See the separate Model Program for Agent/Broker Services Section V.

Also, if an agent who is not an employee of the insurer is chosen, the District reserves the right, based on its evaluation of the value of the service received, to continue such agent upon each renewal or to alternatively consider the direct services of the insurer through its employee agent.

AGENT OF RECORD

The District reserves the right at any time to replace the Agent of Record (if there is one) with another agent of the same company, if, in the opinion of the District, such Agent of Record is not rendering or is incapable or rendering the quality of service and cooperation required.

Please note that agents submitting proposals included or not included with an insurer must be designated on the insurer's applicable Proposal Form(s). If an insurer is proposing with multiple agents, all agents must be shown on the Proposal Form(s), as these are the only agents that will be considered.

FULLY INSURED MEDICAL AND PRESCRIPTION REFERENCES

Insurers should provide at least four (4) references for which similar coverage and services have been provided in the past three (3) years. References from the District's general geographic area and from similarly sized Florida school districts, counties, municipalities and/or other governments are preferred.

MEDICAL AND PRESCRIPTION CLAIMS ADMINISTRATION REFERENCES

Insurers should provide at least four (4) references for which similar coverage and services have been provided in the past three (3) years. References from the District's general geographic area and from similarly sized Florida school districts, counties, municipalities and/or other governments are preferred. Please note that References as an Evaluation Criteria will be ranked based upon original submittal and original submittals are expected to include reference details.

STOP-LOSS INSURER REFERENCES

Insurers should provide at least four (4) references for which similar coverage and services have been provided in the past three (3) years. References from the District's general geographic area and from similarly sized Florida school districts, counties, municipalities and/or other governments are preferred. Please note that References as an Evaluation Criteria will be ranked based upon original submittal and original submittals are expected to include reference details.

AGENT/BROKER REFERENCES

Agent proposers should provide at least four (4) references for which similar coverage and services have been provided in the past three (3) years. References from the District's general geographic area and from similarly sized Florida school districts, counties, municipalities and/or other governments are preferred. Note: Unless factual, the same references used for the medical insurance references are not to be copied. The District is requesting specific references from the Agent/Broker. Please note that References as an Evaluation Criteria will be ranked based upon original submittal and original submittals are expected to include reference details.

DEVIATIONS FROM MODEL PROGRAM

The contract terms and conditions stipulated in this RFP are those desired by the District, and preference will be given to those proposals in full or substantial compliance with them. All deviations from the model program must be clearly stated on the Proposal Forms.

DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Section III

Common Contract Provisions

SECTION III

COMMON CONTRACT PROVISIONS

PROVISIONS INCORPORATED BY REFERENCE

This Section III contains requirements and endorsements, which are common to more than one coverage or service. The contract requirements and endorsements set forth in this Section III are incorporated by reference in such sections. Those provisions, which are identified as endorsements, are to be included verbatim in the insurance policy or contract.

PROHIBITION OF WARRANTY ENDORSEMENT

The Company acknowledges that District, has made a reasonable attempt to provide the Company with relevant and appropriate rating exposures and loss data. The Company therefore waives any right of denial of coverage or voidance of the contract based upon any expressed or implied warranty or representation (whether written or oral) that the rating exposures and loss data provided disclose all exposures or data known to exist.

SOLE AGENT ENDORSEMENT

It is agreed that District shall be the Sole Agent with respect to payment, cancellation, and notice with respect to the Contract between the District and the successful proposer(s). Any notice with respect to the foregoing shall be sent in writing to:

The District School Board of Sumter County, FL
Deborah Smith
Senior Director of Business & Institutional Services
2680 W CR 476, Building #2
Bushnell, FL 33513

HOLD HARMLESS/INDEMNIFICATION PROVISION

The successful Proposer shall hold harmless, indemnify and defend District, its members, officials, officers and employees against any claim, action, loss, damage, injury, liability, cost and expense of whatsoever kind or nature (including, but not by way of limitation, attorneys' fees and court costs) arising out of or incidental to the performance of the contract or work performed thereunder, whether or not due to or caused by negligence of District, its members, officials, officers or employees, excluding only the sole negligence of District, its members, officials, officers and employees.

TERMINATION AND NON-RENEWAL ENDORSEMENT

Notwithstanding any provision in this Contract to the contrary, except with respect to cancellation of this Contract for non-payment (for which at least sixty (60) days' written notice shall be provided), the Company may not cancel, non-renew, restrict coverage, or restrict the Company's contractual obligations with respect to this Contract except:

A. as of the end of the 12 or 36 month anniversary of this Contract; and

B. then only when such action is to be effective at least one hundred and twenty (120) days after receipt by District, of valid written notice from the Company of the Company's intention with respect to such cancellation, non-renewal, restriction of coverage, or restriction of the Company's contractual obligations.

The Company may not effect cancellation of this Contract for non-payment of premium until at least sixty (60) days after receipt by District, of valid written notice from the Company of the Company's intention with respect to such cancellation.

The written notice of any cancellation, non-renewal or restriction of the Company's contractual obligations shall be delivered by certified mail to:

The District School Board of Sumter County, FL
Deborah Smith
Senior Director of Business & Institutional Services
2680 W CR 476, Building #2
Bushnell, FL 33513

This Contract may be canceled at any time at the request of District, by written notice to the Company stating when thereafter cancellation is to be effective. In the event of termination of this Contract, for whatever reason, the earned fees or other consideration shall be computed on a pro rata basis without penalty, and the Company shall refund the excess of paid fees or other consideration to the District, within thirty (30) days from the date of termination.

RERATING ENDORSEMENT

Notwithstanding any provision in this Contract to the contrary, the Company may not affect any increase of rates or other consideration applicable to this Contract except:

A. as of the end of the 12 or 36 month anniversary of this Contract; and

B. then only when such increase is to be effective at least ninety (90) days after receipt by District, of valid written notice from the Company, stating specifically the amount of change proposed. Mere notice that a change in

rates or consideration is proposed, without stating clearly the exact amount and the effect of the proposed change on the overall consideration of this Contract, shall **not** constitute a valid notice.

The written notice of any change in rates or other change in consideration shall be delivered by certified mail to:

The District School Board of Sumter County, FL
Deborah Smith
Senior Director of Business & Institutional Services
2680 W CR 476, Building #2
Bushnell, FL 33513

DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Section IV

Model Program
For
Fully Insured Medical and Prescription Benefits

SECTION IV

MODEL PROGRAM FOR FULLY INSURED MEDICAL AND PRESCRIPTION BENEFITS

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION IV – MODEL PROGRAM FOR FULLY INSURED MEDICAL AND PRESCRIPTION BENEFITS.

SECTION II - GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.

SECTION III – COMMON CONTRACT PROVISIONS – All provisions of Section III are specifically incorporated by reference.

CONTRACT PERIOD

Medical and Prescription

An initial 12-month contract, from January 1, 2016, through and including December 31, 2016, is required with the option of the District to renew for additional plan years after, as agreeable by both parties.

Renewal guarantees are encouraged and will be considered favorably.

RATE GUARANTEE PERIOD

Regardless of actual enrollment, the initial rates shall be guaranteed for 12 months. Changes after the initial 12 month period shall be subject to the Rerating Endorsement.

REMUNERATION

Any remunerations or other similar compensation included must be shown separately. Remuneration arrangements, if any, will be between the District, the successful proposer and any agent, broker or other intermediary representing the successful proposer.

ACCESS TO CLAIM FILES

The proposer agrees that the District shall have reasonable access to all claim files created as a result of the claims services to be provided by the successful Proposer. For the purpose of this provision, reasonable access shall include making available, upon receipt of five (5) days advance written notice, all claim files for review by the District. Further, upon written request of the District, the successful Proposer shall make available to the District at the District's offices and within ten (10) days after the written request, a complete copy of selected files identified by the District.

OWNERSHIP OF CLAIM DATA

The District shall have all right, title, interest and ownership to all loss statistics created as a result of the services to be provided by the successful Proposer. Further, at the sole option of the District, and upon fourteen (14) calendar days' written notice, the successful Proposer shall provide such data to the District.

At the termination of the contract, the successful Proposer shall provide the District with computer tapes or other computer media containing all of the data required to facilitate a smooth transition. Such data shall be made available within 30 days of written request, in a format generally importable into a commonly recognized database for loss statistics.

AUDIT

Proposers shall state to what extent they will allow the District to audit or, to permit designees on behalf of the District, to audit the proposer's files and procedures as they relate to the District.

AUDIT REPORT

Proposers must annually provide the District with a SAS-70 audit, or its equivalent.

ELIGIBILITY & ENROLLMENT

Coverage must match the District's current eligibility requirements (which may be amending due to Healthcare Reform in the near future) as outlined in the District's current plan documents. These documents can be found in the Exposure Section VIII of this RFP and applicable employee handbooks and manuals.

Employees are eligible for medical coverage on the first day of the following month after 30 days of employment. Please note there are additional employees effective 10/1/15 included on the medical active census.

Due to the timing of the school year, the District will complete their open enrollment during the fall, usually in the month of November Please discuss within your proposal the ability to provide on-site meetings (where and when will be determined at a later date) and any other additional resources for the District in their open enrollment process, for example, online or telephonic resources.

Proposers should be aware that it is impossible to predict how many employees will elect each plan design and monthly premiums rates for each plan design must be honored as proposed even if there is a substantial change in plan design choices at enrollment.

CONTINUITY OF COVERAGE (NO LOSS/NO GAIN PROVISION)

Notwithstanding any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan to the contrary, if, but for the replacement of the current plan with the proposed plan, an insured would have been covered by the current plan, the insured shall be entitled to the lesser of:

(1) the benefits which would have been payable had the current plan been continued; or

(2) the benefits which would be payable under the proposed plan without the application of any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan.

CONTRACT

All proposals should include copies of any contract which the District will be required to execute. Any conflicts with requested clauses (Section II and III) must be specifically noted or such will be deemed not required.

SCOPE OF COVERAGE

The medical and prescription documents can be found in the Exposure Section VIII of this RFP.

The District reserves the right to negotiate with proposer finalist(s) on alternative medical and prescription plan designs.

Medical and Prescription

The District is interested in proposals for plan designs that most closely match the District's current medical and prescription plan designs:

1. Florida Blue BlueOptions – Plan 03359
2. Florida Blue BlueOptions – Plan HSA 03160/03161
3. Florida Blue BlueCare – Plan 47

The District would like plan designs that can deliver cost effective prescription benefits to the District's medical benefits plan participants through an extensive pharmacy network, supplemented by a mail order service and specialty pharmacy services.

COBRA and HIPAA services must be included as well. If there is a separate proposal or service provider for either service, please note that any sub-contracted services to be provided must be identified in the proposal.

The prescription benefit should be proposed as similar as possible to the current plan, shown in the plan documents relevant to this RFP. The prescription plan includes:

- Three classes of step-therapy including Statins (Cholesterol), Blood Pressure and Acid Reflux. For those employees that have already gone through the

step-therapy program and are on a non-generic drug, the District wants to ensure that these same employees and their applicable meds can be grandfathered in. Please explain in your proposal how you can accomplish this.

- Free preventative medications.
- Free generics for preventative medications.

Accordingly, this RFP includes a Benefits Match-Up –a,b,c Exhibit – ITEM 4, outlining the current benefits and asking proposers to respond "Match" or provide details regarding the benefits offered for the plan proposed.

Deviations should be noted.

POOLING POINT

Proposers are requested to provide details regarding the pooling point and pooling charges included in premium calculations. Current pooling is at $195,000.

SCOPE OF SERVICES

The successful Proposer shall perform all services indicated below, including:

- Provider and Network Services,
- Service/Customer Service and Administration Services,
- Healthcare Reform Services,
- Prescription Benefit Services,
- Reporting and Data Services, and
- Wellness Program and Disease Management Services.

Proposals must include claims administration, network access and utilization review services. Any sub-contracted services (such as a COBRA administrator) to be provided in connection with these requirements must be identified in the proposal.

BILLING AND ELIGIBILITY

The District currently confirms enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the District's eligibility record. This record is currently provided in an excel format that can be overlaid into the District's system for billing and reconciliation purposes. The District is requesting the same or equivalent accommodation. Please describe how you will accommodate this request. The other option that the District will consider is the online electronic enrollment system.

STANDARD COMMUNICATION MATERIALS

All proposals should include copies of standard communication materials that are sent to members, such as explanation of benefit (EOB) type forms, disease management letters, prescription reminder letters and Health Risk Assessment correspondence, etc.

PROVIDER AND NETWORK SERVICES

Proposer should maintain a provider managed care network consisting of hospitals, physicians, allied and ancillary services, and durable medical equipment. This arrangement should:

1. Provide services with reasonable promptness with respect to geographical location, hours of operation, and after hours care; including emergency care available 24 hours a day, 7 days a week.

2. Contract with network physicians that:
   a. Hold appropriate occupational and professional licenses;
   b. Hold active and unrestricted privileges in their specialty;
   c. Have a valid Drug Enforcement and Administration (DEA) number and hold unrestricted prescribing privileges (except chiropractors);
   d. Have hospital privileges at participating hospitals;
   e. Have not been convicted of a felony or greater crime;
   f. Are specialty board certified (80% or greater); and
   g. Have not been suspended, placed on probation or limited from any hospital privileges or restricted from receiving payments from Medicare, Medicaid, or other third party programs during the last five years.

3. Contract with network hospitals that:
   a. Hold current Joint Commission on Accreditation of Hospitals (JCAH) accreditation without conditions and licensure;
   b. Have at least 80% of staff physicians with full admitting privileges board certified;
   c. Are free from disciplinary action for the last five years;
   d. Are Medicare certified; and
   e. Hold current accreditation with one of the following (in lieu of JCAH), if hospital is primarily of a rehabilitative nature and lacks surgical facilities:
      (1) American Osteopathic Hospital Association; or
      (2) Commission on the Accreditation of Rehabilitative Facilities.

4. Provide a network(s) consisting of providers that have the capacity to provide treatment throughout the State of Florida and for those that are either visiting or reside outside of Florida.

   Accordingly, this RFP includes a Most Utilized Providers Exhibit – ITEM 5, listing the top providers and asking proposers to respond (yes or no) regarding whether the hospitals and providers are included or not in the network for each plan proposed.

   a. The District desires the network to include the District's most utilized hospitals. Proposers should include a detailed list that includes all participating hospitals in the following counties: Sumter, Lake, Citrus, Marion, Pasco and Hernando.

b. The District desires that the hospitals in the network(s), collectively, should offer the following services:
   (1) Anesthesia
   (2) Audiology
   (3) Day Surgery
   (4) Diagnostic, X-Ray, and Laboratory Services
   (5) Emergency Services
   (6) Medical/Surgical Intensive and Acute Care
   (7) Neo-natal Care
   (8) Neurology Services
   (9) Obstetrical Care and High-Risk Obstetrical Care
   (10) Pediatric Care
   (11) Psychiatric Care
   (12) Respiratory Care
   (13) Social Service & Discharge Planning
   (14) Speech Pathology
   (15) Substance Abuse Treatment
   (16) Therapies - Physical, Respiratory, Occupational
   (17) Trauma Care

c. The District desires that the network(s) include the following providers:
   (1) Primary care physicians who include physicians practicing in the field of General Practice, Family Practice, Internal Medicine, OB/GYN, and Pediatrics.
   (2) Specialty physicians in the network(s), collectively, should provide the following medical practice areas:
      - Allergy/Immunology
      - Anesthesiology
      - Cardiology
      - Chiropractic Medicine
      - Endocrinology
      - Dermatology
      - Gastroenterology
      - Internal Medicine
      - Neurology
      - Obstetrics/Gynecology
      - Oncology
      - Ophthalmology
      - Orthopedic Medicine
      - Otolaryngology
      - Pediatrics
      - Physical and Occupational Therapy
      - Podiatry
      - Pulmonary Medicine
      - Radiology
      - Rheumatology

- Speech Pathology and Audiology
- Urology

5. Provide benefits to employees/dependents that are referred to an out-of-network specialist due to the lack of in-network providers in that specialty, at the in-network benefit level.

6. In addition, provide in-network benefits to non-participating providers when services provided at an in-network facility by facility-based providers, such as hospitalists, surgical assistants, anesthesiologists, radiologists, pathologists, etc.

7. Include ancillary providers in the network(s) that are properly licensed and credentialed, and provide the following services: imaging centers, diagnostic x-ray and laboratory facilities, durable medical goods, home health care, skilled nursing facility, birth centers, and hospices.

8. Provide employees with current directories on an annual basis with quarterly updates, and/or provide on-line access to current directory information.

9. Require that network providers hold the employees/dependents and the District harmless from any fees for services which are rendered that are plan eligible charges (except deductibles, co-payments and coinsurance), regardless of the reason for non-payment.

10. Prohibit network providers from balance billing the patient for any excess of contracted amount, except for deductibles, co-payments and coinsurance.

11. Provide Medical Case Management that:
    a. Uses Florida Registered Nurses and vocational counselors to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.
    b. Performs specific services that coordinate the provision of care and the management of benefits in cases of catastrophic illness or injury. Such a program should strive to ensure that patients receive the most appropriate, cost-effective care and derive maximum advantage from available plan benefits. It may require covering expenses not normally covered by the plan (e.g., air conditioners, wheelchair ramps, etc.) in exceptional situations, to return a patient to a productive life.
    c. Follows specific medical/disability criteria to determine which claims may need medical/disability management intervention to include, but not be limited to, the following:

        (1) Spinal cord injury
        (2) Burns (third and fourth degree)
        (3) Amputations
        (4) Traumatic brain injury

(5) Renal failure
(6) Neo-natal single or multiple births
(7) Neoplasm of brain, bone, pancreas, liver
(8) At risk pregnancy
(9) Accidents involving multiple family members with multiple injuries
(10) All claims exceeding a $25,000 threshold
(11) Organ transplants

d. Coordinates with Utilization Review and claims processing for effectiveness and efficiency.
e. Provides quarterly medical case management reports on all claims expected to exceed $50,000 or otherwise identified as being the type of claim which will benefit from medical case management, in addition to reports that identify current and past case loads, prognoses and savings realized through case management.

12. Provide Utilization Review that:
    a. Uses Florida licensed Registered Nurses to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.
    b. Includes the following specific services:
        (1) Pre-admission certification for medical admissions, and determination of medical necessity;
        (2) Continued stay review by telephone of all hospitalizations. Certification of the need for additional days beyond the initial pre-certification. Medical necessity of treatment and length of stay to be strictly observed. No benefits are to be payable if the treatment is not medically necessary;
        (3) Concurrent Review of selected hospitalizations via personal visit by a Registered Nurse (RN) where conditions indicate the need for such;
        (4) Retrospective Utilization Review (after delivery of service, but prior to payment) of all unusual claims plus all claims over $50,000; and
        (5) Discharge planning for medical/surgical patients.

    c. Provides quarterly statistics on the effectiveness of Utilization Review.
    d. Coordinates with Medical Case Management for effectiveness and efficiency.

SERVICE/CUSTOMER SERVICE AND ADMINISTRATION SERVICES

Except for the collection of premium to the successful Proposer and, as except otherwise noted in this RFP, the successful Proposer shall be totally responsible for the administration of the plan. These activities should include, but are not limited to, the following:

1. Assign a dedicated account manager as the District's account representative in each of the respective areas, including medical claims, medical eligibility and reporting and data services.

2. Assign a dedicated and experienced case manager to assist the District with managing high risk and high cost claims.

3. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported claims.

4. Design, print, and furnish descriptive literature and enrollment material in a sufficient quantity. Additionally, certificates/booklets are to be provided as needed. These certificates must have a readability level acceptable to the District. In addition, furnish an electronic version of the certificates/booklets for the District to use on their website. These documents must be provided at no additional cost to the District.

5. Mail/deliver booklets, ID cards, or certificates directly to the District, after the District has reviewed a draft and approved it. This review and approval by the District is to be completed prior to printing by the successful Proposer.

6. Issue ID cards within three (3) calendar weeks (plus four (4) days' mailing time) after completion of open enrollment periods or after enrollment papers are received for new hires.

7. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

8. Provide enrollment assistance, including educational materials pre-approved by the District in advance of distribution, to the District during open enrollment period on an annual basis. These tasks should include, but not be limited to, providing sufficient and properly trained enrollers employed by successful Proposer, and requiring that they attend all scheduled enrollment meetings.

9. Meet with the District, at a minimum, quarterly, to discuss the status of the plan, performance, audits, reports, and planning.

10. Attend meetings, if requested by the District, to discuss items such as medical plan trends, performance audits, reports and planning. Any meeting materials, such as reports, should be provided to the District at least one week in prior to the meeting date for purposes of reviewing and prioritizing data for meeting agenda.

11. Verify claimant's eligibility for benefits based on eligibility requirements furnished by the District.

12. Maintain covered dependent information by dependent's name, date of birth, gender, and relationship to insured and social security number.

13. Verify dependent status at least once per benefit year for overage dependents by pending the first claim of the benefit year and requesting verification from insured regarding status of dependent.

14. Use a fully automated online clinically-oriented claims adjudication and auditing system that analyzes coded claims data to ensure correct identification.

15. Screen for and deny workers' compensation claims.

16. Target (flag) the following types of claims for supervisory review*:

    a. Service required precertification, but certification not obtained;
    b. Actual length of stay or level of service does not match the approved length of stay or level of service;
    c. Dollar amount or diagnoses warrants potential referral to medical case management; or
    d. Any one bill that exceeds $50,000.

    *Supervisory review shall include, as appropriate, at a minimum, review of itemization of invoices exceeding $50,000 and review of case management notes.

17. Identify and maintain separate COB information for each applicable claimant, as well as distinguish between the various types of COB, including retirees eligible for Medicare. Identify and pursue claims that should be properly payable through automobile insurance and/or coordination of benefits (COB). Additionally, report on the savings produced.

18. Maintain the confidentiality requirements of Florida and federal law by having adequate systems security features.

19. Turnaround 95% of all "clean" claims within ten (10) working days and 100% of all claims within thirty (30) working days. A "clean" claim is a claim submitted with all needed information for proper processing and adjudication.

20. Issue EOBs to the claimant within five working days of processing claims.

21. Create an EOB that meets with the District's approval that uses a format and terminology such that a person not of a medical or insurance background can easily understand the content. This EOB must also comply with Health Care Reform requirements (example: Claims and Appeal procedure requirements).

22. Cooperate with the managed care organizations and the UR firm in resolving discrepancies for proper payment of benefits when compliance dictates the use of one or both of these programs.

23. Conduct semi-annual internal audits for claim accuracy and occurrence of mispayments. Report results to the District within ten (10) working days from the end of the reporting period.

24. Provide COBRA and HIPAA administration and pay COBRA beneficiary claims.

25. Establish and maintain a toll-free line for employees. This line should be operational from at least 8 a.m. to 6 p.m. (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls.

26. Maintain access to a Medical Director to evaluate appealed claims.

27. Coordinating with the District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the District's eligibility record in Excel format (as described above in the Billing and Eligibility section).

28. Administer the plan on a detail billing remittance basis by division, separated by active employee, retiree and COBRA beneficiary.

29. Conform accounting procedures and practices to generally accepted accounting principles.

30. Maintain proper records for tax reporting purposes; e.g., 1099s.

31. Retain medical claims history online for minimum of twenty-four (24) months.

32. Prepare, maintain, and file with any applicable federal, state or local governmental agencies, any forms or reports as may be required from time to time by law; e.g., New York Public Goods Pool, COBRA, CMS obligations, etc.

33. Provide assistance with regard to: (1) problems arising in connection with insurance laws, (2) tax aspects of the Plan, (3) litigation arising out of the administration of the Plan, and (4) any other legal matters that may arise in the course of the operation of the Plan.

34. Provide assistance with any regulatory employee notifications, both for Healthcare Reform and on an ongoing basis.

35. Provide claims fiduciary services. Establish claim denial and grievance procedures which are clearly communicated to members. Grievance procedures should be consistent with all applicable federal and state laws, rules and regulations, including but not limited to Healthcare Reform. Maintain access to a Medical Director to evaluate appealed claims.

36. Supply all postage required to service the District's account.

37. Send correspondence using District approved pre-formatted letters to the claimant or provider. The content of these letters must be easily understandable by a person not of a medical or insurance background.

38. The District will have first review and pre-approval of any correspondence that will be sent to claimants or providers that includes changes/amendments to the plan.

HEALTHCARE REFORM SERVICES

1. Provide ongoing Patient Protection and Affordable Care Act (PPACA) (Healthcare Reform) guidance, updates and resources.

2. As the effective and/or implementation dates of the PPACA become applicable to the District, assist the District in a timely manner in staying in compliance with the PPACA for their medical and prescription plans by (at a minimum):
    a. Reviewing the language in their plans in regards to the Guaranteed Availability of Coverage.
    b. Providing plan testing, of each plan offered, of the Essential Health Benefits as defined by the PPACA.
    c. Providing plan testing, of each plan offered, of the actuarial value of benefits (minimum value) as defined by the PPACA.
3. Provide the District a Summary of Benefits and Coverage (SBC).

4. Assist the District with understanding the fees assessed by the PPACA. In addition, assist the District in the assessment, cost and payment of any PPACA fees, including the Patient Centered Outcomes Research (PCOR) fee and the Transitional Reinsurance Program fee.

5. Assist the District with reporting as needed to assist with the filing and payment of PPACA fees.

PRESCRIPTION BENEFIT SERVICES

1. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported prescription claims.

2. Provide appropriate literature to describe the benefits offered by the District to its employees and appropriate educational materials regarding use of generics versus brand names, the advantages of mail order service where it is the most efficient for all concerned, and formulary information.

3. Use a fully automated online clinically-oriented claims adjudication/auditing system that analyzes coded claims data to ensure correct identification.

4. Screen for and deny workers' compensation claims.

5. Maintain the confidentiality requirements of Florida and Federal law by having adequate systems security features.

6. Establish and maintain a toll-free customer service line for employees. This line should be operational from at least 8 a.m. to 6 p.m. (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls, with call backs to occur within twenty-four (24) hours of the next business day.

7. Retain claims history online for minimum of twenty-four (24) months from the last date of any claim activity pertaining to services rendered. All prior claims history incurred during the course of this contract must be captured in such a manner compatible for media storage and delivered to the District at their request. This data must be maintained for the full duration of the contract period, and must also be available for transfer to the subsequent vendor, should the District elect to change vendors in the future.

8. Provide a comprehensive drug utilization review program (DUR).

9. Provide cost effective intervention programs, such as prior authorizations, step therapy, etc. as options for the District to consider.

MEDICAL & PRESCRIPTION REPORTING & DATA SERVICES

1. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

2. Provide the District's designees direct access to claims data and reporting capabilities.

3. Provide the District with aggregated data reporting capabilities.

4. Prepare and furnish the District with monthly exposure and loss data statistics. Exposure data should include census data, such as name of employee, zip code and date of birth and employment status. Loss data reports should include, but not be limited to, the following information: (Data subject to compliance with HIPAA privacy guidelines.)
    a. Claims data should be provided monthly (within 30 days after the end of the month) with cumulative totals for the plan year, separately for participants in each category of plan offered (e.g. PPO and HDHP), preferably in a format that will provide data separately for employees and their dependents, retirees and their dependents and COBRA and their dependents, and total for all participants and all dependents. The desire for separate premium/claims experience for employees, retirees, COBRA and dependents is to permit the District to determine if the rates being charged are equitable. Claim reports should be provided additionally for 12 months after plan termination, or until there are no runout and/or extension of benefits claims.

    b. Claims data should be provided monthly detailing all claims where more than $25,000 has been paid in the current plan year. Data should include amount paid, type of plan participant (employee, dependent, retiree, etc.), diagnosis, prognosis and status of the claim (active, expired, etc.).

5. Provide reports inclusive of data elements specified by the District, and in mutually agreed upon formats. The required standard reports include, but are not limited to, the following:
    a. Monthly reports are due on the 15th workday following the end of the "report" month. These reports should include paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).
    b. Quarterly and Year-to-Date Reports are due on the 15th working day following the "report" quarter. These reports should include: benefit payment summaries, inpatient (utilization) reports, paid claims by coverage and diagnosis types, COB savings, and service inquiries.

6. Provide prescription data reports inclusive of data elements specified by the District, and in mutually agreed upon formats. The required standard reports will include, but are not limited to: monthly reports of claims versus premium are due by the 15th business day following the end of the "report" month. These reports should include: paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).

7. Prepare and furnish the District with periodic prescription reports included in the medical benefits reports that provide claims data. Reports on drug benefits costs should include appropriate data on utilization by category (such as retail and mail order, for generic, preferred brand, non-preferred brand, etc.).

8. Provide access to archived data within ten (10) working days of a request by the District.

WELLNESS PROGRAM AND DISEASE MANAGEMENT SERVICES

Currently, the District's insurer, Florida Blue, provides a $100,000 annual wellness incentive fund. This fund can be used for wellness related activities for the District with their discretion. The District is interested in increasing this wellness fund and would like proposers to state if they can at least match and/or increase the wellness fund and how the District can use the fund specifically.

The District is in the process of requiring active employees on the District health plan take an annual online Health Assessment (HA) and complete a biometric screening this is intended to start 01/01/16. The District would keep track of the administration of the annual HA assessment and biometric screenings via participation reports. The online HAs are offered by Florida Blue with no additional cost to the District or employee.

The District is requesting that insurers match the current wellness offerings with the request to increase the wellness incentive fund.

In addition to the above, the District is interested in proactive wellness and disease management initiatives, including participation incentives, including but not limited to health screenings, flu shot programs and health fairs. The District is interested in proposers stating if they can assist with any of these services and costs.

If there are any additional offerings to those stated above, please provide details in your proposal about these program offerings and list out the pricing. Proposals should detail the support staff and any other assistance that will be provided. Additionally, please outline any wellness services that you think would be advantageous to the District and why.

PERFORMANCE GUARANTEES

Proposers should confirm that they are willing to offer performance guarantees and that they are willing to permit the District access to claims offices, personnel and files to conduct audits necessary to verification of performance standards. Performance may be evaluated on a variety of issues, such as:

- If applicable, timely implementation of the District's account.
- Timely delivery of finalized contracts for the selected program.
- Timely delivery of identification cards, at and subsequent to initial enrollment.
- For provider directories, timely updates either online or if a significant change that will affect a large portion of members, timely communication notices (s) (either verbal or via mail).
- Timely delivery of monthly reporting.
- Timely delivery of plan documents and HCR summaries (as applicable).
- Wellness program health guarantees.
- Claims turnaround time.
- Accuracy of claims coding and payments.
- Telephone response time, and abandonments.
- Quality of service to plan participants, as measured by periodic surveys.
- Quality and timeliness of claims experience reports.
- Network provider participation, with penalties for drops below pre-specified levels.
- Rate of provider turnovers.
- Access to standards of care.
- Collection or other threats to participants by providers not paid by the insurer.

State the extent to which these measurements will be applied specifically to the District's account (account specific) versus your "book of business".

Suggestions on criteria for measuring performance and indications of how the organization is set-up to facilitate auditing of performance should be submitted. If the proposer has a performance guarantee agreement, provide a sample for review.

Please confirm your firm's willingness to enter into such an agreement and to negotiate appropriate terms, and recommend appropriate incentives or disincentives (meaningful penalties) to make the performance guarantee practical.

DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Section V

Model Program For Medical and Prescription Claims Administration Services

SECTION V

MODEL PROGRAM FOR MEDICAL AND PRESCRIPTION CLAIMS ADMINISTRATION SERVICES

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION V – MODEL PROGRAM FOR MEDICAL AND PRESCRIPTION CLAIMS ADMINISTRATION SERVICES.

SECTION II - GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.

SECTION III – COMMON CONTRACT PROVISIONS – All provisions of Section III are specifically incorporated by reference.

CONTRACT PERIOD

An initial 36-month contract, from January 1, 2016, through and including December 31, 2018, is required. Further, it shall be the option of the District to renew the program for additional plan years thereafter.

Renewal guarantees are encouraged and will be considered favorably.

RATE GUARANTEE PERIOD

Regardless of actual enrollment, the initial rates shall be guaranteed for 36 months. Changes after the initial 36-month period shall be subject to the Rerating Endorsement.

REMUNERATION

Any remunerations or other similar compensation included must be shown separately. Remuneration arrangements, if any, will be between the District, the successful proposer and any agent, broker or other intermediary representing the successful proposer.

ACCESS TO CLAIM FILES

The proposer agrees that the District, shall have reasonable access to all claim files created as a result of the claims services to be provided by the successful proposer. For the purpose of this provision, reasonable access shall include making available, upon receipt of five (5) days advance written notice, all claim files for review by the District. Further, upon written request of the District, the successful Proposer shall make available to the District at the District's offices and within ten (10) days after the written request, a complete copy of selected files identified by the District.

OWNERSHIP OF CLAIM DATA

The District shall have all right, title, interest and ownership to all loss statistics created as a result of the services to be provided by the successful Proposer. Further, at the sole option of the District, and upon fourteen (14) calendar days' written notice, the successful Proposer shall provide such data to the District.

At the termination of the contract, the successful Proposer shall provide the District with computer tapes or other computer media containing all of the data required to facilitate a smooth transition. Such data shall be made available within 30 days of written request, in a format generally importable into a commonly recognized database for loss statistics.

AUDIT REQUIREMENT

Proposers shall state to what extent they will allow the District to audit or, to permit designees on behalf of the District, to audit the proposer's files and procedures as they relate to the District.

AUDIT REPORT

Proposers must annually provide the District with a SAS-70 audit, or its equivalent.

ELIGIBILITY & ENROLLMENT

Coverage must match the District's current eligibility requirements (which may be amending due to Healthcare Reform in the near future) as outlined in the District's current plan documents. These documents can be found in the Exposure Section VIII of this RFP and applicable employee handbooks and manuals.

Employees are eligible for medical coverage on the first day of the following month after 30 days of employment. Please note there are additional employees effective 10/1/15 included on the medical active census.

Due to the timing of the school year, the District will complete their open enrollment during the fall, usually in the month of November. Please discuss within your proposal the ability to provide on-site meetings (where and when will be determined at a later date) and any other additional resources for the District in their open enrollment process, for example, online or telephonic resources.

Proposers should be aware that it is impossible to predict how many employees will elect each plan design and monthly premiums rates for each plan design must be honored as proposed even if there is a substantial change in plan design choices at enrollment.

CONTINUITY OF COVERAGE (NO LOSS/NO GAIN PROVISION)

Notwithstanding any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan to the contrary, if, but for the replacement of the current plan with the proposed plan, an insured would have been covered by the current plan, the insured shall be entitled to the lesser of:

(1) the benefits which would have been payable had the current plan been continued; or

(2) the benefits which would be payable under the proposed plan without the application of any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan.

CONTRACT

All proposals should include copies of any contract which the District will be required to execute. Any conflicts with requested clauses (Section II and III) must be specifically noted or such will be deemed not required.

SCOPE OF COVERAGE

The medical and prescription documents can be found in the Exposure Section VIII of this RFP.

The District reserves the right to negotiate with proposer finalist(s) on alternative medical and prescription plan designs.

Medical and Prescription

The District is interested in proposals for plan designs that most closely match the District's current medical and prescription plan designs:

1. Florida Blue BlueOptions – Plan 03359
2. Florida Blue BlueOptions – Plan HSA 03160/03161
3. Florida Blue BlueCare – Plan 47

The District would like plan designs that can deliver cost effective prescription benefits to the District's medical benefits plan participants through an extensive pharmacy network, supplemented by a mail order service and specialty pharmacy services.

COBRA and HIPAA services must be included as well. If there is a separate proposal or service provider for either service, please note that any sub-contracted services to be provided must be identified in the proposal.

The prescription benefit should be proposed as similar as possible to the current plan, shown in the plan documents relevant to this RFP. The prescription plan includes:

- Three classes of step-therapy including Statins (Cholesterol), Blood Pressure and Acid Reflux. For those employees that have already gone through the step-therapy program and are on a non-generic drug, the District wants to ensure that these same employees and their applicable meds can be grandfathered in. Please explain in your proposal how you can accomplish this.
- Free preventative medications.
- Free generics for preventative medications.

Accordingly, this RFP includes a Benefits Match-Up Exhibit – a,b,c – ITEM 4, outlining the current benefits and asking proposers to respond "Match" or provide details regarding the benefits offered for the plan proposed.

Deviations should be noted.

SCOPE OF SERVICES

The District is seeking proposals for claims administrative services from a qualified medical claims administrator to support the District's group plans.

Claims administration for incurred but not reported run out claims following termination of the contract are requested to be outlined in the proposal and proposed fees.

Network Discounts

The District is interested in a medical claims administrator which has successfully developed a cost-effective provider network allowing the District and its plan participants to access needed medical care with significant discounts. Proposers are requested to provide the network discounts for the current/average percent discounts from billed charges in the Sumter and surrounding areas. In addition, proposers will be asked if a guaranteed medical network discount(s) can be provided for the District.

Guaranteed Medical Network Discount

The guaranteed medical network discount will be the discount percent where the administrator is guaranteeing claims in service categories including: inpatient hospital, outpatient hospital, outpatient surgical centers, emergency room facility costs, urgent care facility and professional, to be discounted at a guaranteed percent. Any risk corridor given will be subtracted from the guaranteed network discount percent to come up with a bottom line or "net" guaranteed medical network discount.

Dedicated Staff

The District is requesting the following dedicated staff:

1. One dedicated and experienced account manager to assist the District with managing the everyday details of the District's account. This account manager must be easily accessible and able to answer questions about the District's account. If additional resources are needed to answer questions or address issues, the account manager must be able to know which resources to utilize and be able to do so in a timely and efficient manner.

2. One dedicated and experienced case manager to assist the District with managing high risk and high cost claims. This case manager will oversee the management of the medical needs of the individual members and keep the District and their stop-loss carrier informed of the financial risks.

The successful Proposer shall perform all services indicated below, including:

- Provider and Network Services,
- Service/Customer Service and Administration Services,
- Healthcare Reform Services,
- Prescription Benefit Services,
- Reporting and Data Services, and
- Wellness Program and Disease Management Services.

STANDARD COMMUNICATION MATERIALS

All proposals should include copies of standard communication materials that are sent to members, such as explanation of benefit (EOB) type forms, disease management letters, prescription reminder letters and Health Risk Assessment correspondence, etc.

PROVIDER AND NETWORK SERVICES

Proposer should maintain a provider managed care network consisting of hospitals, physicians, allied and ancillary services, and durable medical equipment. This arrangement should:

1. Provide services with reasonable promptness with respect to geographical location, hours of operation, and after hours care; including emergency care available 24 hours a day, 7 days a week.

2. Contract with network physicians that:
   a. Hold appropriate occupational and professional licenses;
   b. Hold active and unrestricted privileges in their specialty;
   c. Have a valid Drug Enforcement and Administration (DEA) number and hold unrestricted prescribing privileges (except chiropractors);
   d. Have hospital privileges at participating hospitals;
   e. Have not been convicted of a felony or greater crime;
   f. Are specialty board certified (80% or greater); and
   g. Have not been suspended, placed on probation or limited from any hospital privileges or restricted from receiving payments from Medicare, Medicaid, or other third party programs during the last five years.

3. Contract with network hospitals that:
   a. Hold current Joint Commission on Accreditation of Hospitals (JCAH) accreditation without conditions and licensure;
   b. Have at least 80% of staff physicians with full admitting privileges board certified;
   c. Are free from disciplinary action for the last five years;
   d. Are Medicare certified; and

e. Hold current accreditation with one of the following (in lieu of JCAH), if the hospital is primarily of a rehabilitative nature and lacks surgical facilities:

(1) American Osteopathic Hospital Association; or
(2) Commission on the Accreditation of Rehabilitative Facilities.

4. Provide a network(s) consisting of providers that have the capacity to provide treatment throughout the State of Florida and for those that are either visiting or reside outside of Florida.

Accordingly, this RFP includes a Most Utilized Providers Exhibit – ITEM 5, listing the top providers and asking proposers to respond (yes or no) regarding whether the hospitals and providers are included or not in the network for each plan proposed.

a. Proposers should include a detailed list that includes all participating hospitals in the following counties: Sumter, Lake, Citrus, Marion and Pasco.
b. The District desires that the hospitals in the network(s), collectively, should offer the following services:
(1) Anesthesia
(2) Audiology
(3) Day Surgery
(4) Diagnostic, X-Ray, and Laboratory Services
(5) Emergency Services
(6) Medical/Surgical Intensive and Acute Care
(7) Neo-natal Care
(8) Neurology Services
(9) Obstetrical Care and High-Risk Obstetrical Care
(10) Pediatric Care
(11) Psychiatric Care
(12) Respiratory Care
(13) Social Service & Discharge Planning
(14) Speech Pathology
(15) Substance Abuse Treatment
(16) Therapies - Physical, Respiratory, Occupational
(17) Trauma Care

c. The District desires that the network(s) include the following providers:
(1) Primary care physicians who include physicians practicing in the field of General Practice, Family Practice, Internal Medicine, OB/GYN, and Pediatrics.
(2) Specialty physicians in the network(s), collectively, should provide the following medical practice areas:
- Allergy/Immunology
- Anesthesiology

- Cardiology
- Chiropractic Medicine
- Endocrinology
- Dermatology
- Gastroenterology
- Internal Medicine
- Neurology
- Obstetrics/Gynecology
- Oncology
- Ophthalmology
- Orthopedic Medicine
- Otolaryngology
- Pediatrics
- Physical and Occupational Therapy
- Podiatry
- Pulmonary Medicine
- Radiology
- Rheumatology
- Speech Pathology and Audiology
- Urology

5. Provide benefits to employees/dependents that are referred to an out-of-network specialist due to the lack of in-network providers in that specialty, at the in-network benefit level.

6. In addition, provide in-network benefits to non-participating providers when services provided at an in-network facility by facility-based providers, such as hospitalists, surgical assistants, anesthesiologists, radiologists, pathologists, etc.

7. Include ancillary providers in the network(s) that are properly licensed and credentialed, and provide the following services: imaging centers, diagnostic x-ray and laboratory facilities, durable medical goods, home health care, skilled nursing facility, birth centers, and hospices.

8. Provide employees with current directories on an annual basis with quarterly updates, and/or provide on-line access to current directory information.

9. Require that network providers hold the employees/dependents and the District harmless from any fees for services which are rendered that are plan eligible charges (except deductibles, co-payments and coinsurance), regardless of the reason for non-payment.

10. Prohibit network providers from balance billing the patient for any excess of contracted amount, except for deductibles, co-payments and coinsurance.

11. Provide Medical Case Management that:
    a. Uses Florida Registered Nurses and vocational counselors to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.
    b. Performs specific services that coordinate the provision of care and the management of benefits in cases of catastrophic illness or injury. Such a program should strive to ensure that patients receive the most appropriate, cost-effective care and derive maximum advantage from available plan benefits. It may require covering expenses not normally covered by the plan (e.g., air conditioners, wheelchair ramps, etc.) in exceptional situations, to return a patient to a productive life.
    c. Follows specific medical/disability criteria to determine which claims may need medical/disability management intervention to include, but not be limited to, the following:
        (1) Spinal cord injury
        (2) Burns (third and fourth degree)
        (3) Amputations
        (4) Traumatic brain injury
        (5) Renal failure
        (6) Neo-natal single or multiple births
        (7) Neoplasm of brain, bone, pancreas, liver
        (8) At risk pregnancy
        (9) Accidents involving multiple family members with multiple injuries
        (10) All claims exceeding a $50,000 threshold
        (11) Organ transplants

    d. Coordinates with Utilization Review and claims processing for effectiveness and efficiency.
    e. Provides quarterly medical case management reports on all claims expected to exceed $50,000 or otherwise identified as being the type of claim which will benefit from medical case management, in addition to reports that identify current and past case loads, prognoses and savings realized through case management.

12. Provide Utilization Review that:
    a. Uses Florida licensed Registered Nurses to provide all the services described below. Refer more complicated cases and/or disputes with providers to physician consultants who are licensed and are board certified in their specialty.
    b. Includes the following specific services:

        (1) Pre-admission certification for medical admissions, and determination of medical necessity;
        (2) Continued stay review by telephone of all hospitalizations. Certification of the need for additional days beyond the initial pre-certification. Medical necessity of treatment and length of stay to be

strictly observed. No benefits are to be payable if the treatment is not medically necessary;

(3) Concurrent Review of selected hospitalizations via personal visit by a Registered Nurse (RN) where conditions indicate a need for such;

(4) Retrospective Utilization Review (after delivery of service, but prior to payment) of all unusual claims plus all claims over $50,000; and

(5) Discharge planning for medical/surgical patients.

c. Provides quarterly statistics on the effectiveness of Utilization Review.

d. Coordinates with Medical Case Management for effectiveness and efficiency.

SERVICE/CUSTOMER SERVICE AND ADMINISTRATION SERVICES

Except for the collection of premium to the successful Proposer and, as except otherwise noted in this RFP, the successful Proposer shall be totally responsible for the administration of the plan. These activities should include, but are not limited to, the following:

1. Assign a dedicated account manager as the District's account representative in each of the respective areas, including medical claims, medical eligibility and reporting and data services.

2. Assign a dedicated and experienced case manager to assist the District with managing high risk and high cost claims.

3. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported claims.

4. Design, print, and furnish descriptive literature and enrollment material in a sufficient quantity. Additionally, certificates/booklets are to be provided as needed. These certificates must have a readability level acceptable to the District. In addition, furnish an electronic version of the certificates/booklets for the District to use on their website. These documents must be provided at no additional cost to the District.

5. Mail/deliver booklets, ID cards, or certificates directly to the District, after the District has reviewed a draft and approved it. This review and approval by the District is to be completed prior to printing by the successful Proposer.

6. Issue ID cards within three (3) calendar weeks (plus four (4) days' mailing time) after completion of open enrollment periods or after enrollment papers are received for new hires.

7. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

8. Provide enrollment assistance, including educational materials pre-approved by the District in advance of distribution, to the District during open enrollment period on an annual basis. These tasks should include, but not be limited to, providing sufficient and properly trained enrollers employed by successful Proposer, and requiring that they attend all scheduled enrollment meetings.

9. Meet with the District, at a minimum, quarterly, to discuss the status of the plan, performance, audits, reports, and planning.
10. Attend meetings, if requested by the District.

11. Verify claimant's eligibility for benefits based on eligibility requirements furnished by the District.

12. Maintain covered dependent information by dependent's name, date of birth, gender, and relationship to insured and social security number.

13. Verify dependent status at least once per benefit year for overage dependents by pending the first claim of the benefit year and requesting verification from insured regarding status of dependent.

14. Use a fully automated online clinically-oriented claims adjudication and auditing system that analyzes coded claims data to ensure correct identification.

15. Screen for and deny workers' compensation claims.

16. Target (flag) the following types of claims for supervisory review*:
    a. Service required precertification, but certification not obtained;
    b. Actual length of stay or level of service does not match the approved length of stay or level of service;
    c. Dollar amount or diagnoses warrants potential referral to medical case management; or
    d. Any one bill that exceeds $50,000.

    *Supervisory review shall include, as appropriate, at a minimum, a review of itemization of invoices exceeding $50,000 and review of case management notes.

17. Identify and maintain separate COB information for each applicable claimant, as well as distinguish between the various types of COB, including retirees eligible for Medicare.

18. Maintain the confidentiality requirements of Federal and Florida law by having adequate systems security features.

19. Turnaround 95% of all "clean" claims within ten (10) working days and 100% of all claims within thirty (30) working days. A "clean" claim is a claim submitted with all needed information for proper processing and adjudication.

20. Issue EOBs to the claimant within five working days of processing claims.

21. Create an EOB that meets with the District's approval that uses a format and terminology such that a person not of a medical or insurance background can easily understand the content. This EOB must also comply with Health Care Reform requirements (example: Claims and Appeal procedure requirements).

22. Cooperate with the managed care organizations and the UR firm in resolving discrepancies for proper payment of benefits when compliance dictates the use of one or both of these programs.

23. Conduct semi-annual internal audits for claim accuracy and occurrence of mispayments. Report results to the District within ten (10) working days from the end of the reporting period.

24. Provide COBRA and HIPAA administration and pay COBRA beneficiary claims.

25. Establish and maintain a toll-free line for employees. This line should be operational from at least 8 a.m. to 6 p.m. (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls.

26. Maintain access to a Medical Director to evaluate appealed claims.

27. Coordinating with the District to continue confirming enrollment/eligibility on a monthly basis by comparing the insurer's eligibility record to the District's eligibility record in Excel format (as described above in the Billing and Eligibility section).

28. Administer the plan on a detail billing remittance basis by division, separated by active employee, retiree and COBRA beneficiary.

29. Conform accounting procedures and practices to generally accepted accounting principles.

30. Maintain proper records for tax reporting purposes; e.g., 1099s.

31. Retain medical claims history online for minimum of twenty-four (24) months.

32. Prepare, maintain, and file with any applicable federal, state or local governmental agencies, any forms or reports as may be required from time to time by law; e.g., New York Public Goods Pool, COBRA, CMS obligations, etc.

33. Provide assistance with regard to: (1) problems arising in connection with insurance laws, (2) tax aspects of the Plan, (3) litigation arising out of the administration of the Plan, and (4) any other legal matters that may arise in the course of the operation of the Plan.

34. Provide assistance with any regulatory employee notifications, both for Healthcare Reform and on an ongoing basis.

35. Provide claims fiduciary services. Establish claim denial and grievance procedures which are clearly communicated to members. Grievance procedures should be consistent with all applicable federal and state laws, rules and regulations, including but not limited to Healthcare Reform. Maintain access to a Medical Director to evaluate appealed claims.

36. Supply all postage required to service the District's account.

37. Send correspondence using District approved pre-formatted letters to the claimant or provider. The content of these letters must be easily understandable by a person not of a medical or insurance background.

38. The District will have first review and pre-approval of any correspondence that will be sent to claimants or providers that includes changes/amendments to the plan.

HEALTHCARE REFORM SERVICES

1. Provide ongoing Patient Protection and Affordable Care Act (PPACA) (Healthcare Reform) guidance, updates and resources.

2. As the effective and/or implementation dates of the PPACA become applicable to the District, assist the District in a timely manner in staying in compliance with the PPACA for their medical and prescription plans by (at a minimum):
    a. Reviewing the language in their plans in regards to the Guaranteed Availability of Coverage.
    b. Providing plan testing, of each plan offered, of the Essential Health Benefits as defined by the PPACA.
    c. Providing plan testing, of each plan offered, of the actuarial value of benefits (minimum value) as defined by the PPACA.
3. Provide the District a Summary of Benefits and Coverage (SBC).

4. Assist the District with understanding the fees assessed by the PPACA. In addition, assist the District in the assessment, cost and payment of any PPACA fees, including the Patient Centered Outcomes Research (PCOR) fee and the Transitional Reinsurance Program fee.

5. Assist the District with reporting as needed to assist with the filing and payment of PPACA fees.

PRESCRIPTION BENEFIT SERVICES

1. Subject to the exercise of professional judgment, the winning Proposer shall accept and settle or deny all reported prescription claims.

2. Provide appropriate literature to describe the benefits offered by the District to its employees and appropriate educational materials regarding use of generics versus brand names, the advantages of mail order service where it is the most efficient for all concerned, and formulary information.

3. Use a fully automated online clinically-oriented claims adjudication/auditing system that analyzes coded claims data to ensure correct identification.

4. Screen for and deny workers' compensation claims.

5. Maintain the confidentiality requirements of Florida and Federal law by having adequate systems security features.

6. Establish and maintain a toll-free customer service line for employees. This line should be operational from at least 8 a.m. to 6 p.m. (Eastern Standard Time). A voice mail system or equivalent system should be available to take off-hour or weekend calls, with call backs to occur within twenty-four (24) hours of the next business day.

7. Retain claims history online for minimum of twenty-four (24) months from the last date of any claim activity pertaining to services rendered. All prior claims history incurred during the course of this contract must be captured in such a manner compatible for media storage and delivered to the District at their request. This data must be maintained for the full duration of the contract period, and must also be available for transfer to the subsequent vendor, should the District elect to change vendors in the future.

8. Provide a comprehensive drug utilization review program (DUR).

9. Provide cost effective intervention programs, such as prior authorizations, step therapy, etc. as options for the District to consider.

MEDICAL & PRESCRIPTION REPORTING & DATA SERVICES

1. Establish claims reporting procedures that are compatible with the needs and organizational structure of the District.

2. Provide the District's designees direct access to claims data and reporting capabilities.

3. Provide the District with aggregated data reporting capabilities.

4. Prepare and furnish the District with monthly exposure and loss data statistics. Exposure data should include census data, such as name of employee, zip code and date of birth and employment status. Loss data reports should include, but not be limited to, the following information: (Data subject to compliance with HIPAA privacy guidelines.)
    a. Claims data should be provided monthly (within 30 days after the end of the month) with cumulative totals for the plan year, separately for participants in each category of plan offered (e.g. PPO, HMO and HDHP), preferably in a format that will provide data separately for employees and their dependents, retirees and their dependents and COBRA and their dependents, and total for all participants and all dependents. The desire for separate premium/claims experience for employees, retirees, COBRA and dependents is to permit the District to determine if the rates being charged are equitable. Claim reports should be provided additionally for 12 months after plan termination, or until there are no runout and/or extension of benefits claims.

    b. Claims data should be provided monthly detailing all claims where more than $25,000 has been paid in the current plan year. Data should include amount paid, type of plan participant (employee, dependent, retiree, etc.), diagnosis, prognosis and status of the claim (active, expired, etc.).

5. Provide reports inclusive of data elements specified by the District, and in mutually agreed upon formats. The required standard reports include, but are not limited to, the following:
    c. Monthly reports are due on the 15th workday following the end of the "report" month. These reports should include paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).

    d. Quarterly and Year-to-Date Reports are due on the 15th working day following the "report" quarter. These reports should include: benefit payment summaries, inpatient (utilization) reports, paid claims by coverage and diagnosis types, COB savings, and service inquiries.

6. Provide prescription data reports inclusive of data elements specified by the District, and in mutually agreed upon formats. The required standard reports will include, but are not limited to: monthly reports of claims versus premium are due

by the 15th business day following the end of the "report" month. These reports should include: paid claims summaries (separated by employee, dependent, retiree, and COBRA beneficiary).

7. Prepare and furnish the District with periodic prescription reports included in the medical benefits reports that provide claims data. Reports on drug benefits costs should include appropriate data on utilization by category (such as retail and mail order, for generic, preferred brand, non-preferred brand, etc.).

8. Provide access to archived data within ten (10) working days of a request by the District.

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- Collection or other threats to participants by providers not paid by the insurer.

State the extent to which these measurements will be applied specifically to the District's account (account specific) versus your "book of business".

Suggestions on criteria for measuring performance and indications of how the organization is set-up to facilitate auditing of performance should be submitted. If the proposer has a performance guarantee agreement, provide a sample for review.

Please confirm your firm's willingness to enter into such an agreement and to negotiate appropriate terms, and recommend appropriate incentives or disincentives (meaningful penalties) to make the performance guarantee practical.

DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Section VI

Model Program For Stop-Loss Insurance

SECTION VI

MODEL PROGRAM FOR STOP-LOSS INSURANCE

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION VI - MODEL PROGRAM FOR STOP-LOSS INSURANCE.

SECTION II - GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.

SECTION III – COMMON CONTRACT PROVISIONS – All provisions of Section III are specifically incorporated by reference.

CONTRACT PERIOD

For Stop-Loss Insurance (specific and aggregate), an initial contract from January 1, 2016, through and including December 31, 2016, (12 months) is required, with the District having the option of renewing the option of the program for additional plan years thereafter.

RATE GUARANTEE PERIOD

Regardless of actual enrollment, the initial rates shall be guaranteed for 12 months. Changes after the initial 12 month period shall be subject to the Rerating Endorsement.

REMUNERATION

Any remuneration or other similar compensation included must be shown separately. Remuneration arrangements, if any, will be between the District, the successful proposer, and any agent, broker or other intermediary representing the successful proposer.

OWNERSHIP OF CLAIM DATA

The District shall have all right, title, interest and ownership to all loss statistics created as a result of the services to be provided by the successful Proposer. Further, at the sole option of the District, and upon fourteen (14) calendar days' written notice, the successful Proposer shall provide such data to the District.

At the termination of the contract, the successful Proposer shall provide the District with computer tapes or other computer media containing all of the data required to facilitate a smooth transition. Such data shall be made available within 30 days of written request, in a format generally importable into a commonly recognized database for loss statistics.

ELIGIBILITY & ENROLLMENT

Proposers must honor the District's current eligibility requirements, including for retirees, as outlined in the District's current plan documents, found in the Exposure Section of this RFP, and applicable employee handbooks and manuals.

Proposers should be aware that it is impossible to predict how many employees will elect each plan design and monthly premiums/rates for each plan design must be honored as proposed even if there is a substantial change in plan design choices at enrollment.

CONTINUITY OF COVERAGE (NO LOSS/NO GAIN PROVISION)

Notwithstanding any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan to the contrary, if, but for the replacement of the current plan with the proposed plan, an insured would have been covered by the current plan, the insured shall be entitled to the lesser of:

(1) the benefits which would have been payable had the current plan been continued; or

(2) the benefits which would be payable under the proposed plan without the application of any actively at work, waiting period, pre-existing condition, or other provision or limitation in the proposed plan.

SCOPE OF COVERAGE

The District is interested in proposals for stop-loss insurance for plan designs that most closely match the District's current plan designs:

1. Florida Blue BlueOptions – Plan 03359
2. Florida Blue BlueOptions – Plan HSA 03160/03161
3. Florida Blue BlueCare – Plan 47

Please review the plan documents in the Exhibits section for more information. Benefits should be proposed as similar as possible and any deviations should be noted.

Proposals for both specific and aggregate coverage are being requested and should include both medical and prescription coverage.

Stop-loss proposals should be on a 12/15 contract basis with an unlimited specific limit and a specific retention of $150,000. Additional aggregate retentions will be considered. The aggregate limit should be $1,000,000 and the attachment point should be at 125% of expected claims.

Proposals with enhancements to the contract basis, aggregate limit and/or attachment point will be favored. In addition, proposals with preferred terms regarding renewal disclosures, timelines and potentials for lasers will also be favored.

If your proposal is contingent upon use of a specific insurer network, please make sure this is clearly stated.

All proposals should include copies of any contract which the District will be required to execute.

The District reserves the right to negotiate with proposer finalist(s) on alternative plan designs, coverage terms and provisions.

ACCOUNT MANAGEMENT

Proposals must be clear on who will be responsible for filing the medical and prescription claims. In addition, specific details regarding the process, accounting of claims and reconciliation of claims is requested.

DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Section VII

Model Program For Agent/Broker Services

SECTION VII

MODEL PROGRAM FOR AGENT/BROKER SERVICES

PROVISIONS INCORPORATED BY REFERENCE

The following provisions of this RFP are incorporated by reference into this SECTION VII – MODEL PROGRAM FOR AGENT/BROKER SERVICES.

> SECTION II - GENERAL REQUIREMENTS - All the provisions of Section II are specifically incorporated by reference.
>
> SECTION III – COMMON CONTRACT PROVISIONS – All the provisions of Section III are specifically incorporated by reference.

The District does currently have an agent/broker on the medical and prescription benefits plan.

Proposals are requested, but not required, to be submitted net of any agent or broker commissions. The Proposal Forms for all proposals must identify any agents or other intermediaries who are not employees of the insurers being proposed, and who will be receiving remuneration for the District's plan(s). The Proposal Forms must disclose the remuneration basis and estimated annual amounts. Any such agents that will be receiving remuneration in connection with proposals submitted in response to this RFP should complete the Proposal Forms contained in Section XII.

Please note that such agents submitting proposals must be designated by their choice of insurer(s) on the applicable Proposal Form(s). Whether an insurer is proposing with one such agent or multiple agents, all agents must be shown on the Proposal Form(s) submitted by such insurer, as these are the only agents that will be considered.

APPLICABILITY OF THIS SECTION

If the District chooses to engage an agent who is not an employee of the insurer, rather than choosing a direct proposal by the insurer (utilizing an employee agent), the items in this section are applicable.

CONTRACT PERIOD

There will be an initial 12-month contract, from January 1, 2016, through and including December 31, 2016. Renewal of such contract will be at the District's option, based on its evaluation of the value of the service received. The District may opt to continue such agent upon each renewal or to alternatively consider the direct services of the insurer through its employee agent.

Renewal guarantees are encouraged and may be considered favorably.

SCOPE OF SERVICES

The agent selected should provide the following services. Proposals should clearly state if any additional fees apply to any services.

1. Assist in the coordination of the implementation of the new medical program, including coordination of enrollment materials, planning of enrollment meetings, staffing enrollment meetings.

2. Assist in planning and staffing each annual enrollment process.

3. Assist with any Healthcare Reform items/issues.

4. Assist with the implementation of changes, including preparation of communication materials, as needed.

5. Respond to questions regarding the medical plan as submitted by the District and by employees.

6. Be available on-site, as needed, for meetings. At the District's request, attend scheduled employee benefit meetings. Meet with the District at least quarterly to review and discuss plan performance, premium/claims history, market trends, medical insurance trends, and provide observations. Agent representation will not preclude the District from gaining centralized electronic access to open enrollment services, claims administration, reporting, billing and customer service.

7. Provide, or coordinate with the medical insurer to provide an estimated renewal projection in the early part of the year (for example, March or April) of each year based upon standard underwriting formulas.

8. Present, or coordinate with other vendors to present, final renewal pricing on a schedule agreed upon with District human resources staff.

9. If the District conducts a procurement process for medical coverage, promptly assist in coordination of necessary documentation, background and rating data, premiums/claims history as needed.

10. Compare and contrast the District's plan and performance with other similar plans, as requested by the District.

11. Provide, and/or coordinate with the District and other vendors to provide, annual benefit statements for employees.

12. Other services, as agreed between proposer and District.

All proposals should include copies of any contract which the District will be required to execute. Please indicate if the contract terms are negotiable.

REMUNERATION

If the services of the chosen insurer will be supplemented by an agent who is not an employee of the insurer, remuneration of such agent in the form or commissions or other compensation must be shown separately by the proposing agent.

Insurance agents should recognize that the District will be scrutinizing the amount of remuneration in relation to the expected level of service to be received. The District is desirous of avoiding payment of remuneration that may appear to be excessive. The District may be interested in negotiating such remuneration, especially when two or more agents have similar or identical lowest cost proposals. Proposing agents should state if they are willing to negotiate such remuneration.

Remuneration for the contract year January 1, 2016 through December 31, 2016 shall be specifically described by the submitting agent. If offering subsequent year remuneration guarantees that may be selected prior to future renewals, such guarantees shall be specifically described.

Remuneration arrangements, if any, will be between the District, the successful insurance proposer and any agent or other intermediary representing the successful proposer.

WELLNESS PROGRAM AND DISEASE MANAGEMENT SERVICES

The District is interested in all Wellness and Disease Management services offered by proposers. How and what can you provide to assist the District in their wellness endeavors? Please provide details in your proposal of all current program offerings including, if applicable, any additional cost.

The District is interested in proactive wellness and disease management initiatives, including participation incentives, including but not limited to health screenings, flu shot programs, health risk assessments and health fairs. Proposals should detail the support staff and other assistance that will be provided.

DISTRICT SCHOOL BOARD OF SUMTER COUNTY, FL

Section VIII

Exposure, Loss Data, And Contract Provisions

SECTION VIII

EXPOSURE, LOSS DATA AND CONTRACT PROVISIONS

SOURCE OF INFORMATION

The District School Board of Sumter County, FL and current vendors and carriers supplied all data and statistical information. In some instances, data was retyped for clarity. If there are omissions, additional data is not readily available.

Item 1 – Florida Blue plan summaries and plan documents

Item 2 – Medical Rates and Monthly Contributions

Item 3 – Experience Reports

Item 4 – Benefits Match-Up – a,b,c (In Word format)

Item 5 – Most Utilized Provider Comparison Match-Up (In Excel format)

Item 6 – Medical Census (In Excel format – 2 tabs)

Item 1

Florida Blue plan summaries and plan documents

The District School Board of Sumter Schools
Plan History

2013

BlueCHoice 727
BlueOptions 3359
BlueOptions HSA 03160/03161

2014

BlueOptions 3359
BlueOptions HSA 03160/03161

2015

BlueOptions 03359
BlueOptions HSA 03160/03161
BlueCare 47

School District of Sumter County

Summary of Benefits 1-1-13 thru 12-31-13

The information contained in this proposal includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary.

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 727	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Deductible (DED) (Per Person/Family Agg)				
In-Network	$750 / $1,500	$1,000 / $3,000	$1,500 / Not Applicable	Not Applicable / $3,000
Out-of-Network	Combined w/In-Ntwk	Combined w/In-Ntwk	$3,000 / Not Applicable	Not Applicable / $6,000
Coinsurance (Member Responsibility)				
In-Network	20%	20%	10%	10%
Out-of-Network	50%	40%	30%	30%
Out of Pocket Maximum (Per Person/Family Agg)	Includes only Coins; Excludes Rx	Includes DED, Coins, Copays; Excludes Rx	Includes DED, Coins, Copays	Includes DED, Coins, Copays
In-Network	$4,000 / $8,000	$4,000 / $12,000	$3,000 / Not Applicable	Not Applicable / $6,000
Out-of-Network	Combined w/In-Ntwk	Combined w/In-Ntwk	$6,000 / Not Applicable	Not Applicable / $12,000
Lifetime Maximum	No Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES				
Allergy Injections				
In-Network Family Physician	$5	$10	DED + 10%	DED + 10%
In-Network Specialist	$5	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
E-Office Visit Services				
In-Network Family Physician	$30 FP	$10	DED + 10%	DED + 10%
In-Network Specialist	$35 SP	$10	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Office Services				
In-Network Family Physician	$30 FP	$25 FP	DED + 10%	DED + 10%
In-Network Specialist	$35 SP	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Provider Services at Hospital and ER				
In-Network Family Physician	DED + 20%	DED + 20%	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Provider Services at Other Locations				
In-Network Family Physician	DED + 20%	DED + 20%	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center				
In-Network Specialist	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
PREVENTIVE CARE				
Adult Wellness Office Services				
In-Network Family Physician	$30 FP	$25 FP	$0	$0
In-Network Specialist	$35 SP	20% (No DED)	$0	$0
Out-of-Network	50% (No DED)	40% (No DED)	30% (No DED)	30% (No DED)

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 727	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies
In-Network	20% (No DED)	$0	$0	$0
Out-of-Network	50% (No DED)	$0	$0	$0
Independent Clinical Lab				
In-Network	20% (No DED)	$0	$0	$0
Out-of-Network	50% (No DED)	DED + 40%	30% (No DED)	30% (No DED)
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)				
In-Network - Advanced Imaging Services (AIS)	$35 SP	$125	$0	$0
In-Network - Other Diagnostic Services	$35 SP	$50	$0	$0
Out-of-Network	DED + 50%	DED + 40%	30% (No DED)	30% (No DED)
Mammograms (Routine and Dx)				
In-Network	$0	$0	$0	$0
Out-of-Network	$0	$0	$0	$0
Well Child Office Visits (No BPM)				
In-Network Family Physician	$30 FP	$25 FP	$0	$0
In-Network Specialist	$35 SP	20% (No DED)	$0	$0
Out-of-Network	50% (No DED)	40% (No DED)	30% (No DED)	30% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE				
Ambulance Maximum (per Day)	No Per Day Maximum (Applicable Cost Share Applies)	$5,500	$5,500	$5,500
In-Network	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Convenient Care Centers (CCC)				
In-Network	$30 FP	$25 FP	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Emergency Room Facility Services (also see Professional Provider Services)				
In-Network	$100	$100 + 20%	DED + 10%	DED + 10%
Out-of-Network	$100	$100 + 40%	OON DED + 10%	OON DED + 10%
Urgent Care Centers (UCC)				
In-Network	$30 FP	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
FACILITY SERVICES HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.				
Ambulatory Surgical Center				
In-Network	DED + 20%	$100	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Independent Clinical Lab				
In-Network	20% (No DED)	$0	DED	DED
Out-of-Network	50% (No DED)	DED + 40%	DED + 30%	DED + 30%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)				
In-Network - Advanced Imaging Services (AIS)	$35 SP	$125	DED + 10%	DED + 10%
In-Network - Other Diagnostic Services	$35 SP	$50	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Inpatient Hospital (per admit)				
In-Network	DED + 20%	Option 1 - $500 Option 2 - $1,000	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	$500 PAD + DED + 50%	DED + 40%	DED + 30%	DED + 30%
Inpatient Rehab Maximum	No Maximum	21 Days	21 Days	21 Days

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 727	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Outpatient Hospital (per visit)				
In-Network	DED + 20%	Option 1 - $150 Option 2 - $250	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Therapy at Outpatient Hospital				
In-Network	DED + 20%	Option 1 - $45 Option 2 - $60	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
MENTAL HEALTH AND SUBSTANCE ABUSE				
Inpatient Hospitalization				
In-Network	DED + 20%	Option 1 - $500 Option 2 - $500	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	$500 PAD + DED + 50%	DED + 40%	DED + 30%	DED + 30%
Outpatient Hospitalization (per visit)				
In-Network	DED + 20%	Option 1 - $150 Option 2 - $150	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Provider Services at Hospital and ER (per provider per day)				
In-Network Family Physician or Specialist	$0	$0	DED + 10%	DED + 10%
Out-of-Network Provider	$0	$0	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Physician Office Visit				
In-Network Family Physician or Specialist	$0	$0	DED + 10%	DED + 10%
Out-of-Network Provider	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Emergency Room Facility Services (per visit)				
In-Network	$100	$0	DED	DED
Out-of-Network	$100	$0	In-Ntwk DED	In-Ntwk DED
Provider Services at Locations other than Hospital and ER (per provider per day)				
In-Network Family Physician	$0	$0	DED + 10%	DED + 10%
In-Network Specialist	$0	$0	DED + 10%	DED + 10%
Out-of-Network Provider	DED + 50%	DED + 40%	DED + 30%	DED + 30%
OTHER SPECIAL SERVICES AND LOCATIONS				
Advanced Imaging Services in Physician's Office				
In-Network Family Physician	$30 FP	$125	DED + 10%	DED + 10%
In-Network Specialist	$35 SP	$125	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Birthing Center				
In-Network	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Diabetic Equipment and Supplies*				
In-Network	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Durable Medical Equipment, Prosthetics, Orthotics BPM	Enteral Formulas:$2,500 All Other: No Maximum	Enteral Formulas:$2,500 All Other: No Maximum	Enteral Formulas:$2,500 All Other: No Maximum	Enteral Formulas:$2,500 All Other: No Maximum
In-Network	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Home Health Care BPM	20 Visits	20 Visits	20 Visits	20 Visits
In-Network	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%
Hospice LTM	No Maximum	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 30%

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice 727	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Outpatient Therapy and Spinal Manipulations BPM	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	60 Days	60 Days	60 Days	60 Days
In-Network	DED + 20%	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 50%	DED + 40%	DED + 30%	DED + 40%
PRESCRIPTION DRUGS				
Deductible	$100	$100	In-Network DED	In-Network DED
In-Network				
Retail (30 Days)				
Generic/Preferred Brand/Non-Preferred	$20 / $40 / $60	$20 / $40 / $60	$15 / $30 / $50	$15 / $30 / $50
Mail Order (90 Days)				
Generic/Preferred Brand/Non-Preferred	$50 / $100 / $150	$50 / $100 / $150	$40 / $75 / $125	$40 / $75 / $125
Out-of-Network				
Retail (30 Days)				
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Mail Order (90 Days)				
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Medical Pharmacy (Provider-Administered Rx)**	$200 Monthly OOP Max	$200 Monthly OOP Max	$200 Monthly OOP Max applies after DED	$200 Monthly OOP Max applies after DED
In-Network	20% (No DED)	20% (No DED)	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%	DED + 50%

*** Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit except when the group carves out pharmacy. When pharmacy is carved out, they are available through DME. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.**

**** (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.**

This is not an insurance contract or Benefit Booklet. **The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.**

School District of Sumter County

Summary of Benefits 1-1-14 thru 12-31-14

The information contained in this proposal includes benefit changes required as a result of the Patient Protection And Affordable Care Act (PPACA), otherwise known as Health Care Reform (HCR). Please note that plan benefits are subject to change and may be revised based on guidance and regulations issued by the Secretary of Health and Human Services (HHS) or other applicable federal agency. In addition, the rates quoted within this proposal are based on the plan benefits at the time the proposal is issued and may change before the plan effective date if additional plan changes become necessary.

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Deductible (DED) (Per Person/Family Agg)			
In-Network	$1,000 / $3,000	$1,500 / Not Applicable	Not Applicable / $3,000
Out-of-Network	Combined w/In-Ntwk	$3,000 / Not Applicable	Not Applicable / $6,000
Coinsurance (Member Responsibility)			
In-Network	20%	10%	10%
Out-of-Network	40%	30%	30%
Out of Pocket Maximum (Per Person/Family Agg)	Includes DED, Coins, Copays	Includes DED, Coins, Copays	Includes DED, Coins, Copays
In-Network	$4,000 / $12,000	$3,000 / Not Applicable	Not Applicable / $6,000
Out-of-Network	Combined w/In-Ntwk	$6,000 / Not Applicable	Not Applicable / $12,000
Lifetime Maximum	No Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES			
Allergy Injections			
In-Network Family Physician	$10	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
E-Office Visit Services			
In-Network Family Physician	$10	DED + 10%	DED + 10%
In-Network Specialist	$10	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Office Services			
In-Network Family Physician	$25	DED + 10%	DED + 10%
In-Network Specialist	$35	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Provider Services at Hospital and ER			
In-Network Family Physician	DED + 20%	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Provider Services at Other Locations			
In-Network Family Physician	DED + 20%	DED + 10%	DED + 10%
In-Network Specialist	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center			
In-Network Specialist	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
PREVENTIVE CARE			
Adult Wellness Office Services			
In-Network Family Physician	$25	$0	$0
In-Network Specialist	$35	$0	$0
Out-of-Network	40% (No DED)	30% (No DED)	30% (No DED)

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Colonoscopies (Routine)	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies	Age 50+ then Frequency Schedule Applies
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0
Independent Clinical Lab			
In-Network	$0	$0	$0
Out-of-Network	DED + 40%	30% (No DED)	30% (No DED)
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS)	$125	$0	$0
In-Network - Other Diagnostic Services	$50	$0	$0
Out-of-Network	DED + 40%	30% (No DED)	30% (No DED)
Mammograms (Routine and Dx)			
In-Network	$0	$0	$0
Out-of-Network	$0	$0	$0
Well Child Office Visits (No BPM)			
In-Network Family Physician	$25	$0	$0
In-Network Specialist	$35	$0	$0
Out-of-Network	40% (No DED)	30% (No DED)	30% (No DED)
EMERGENCY/URGENT/CONVENIENT CARE			
Ambulance Maximum (per Day)	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	In-Ntwk DED + 20%	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Convenient Care Centers (CCC)			
In-Network	$25 FP	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Emergency Room Facility Services (also see Professional Provider Services)			
In-Network	$100 + 20%	DED + 10%	DED + 10%
Out-of-Network	$100 + 40%	OON DED + 10%	OON DED + 10%
Urgent Care Centers (UCC)			
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
FACILITY SERVICES HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.			
Ambulatory Surgical Center			
In-Network	$100	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Independent Clinical Lab			
In-Network	$0	DED	DED
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)			
In-Network - Advanced Imaging Services (AIS)	$125	DED + 10%	DED + 10%
In-Network - Other Diagnostic Services	$50	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Inpatient Hospital (per admit)			
In-Network	Option 1 - $500 Option 2 - $1,000	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Inpatient Rehab Maximum	30 Days	30 Days	30 Days

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Outpatient Hospital (per visit)			
In-Network	Option 1 - $150 Option 2 - $250	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Therapy at Outpatient Hospital			
In-Network	Option 1 - $45 Option 2 - $60	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
MENTAL HEALTH AND SUBSTANCE ABUSE			
Inpatient Hospitalization			
In-Network	Option 1 - $500 Option 2 - $500	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Outpatient Hospitalization (per visit)			
In-Network	Option 1 - $150 Option 2 - $150	Option 1 - DED + 10% Option 2 - DED + 10%	Option 1 - DED + 10% Option 2 - DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Provider Services at Hospital and ER (per provider per day)			
In-Network Family Physician or Specialist	$0	DED + 10%	DED + 10%
Out-of-Network Provider	$0	In-Ntwk DED + 10%	In-Ntwk DED + 10%
Physician Office Visit			
In-Network Family Physician or Specialist	$0	DED + 10%	DED + 10%
Out-of-Network Provider	DED + 40%	DED + 30%	DED + 30%
Emergency Room Facility Services (per visit)			
In-Network	$0	DED	DED
Out-of-Network	$0	In-Ntwk DED	In-Ntwk DED
Provider Services at Locations other than Hospital and ER (per provider per day)			
In-Network Family Physician	$0	DED + 10%	DED + 10%
In-Network Specialist	$0	DED + 10%	DED + 10%
Out-of-Network Provider	DED + 40%	DED + 30%	DED + 30%
OTHER SPECIAL SERVICES AND LOCATIONS			
Advanced Imaging Services in Physician's Office			
In-Network Family Physician	$125	DED + 10%	DED + 10%
In-Network Specialist	$125	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Birthing Center			
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Diabetic Equipment and Supplies*			
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Durable Medical Equipment, Prosthetics, Orthotics BPM	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Home Health Care BPM	20 Visits	20 Visits	20 Visits
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%
Hospice LTM	No Maximum	No Maximum	No Maximum
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 30%

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueOptions 3359	BlueOptions HSA Compatible 03160	BlueOptions HSA Compatible 03161
Outpatient Therapy and Spinal Manipulations BPM	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)	35 Visits (Includes up to 26 Spinal Manipulations)
Skilled Nursing Facility BPM	60 Days	60 Days	60 Days
In-Network	DED + 20%	DED + 10%	DED + 10%
Out-of-Network	DED + 40%	DED + 30%	DED + 40%
PRESCRIPTION DRUGS			
Deductible	$100	In-Network DED	In-Network DED
In-Network			
Retail (30 Days)			
Generic/Preferred Brand/Non-Preferred	$20 / $40 / $60	$15 / $30 / $50	$15 / $30 / $50
Mail Order (90 Days)			
Generic/Preferred Brand/Non-Preferred	$50 / $100 / $150	$40 / $75 / $125	$40 / $75 / $125
Out-of-Network			
Retail (30 Days)			
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Mail Order (90 Days)			
Generic/Preferred Brand/Non-Preferred	50% / 50% / 50%	50% / 50% / 50%	50% / 50% / 50%
Medical Pharmacy (Provider-Administered Rx)**	$200 Monthly OOP Max	$200 Monthly OOP Max applies after DED	$200 Monthly OOP Max applies after DED
In-Network	20% (No DED)	DED + 20%	DED + 20%
Out-of-Network	DED + 50%	DED + 50%	DED + 50%

*** Diabetic Supplies (lancets, strips, etc.) are covered under the Rx benefit. Diabetic Equipment (insulin pumps, tubing) are always covered under the medical benefit.**

**** (1) Medical Pharmacy Monthly OOP Max includes the drug cost share and applies to the health plan OOP Max. (2) Physician Services are in addition to drug costs (separate cost share applies). (3) Separate drug cost share does not apply to allergy injections or immunizations; only office cost share applies.**

This is not an insurance contract or Benefit Booklet. **The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.**

BlueOptions
For Large Groups
Health Benefit Plan 03359

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

Summary of Benefits for Covered Services

	Amount Member Pays
Office Services	
Physician Office Services	
In-Network Family Physician	$25 Copayment
In-Network Specialist	$35 Copayment
Out-of-Network Office Visit	DED + 40% Coinsurance
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	DED + 40% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)	
In-Network	$125 Copayment
Out-of-Network	DED + 40% Coinsurance
Maternity Initial Visit	
In-Network Specialist	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Allergy Injections (per visit)	
In-Network Family Physician	$10 Copayment
In-Network Specialist	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)	
In-Network Monthly Out-of-Pocket (OOP) Maximum[2]	$200
In-Network Provider	20% Coinsurance
Out-of-Network	DED + 50% Coinsurance
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**	
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network	40% Coinsurance
Mammograms	
In-Network and Out-of-Network	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)	
In-Network and Out-of-Network	$0
Emergency Medical Care	
Urgent Care Centers	
In-Network	DED + 20% Coinsurance
Out-of-Network	DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network and Out-of-Network	$100 Copayment + 20% Coinsurance
Ambulance Services	
In-Network and Out-of-Network	In-Network DED + 20% Coinsurance

[1] DED = Deductible
[2] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

BlueOptions
For Large Groups
Health Benefit Plan 03359

Summary of Benefits for Covered Services	*Amount Member Pays*
Outpatient Diagnostic Services	
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Out-of-Network	 $50 Copayment $125 Copayment DED + 40% Coinsurance
Independent Clinical Lab (e.g. Blood Work) In-Network Out-of-Network	 $0 DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network (Option 1 and Option 2) Out-of Network	 $150 Copayment / $250 Copayment DED + 40% Coinsurance
Other Provider Services	
Provider Services at Hospital and ER In-Network and Out-of-Network	 In-Network DED + 20% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network and Out-of-Network	 In-Network DED + 20% Coinsurance
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 20% Coinsurance DED + 20% Coinsurance DED + 40% Coinsurance
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max) Outpatient Rehab Therapy Center In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network (Option 1 / Option 2) Out-of-Network	35 Visits DED + 20% Coinsurance DED + 40% Coinsurance $45 Copayment / $60 Copayment DED + 40% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics In-Network Out-of-Network	 DED + 20% Coinsurance DED + 40% Coinsurance
Home Health Care (PBP Max) In-Network Out-of-Network	20 Visits DED + 20% Coinsurance DED + 40% Coinsurance
Skilled Nursing Facility (PBP Max) In-Network Out-of-Network	60 days DED + 20% Coinsurance DED + 40% Coinsurance
Hospice In-Network Out-of-Network	 DED + 20% Coinsurance DED + 40% Coinsurance
Hospital/Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $100 Copayment DED + 40% Coinsurance

[3] PBP = Per Benefit Period

BlueOptions

For Large Groups
Health Benefit Plan 03359

Summary of Benefits for Covered Services	*Amount Member Pays*
Hospital/Surgical (Continued)	
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network (Option 1 / Option 2) Out-of-Network	Rehabilitation Services limit - 30 days $500 Copayment / $1,000 Copayment DED + 40% Coinsurance
Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services (Option 1 / Option 2) In-Network – All other Services (Option 1 / Option 2) Out-of-Network	 $45 Copayment / $60 Copayment $150 Copayment / $250 Copayment DED + 40% Coinsurance
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network and Out-of-Network	$100 Copayment + 20% Coinsurance
Mental Health/Substance Dependency	
Inpatient Hospital Facility Services (per admit) In-Network (Option 1 and Option 2) Out-of-Network	 $500 40% Coinsurance
Outpatient Hospitalization Facility Service (per visit) In-Network (Option 1 and Option 2) Out-of-Network	 $150 40% Coinsurance
Emergency Room Facility Services (per visit) In-Network and Out-of-Network	 $0
Provider Services at Hospital and ER In-Network Family Physician / Specialist Out-of-Network	 $0 $0
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician / Specialist Out-of-Network	 $0 40% Coinsurance
Outpatient Office Visit In-Network Family Physician / Specialist Out-of-Network	 $0 40% Coinsurance
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before Florida Blue pays)	 $1,000 / $3,000 Combined with In Network
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 20% 40%
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	 $4.000 / $12,000 Combined with In Network
Total Lifetime Maximum Benefit	No Maximum

BlueOptions
For Large Groups
Health Benefit Plan 03359

BlueScript Pharmacy Benefits - $20/$40/$60 after $100 Deductible

	In-Network	Out-of-Network	Mail Order* (90 days)
Pharmacy Deductible**	$100		
Preferred Generic Prescription Drugs	$20	50%	$50
Preferred Brand Name Prescription Drugs	$40	50%	$100
Non-Preferred Prescription Drugs	$60	50%	$150

Additional Benefits and Features

BlueScript Prescription Drug Program
In the event your Group has purchased pharmacy coverage from Florida Blue, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

An Array of Value-Added Programs and Services
- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***floridablue.com*** and other interactive web-based support tools.
- **Expert advice on call.** We encourage you to call our care consultants team at 1-888-476-2227 to find out how much they can help you SAVE. Whether comparing the cost of your medications between local pharmacies or researching the quality and cost of treatment options before you make a decision, we can help you shop for the best value for you and your family.
- Online access to everything about your health benefit plan as well as all of our self-service tools.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.*
- BlueOptions members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Access to Our Strong Networks
NetworkBlue[SM] is the Preferred Provider Network designated as "In-Network" for BlueOptions. While In-Network providers remain the best value, members are still **protected from balance billing** if they go Out-of-Network to someone who is part of our Traditional Provider Network. You may also receive **out-of-state coverage through the BlueCard**® Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount
Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, Florida Blue does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at **floridablue.com.**

BlueOptions
For Large Groups
Health Benefit Plan 03359

BlueScript Prescription Drug Program
The BlueOptions® health benefit plan your employer is offering you is paired with our BlueScript® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain Prescription Drugs at a location convenient to you. You may also be able to receive more savings on Prescription Drugs by purchasing your Drugs through the mail order program.

Advantages of our Pharmacy Program: With our BlueScript Pharmacy Program, you'll receive coverage for Preferred Generic, Preferred Brand Name, and Non-Preferred Prescription Drugs, as well as Self-administered Injectables and specialty medications. You have easy access to Participating Pharmacies throughout Florida and to National Network Pharmacies with over 60,000 locations.

Save when purchasing your Prescription Drugs: You can reduce your out-of-pocket costs by purchasing Covered Prescription Drugs listed on our Preferred Medication List. These Prescription Drugs should cost you less than Prescription Drugs not on the list.

Generic Prescription Drugs
You pay a lower cost for Generic Prescription Drugs that appear on the Preferred Medication List. If you request a Brand Name Prescription Drug when a Generic is available, you will be responsible for:
1. The copayment applicable to Brand Name Prescription Drugs; and
2. The difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueOptions Pharmacy Program Schedule of Benefits.

More convenient than ever:
Take your prescriptions to a participating pharmacy to have it filled. Or, if you are taking a prescription medication on an ongoing basis, you have a couple of convenient options:
1. Your doctor can prescribe a 3-month supply and you can have it filled at select participating retail pharmacies. A 3-month out-of-pocket cost (copay, coinsurance and/or deductible) applies.
2. For additional savings, fill prescriptions via our mail-order program. This program allows covered members taking Prescription Drugs to receive up to a 3-month supply for one Mail Order Copayment, after Pharmacy Deductible, if applicable. Prescription Drugs ordered through this program are provided by Prime Therapeutics'® mail order facility, PrimeMail®.

Diabetic Supplies
Diabetic supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/ or syringes and needles are covered under your pharmacy benefit. Diabetic supplies require a prescription and can be obtained from a participating pharmacy

Medication Guide
The Preferred Medication List, which is part of the Medication Guide, is available online at www.bcbsfl.com. Changes in the formulary can occur over time and the most up-to-date listing can always be found by viewing the Medication Guide online or by calling the customer service number listed on your identification card. For the hearing impaired, call Florida TTY Relay Service 711. The Medication Guide also identifies specialty drugs, and drugs requiring prior authorization. When reviewing the Preferred Medication List with your doctor, ask your provider to consider a Prescription Drug from the Preferred Medication List, particularly a Preferred Generic Prescription Drug.

Pharmacy Options Affect Your Out of Pocket
There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled—retail pharmacies and specialty pharmacies. To save the most money, before you get a prescription filled you should confirm which pharmacy is considered 'in-network' for that particular medication.

- **Retail Pharmacy Network** - Non-specialty 'Generic' medications and 'Brand Name' medications listed in the Medication Guide can be filled at these pharmacies at a lower cost to you than other pharmacies in your area. If you go to a non-participating pharmacy, your prescription will cost you more.
- **Specialty Pharmacy Network** - We have identified certain drugs as specialty drugsdue to requirements such as special handling, storage, training, distribution, and management of the therapy. These drugs are listed as a 'Specialty Drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy. These pharmacies are different than the retail pharmacies and are identified in both the Provider Directory and the Medication Guide.

Using an in-network Specialty Pharmacy to provide these Specialty Drugs lowers the amount you pay for these medications.

• **Non-Participating Pharmacy** - Choosing a non-participating pharmacy will cost you more money. You may have to pay the full cost of the medication and then file a claim to be reimbursed. Our payment will be based on our Non-Participating Pharmacy Allowance minus your deductible and/or coinsurance. You will be responsible for the deductible and/or coinsurance and the difference between our Allowance and the cost of the medication.

• **The National Pharmacy Network** - The National Pharmacy Network includes more than 50,000 chain and independent Pharmacies across the United States. These National Network Pharmacies are available to our members traveling or residing outside of Florida. Simply present your member ID card at time of purchase.

Utilization Management / Responsible Rx Programs

Prior Coverage Authorization - Drugs selected for Prior Coverage Authorization (PA) may require that specific clinical criteria be met before the Drugs will be covered under your pharmacy benefit. The list of drugs requiring Prior Authorization is located in the Medication Guide and are designated with a “PA” following the product name, BCBSF reserves the right to change the Drugs that require PA at any time and for any reason.

Responsible Quantity - Drugs included in this program allow a maximum quantity per time period. Quantity limits are typically developed based upon FDA-approved Drug labeling and nation allyrecognized therapeutic clinical guidelines. The list of Drugs that have quantity limits are designated in the Formulary List with ”QL” following the product name. BCBSF reserves the right to change the Drugs and the quantity limits subject to the Responsible Quantity Program at any time and for any reason. In cases where a larger quantity of a Responsible Quantity Drug is medically required, your doctor or health care provider can request an override. Responsible Quantity override forms are available at www.bcbsfl.com.

Responsible Steps - Drugs included in this program require that you try another designated or prerequisite Drug first before a Drug listed in the Responsible Steps Medication Chart will be covered. If due to medical reasons you cannot use the prerequisite Drug and require the Responsible Steps Medication, your doctor or health care provider may request prior authorization for an override. If the override request is approved, coverage will be provided for the Responsible Steps Medication. These medications are designated in the Formulary List with “RS” following the product name. Medications included in the Responsible Steps Program are listed in the Medication Guide. BCBSF reserves the right to change the Drugs subject to the Responsible Steps program at any time and for any reason.

Drugs That Are Not Covered

Your Pharmacy benefit may not cover select medications. The Medication Guide contains of a list of non-covered drugs. Some reasons a medication may not be covered are:

- The Drug has been shown to have excessive adverse effects and/or safer alternatives are available.
- The Drug has a preferred formulary alternative

Prescription Discounts - With the BlueSaver® prescription savings card program, you will receive special discounted pricing on non-covered prescription medications when you show your BlueSaver ID card at select participating pharmacies. This card provides savings for you or any of your covered family members on medications that are not covered under your BlueScript pharmacy benefit. The BlueSaver savings program is not an insurance product or part of your health benefit plan.

* As a courtesy, Florida Blue has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueOptions

For Large Groups
Health Benefit Plans 03160 and 03161

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

Summary of Benefits for Covered Services

Amount Member Pays

	HSA Compatible Plan 03160 Single Coverage	HSA Compatible Plan 03161 Family Coverage
Office Services		
Physician Office Services		
In-Network Family Physician	DED[1] + 10% Coinsurance	DED + 10% Coinsurance
In-Network Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network Office Visit	DED + 30% Coinsurance	DED + 30% Coinsurance
In-Network e-Office Visit	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network e-Office Visit	DED + 30% Coinsurance	DED + 30% Coinsurance
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.)		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Maternity Initial Visit		
In-Network Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Allergy Injections (per visit)		
In-Network Family Physician	DED + 10% Coinsurance	DED + 10% Coinsurance
In-Network Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)		
In-Network Monthly Out-of-Pocket (OOP) Maximum[2]	$200	$200
In-Network Provider	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 50% Coinsurance	DED + 50% Coinsurance
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**		
Preventive Care		
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations		
In-Network	$0	$0
Out-of-Network	30% Coinsurance	30% Coinsurance
Mammograms		
In-Network and Out-of-Network	$0	$0
Colonoscopy (Routine for age 50+ then frequency schedule applies)		
In-Network and Out-of-Network	$0	$0
Emergency Medical Care		
Urgent Care Centers		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Emergency Room Facility Services (per visit)		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 20% Coinsurance	DED + 20% Coinsurance

[1] DED = Deductible
[2] Monthly OOP max does not apply until the In-Network DED is met. In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

BlueOptions
For Large Groups
Health Benefit Plans 03160 and 03161

Summary of Benefits for Covered Services

Amount Member Pays

	HSA Compatible Plan 03160 Single Coverage	HSA Compatible Plan 03161 Family Coverage
Emergency Medical Care (Continued)		
Ambulance Services In-Network and Out-of-Network	In-Network DED + 10% Coinsurance	In-Network DED + 10% Coinsurance
Outpatient Diagnostic Services		
Independent Diagnostic Testing Facility Services (per visit) (e.g. X-rays) (Includes Provider Services) In-Network Diagnostic Services (except AIS) In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Med.) Out-of-Network	 DED + 10% Coinsurance DED + 10% Coinsurance DED + 30% Coinsurance	 DED + 10% Coinsurance DED + 10% Coinsurance DED + 30% Coinsurance
Independent Clinical Lab (e.g. Blood Work) In-Network Out-of-Network	 DED DED + 30% Coinsurance	 DED DED + 30% Coinsurance
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays) In-Network Option 1 Option 2 Out-of-Network	 DED + 10% Coinsurance DED + 25% Coinsurance DED + 30% Coinsurance	 DED + 10% Coinsurance DED + 25% Coinsurance DED + 30% Coinsurance
Other Provider Services		
Provider Services at Hospital and ER In-Network and Out-of-Network	In-Network DED + 10% Coinsurance	In-Network DED + 10% Coinsurance
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC) In-Network and Out-of-Network	In-Network DED + 10% Coinsurance	In-Network DED + 10% Coinsurance
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician In-Network Specialist Out-of-Network	 DED + 10% Coinsurance DED + 10% Coinsurance DED + 30% Coinsurance	 DED + 10% Coinsurance DED + 10% Coinsurance DED + 30% Coinsurance
Other Special Services		
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max) Outpatient Rehab Therapy Center In-Network Out-of-Network Outpatient Hospital Facility Services (per visit) In-Network Option 1 Option 2 Out-of-Network	 35 Visits DED + 10% Coinsurance DED + 30% Coinsurance DED + 10% Coinsurance DED + 25% Coinsurance DED + 30% Coinsurance	 35 Visits DED + 10% Coinsurance DED + 30% Coinsurance DED + 10% Coinsurance DED + 25% Coinsurance DED + 30% Coinsurance
Durable Medical Equipment, Prosthetics and Orthotics In-Network Out-of-Network	 DED + 10% Coinsurance DED + 30% Coinsurance	 DED + 10% Coinsurance DED + 30% Coinsurance

[3] PBP = Per Benefit Period

BlueOptions

For Large Groups
Health Benefit Plans 03160 and 03161

Summary of Benefits for Covered Services

Amount Member Pays

	HSA Compatible Plan 03160 Single Coverage	HSA Compatible Plan 03161 Family Coverage
Other Special Services (Continued)		
Home Health Care (PBP Max)	20 Visits	20 Visits
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Skilled Nursing Facility (PBP Max)	60 days	60 days
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Hospice		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Hospital/Surgical		
Ambulatory Surgical Center Facility (ASC)		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max)	Rehabilitation Services limit - 30 days	Rehabilitation Services limit - 30 days
In-Network		
Option 1	DED + 10% Coinsurance	DED + 10% Coinsurance
Option 2	DED + 25% Coinsurance	DED + 25% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Outpatient Hospital Facility Services (per visit)		
In-Network – Therapy Services		
Option 1	DED + 10% Coinsurance	DED + 10% Coinsurance
Option 2	DED + 25% Coinsurance	DED + 25% Coinsurance
In-Network – All other		
Option 1	DED + 10% Coinsurance	DED + 10% Coinsurance
Option 2	DED + 25% Coinsurance	DED + 25% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Emergency Room Facility Services (per visit)		
In-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 20% Coinsurance	DED + 20% Coinsurance
Mental Health/Substance Dependency		
Inpatient Hospitalization Facility Services (per admit)		
In-Network (Option 1 and Option 2)	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Outpatient Hospitalization Facility Service (per visit)		
In-Network (Option 1 and Option 2)	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance
Emergency Room Facility Services (per visit)		
In-Network and Out-of-Network	In-Network DED	In-Network DED
Provider Services at Hospital and ER		
In-Network Family Physician / Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 10% Coinsurance	DED + 10% Coinsurance
Provider Services at Locations other than Office, Hospital and ER		
In-Network Family Physician / Specialist	DED + 10% Coinsurance	DED + 10% Coinsurance
Out-of-Network	DED + 30% Coinsurance	DED + 30% Coinsurance

	HSA Compatible Plan 03160	HSA Compatible Plan 03161

BlueOptions
For Large Groups
Health Benefit Plans 03160 and 03161

Summary of Benefits for Covered Services

	Amount Member Pays	
	Single Coverage	**Family Coverage**
Mental Health/Substance Dependency (Continued)		
Outpatient Office Visit In-Network Family Physician / Specialist Out-of-Network	 DED + 10% Coinsurance DED + 30% Coinsurance	 DED + 10% Coinsurance DED + 30% Coinsurance
Financial Features		
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before Florida Blue pays)	 $1,500 / Not Applicable $3,000 / Not Applicable	 Not Applicable/ $3,000 Not Applicable/ $6,000
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 10% 30%	 10% 30%
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance and Prescription Drugs)	 $3,000 / Not Applicable $6,000 / Not Applicable	 $5,000 / $5,000 $10,000 / $10,000
Total Lifetime Maximum Benefit	No Maximum	No Maximum

BlueScript Pharmacy Benefits

Pharmacy Deductible
In/Out-of-Network .....In-Network Deductible

Preferred Generic Prescription Drugs
In-Network .....$15 after In-Network DED
Mail Order (90 days).....$40 after In-Network DED
Out-of-Network ..... 50% Coinsurance after In-Network DED

Preferred Brand Name Prescription Drugs
In-Network .....$30 after In-Network DED
Mail Order (90 days).....$75 after In-Network DED
Out-of-Network ..... 50% Coinsurance after In-Network DED

Non-Preferred Prescription Drugs
In-Network .....$50 after In-Network DED
Mail Order (90 days)....$125 after In-Network DED
Out-of-Network ..... 50% Coinsurance after In-Network DED

BlueOptions

For Large Groups
Health Benefit Plans 03160 and 03161

Summary of Benefits for Covered Services

Amount Member Pays

Additional Benefits and Features

An Array of Value-Added Programs and Services

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***floridablue.com*** and other interactive web-based support tools.
- **Expert advice on call.** We encourage you to call our care consultants team at 1-888-476-2227 to find out how much they can help you SAVE. Whether comparing the cost of your medications between local pharmacies or researching the quality and cost of treatment options before you make a decision, we can help you shop for the best value for you and your family.
- Online access to everything about your health benefit plan as well as all of our self-service tools.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.*
- BlueOptions members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Access to Our Strong Networks

NetworkBlue[SM] is the Preferred Provider Network designated as "In-Network" for BlueOptions. While In-Network providers remain the best value, members are still **protected from balance billing** if they go Out-of-Network to someone who is part of our Traditional Provider Network. You may also receive **out-of-state coverage through the BlueCard**® Program with access to the participating providers of independent Blue Cross and/or Blue Shield organizations across the country.

Physician Discount

Many NetworkBlue physicians offer BlueOptions members a rate which is at least 25 percent below the usual fees charged for services that are **not Covered Services** under your health plan. By taking advantage of this discount, you get the care you need from the doctor you trust. However, Florida Blue does not guarantee that a physician will honor the discount. Since you pay out-of-pocket for any non-covered services, it's your responsibility to discuss the costs and discounted rates for non-covered services with your physician **before** you receive services. 'Physician Discount' is not part of your insurance coverage or a discount medical plan. For more information, please refer to the online Provider Directory at **floridablue.com.**

BlueScript Prescription Drug Program

The BlueOptions® health benefit plan your employer is offering you is paired with our BlueScript® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain Prescription Drugs at a location convenient to you. You may also be able to receive more savings on Prescription Drugs by purchasing your Drugs through the mail order program.

Advantages of our Pharmacy Program: With our BlueScript Pharmacy Program, you'll receive coverage for Preferred Generic, Preferred Brand Name, and Non-Preferred Prescription Drugs, as well as Self-administered Injectables and specialty medications. You have easy access to Participating Pharmacies throughout Florida and to National Network Pharmacies with over 60,000 locations.

Save when purchasing your Prescription Drugs: You can reduce your out-of-pocket costs by purchasing Covered Prescription Drugs listed on our Preferred Medication List. These Prescription Drugs should cost you less than Prescription Drugs not on the list.

Generic Prescription Drugs

You pay a lower cost for Generic Prescription Drugs that appear on the Preferred Medication List. If you request a Brand Name Prescription Drug when a Generic is available, you will be responsible for:
1. The copayment applicable to Brand Name Prescription Drugs; and
2. The difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueOptions Pharmacy Program Schedule of Benefits.

More convenient than ever:

Take your prescriptions to a participating pharmacy to have it filled. Or, if you are taking a prescription medication on an ongoing basis, you have a couple of convenient options:
1. Your doctor can prescribe a 3-month supply and you can have it filled at select participating retail pharmacies. A 3-month out-of-pocket cost (copay, coinsurance and/or deductible) applies.

2. For additional savings, fill prescriptions via our mail-order program. This program allows covered members taking Prescription Drugs to receive up to a 3-month supply for one Mail Order Copayment, after Pharmacy Deductible, if applicable. Prescription Drugs ordered through this program are provided by Prime Therapeutics'® mail order facility, PrimeMail®.

Diabetic Supplies
Diabetic supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/or syringes and needles are covered under your pharmacy benefit. Diabetic supplies require a prescription and can be obtained from a participating pharmacy

Medication Guide
The Preferred Medication List, which is part of the Medication Guide, is available online at www.bcbsfl.com. Changes in the formulary can occur over time and the most up-to-date listing can always be found by viewing the Medication Guide online or by calling the customer service number listed on your identification card. For the hearing impaired, call Florida TTY Relay Service 711. The Medication Guide also identifies specialty drugs, and drugs requiring prior authorization. When reviewing the Preferred Medication List with your doctor, ask your provider to consider a Prescription Drug from the Preferred Medication List, particularly a Preferred Generic Prescription Drug.

Pharmacy Options Affect Your Out of Pocket
There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled—retail pharmacies and specialty pharmacies. To save the most money, before you get a prescription filled you should confirm which pharmacy is considered 'in-network' for that particular medication.

- **Retail Pharmacy Network** - Non-specialty 'Generic' medications and 'Brand Name' medications listed in the Medication Guide can be filled at these pharmacies at a lower cost to you than other pharmacies in your area. If you go to a non-participating pharmacy, your prescription will cost you more.
- **Specialty Pharmacy Network** - We have identified certain drugs as specialty drugsdue to requirements such as special handling, storage, training, distribution, and management of the therapy. These drugs are listed as a 'Specialty Drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy. These pharmacies are different than the retail pharmacies and are identified in both the Provider Directory and the Medication Guide. Using an in-network Specialty Pharmacy to provide these Specialty Drugs lowers the amount you pay for these medications.
- **Non-Participating Pharmacy** - Choosing a non-participating pharmacy will cost you more money. You may have to pay the full cost of the medication and then file a claim to be reimbursed. Our payment will be based on our Non-Participating Pharmacy Allowance minus your deductible and/or coinsurance. You will be responsible for the deductible and/or coinsurance and the difference between our Allowance and the cost of the medication.
- **The National Pharmacy Network** - The National Pharmacy Network includes more than 50,000 chain and independent Pharmacies across the United States. These National Network Pharmacies are available to our members traveling or residing outside of Florida. Simply present your member ID card at time of purchase.

Utilization Management / Responsible Rx Programs

Prior Coverage Authorization - Drugs selected for Prior Coverage Authorization (PA) may require that specific clinical criteria be met before the Drugs will be covered under your pharmacy benefit. The list of drugs requiring Prior Authorization is located in the Medication Guide and are designated with a "PA" following the product name, BCBSF reserves the right to change the Drugs that require PA at any time and for any reason.

Responsible Quantity - Drugs included in this program allow a maximum quantity per time period. Quantity limits are typically developed based upon FDA-approved Drug labeling and nation allyrecognized therapeutic clinical guidelines. The list of Drugs that have quantity limits are designated in the Formulary List with "QL" following the product name. BCBSF reserves the right to change the Drugs and the quantity limits subject to the Responsible Quantity Program at any time and for any reason. In cases where a larger quantity of a Responsible Quantity Drug is medically required, your doctor or health care provider can request an override. Responsible Quantity override forms are available at www.bcbsfl.com.

Responsible Steps - Drugs included in this program require that you try another designated or prerequisite Drug first before a Drug listed in the Responsible Steps Medication Chart will be covered. If due to medical reasons you cannot use the prerequisite Drug and require the Responsible Steps Medication, your doctor or health care provider may request prior authorization for an override. If the override request is approved, coverage will be provided for the Responsible Steps Medication. These medications are designated in the Formulary List with "RS" following the product name. Medications included in the Responsible Steps Program are listed in the Medication Guide. BCBSF reserves the right to change the Drugs subject to the Responsible Steps program at any time and for any reason.

Drugs That Are Not Covered
Your Pharmacy benefit may not cover select medications. The Medication Guide contains of a list of non-covered drugs. Some reasons a medication may not be covered are:

- The Drug has been shown to have excessive adverse effects and/or safer alternatives are available.
- The Drug has a preferred formulary alternative

Prescription Discounts - With the BlueSaver® prescription savings card program, you will receive special discounted pricing on non-covered prescription medications when you show your BlueSaver ID card at select participating pharmacies. This card provides savings for you or any of your covered family members on medications that are not covered under your BlueScript pharmacy benefit. The BlueSaver savings program is not an insurance product or part of your health benefit plan.

* As a courtesy, Florida Blue has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

This is not an insurance contract or Benefit Booklet. This Benefit Summary is only a partial description of the many benefits and services provided or authorized by Florida blue. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue BlueOptions Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueCare
For Large Groups
Health Benefit Plan 47

Florida Blue HMO

Summary of Benefits for Covered Services *Amount Member Pays*

Office Services	
Physician Office Services	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$55 Copayment
Out-of-Network Office Visit	Not Covered
In-Network e-Office Visit	$10 Copayment
Out-of-Network e-Office Visit	Not Covered
Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	
In-Network	$250 Copayment
Out-of-Network	Not Covered
Maternity Initial Visit	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$55 Copayment
Out-of-Network	Not Covered
Allergy Injections (per visit)	
In-Network	$10 Copayment
Out-of-Network	Not Covered
Medical Pharmacy - Physician-Administered Medications (applies to Office Setting and Specialty Pharmacy Vendors)	
In-Network Monthly Out-of-Pocket (OOP) Maximum[1]	$200
In-Network Provider	20% Coinsurance
Out-of-Network	Not Covered
Physician-Administered Medications – These medications require the administration to be performed by a health care provider. The medications are ordered by a provider and administered in an office or outpatient setting. Physician-Administered medications are covered under your *medical* benefit. **Please refer to the Physician-Administered medication list in the Medication Guide for a list of drugs covered under this benefit.**	
Convenient Care Centers	
In-Network	$30 Copayment
Out-of-Network	Not Covered
Preventive Care	
Routine Adult & Child Preventive Services, Wellness Services, and Immunizations	
In-Network	$0
Out-of-Network	Not Covered
Mammograms	
In-Network	$0
Out-of-Network	Not Covered
Colonoscopy (Routine for age 50+ then frequency schedule applies)	
In-Network	$0
Out-of-Network	Not Covered
Emergency Medical Care	
Urgent Care Centers	
In-Network	$60 Copayment
Out-of-Network	Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted)	
In-Network and Out-of-Network	$250 Copayment

[1] In-Network Medical Pharmacy will be paid at 100% for the remainder of the calendar month once OOP max is met.

Summary of Benefits for Covered Services	*Amount Member Pays*
Emergency Medical Care (Continued)	
Ambulance Services	
In-Network	DED[2] + 20% Coinsurance
Out-of-Network (Emergency Services Only)	DED + 20% Coinsurance
Outpatient Diagnostic Services	
Independent Diagnostic Testing Center Services (per visit) (e.g. X-rays) (Includes Provider Services)	
In-Network Diagnostic Services (except AIS)	$50 Copayment
In-Network Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$250 Copayment
Out-of-Network	Not Covered
Independent Clinical Lab (e.g. Blood Work)	
In-Network	$0
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit) (e.g. Blood Work and X-rays)	
In-Network	DED + 20% Coinsurance
Out-of Network	Not Covered
Other Provider Services	
Provider Services at Hospital and ER	
In-Network	DED + 20% Coinsurance
Out-of-Network ER	DED + 20% Coinsurance
Out-of-Network Hospital	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at an Ambulatory Surgical Center (ASC)	
In-Network Specialist	$55 Copayment
Out-of-Network	Not Covered
Provider Services at Locations other than Office, Hospital and ER	
In-Network Family Physician	$30 Copayment
In-Network Specialist	$55 Copayment
Out-of-Network	Not Covered
Other Special Services	
Combined Outpatient Cardiac Rehabilitation and Occupational, Physical, Speech and Massage Therapies and Spinal Manipulations (PBP[3] Max)	35 Visits
Outpatient Rehab Therapy Center	
In-Network	$55 Copayment
Out-of-Network	Not Covered
Outpatient Hospital Facility Services (per visit)	
In-Network	$55 Copayment
Out-of-Network	Not Covered
Durable Medical Equipment, Prosthetics and Orthotics	
In-Network – Motorized Wheelchair	$500 Copayment
In-Network – All Other	$0
Out-of-Network	Not Covered
Home Health Care (PBP Max)	20 Visits
In-Network	$0
Out-of-Network	Not Covered
Skilled Nursing Facility (PBP Max)	60 days
In-Network	DED + 20% Coinsurance
Out-of-Network	Not Covered

[2] DED = Deductible
[3] PBP = Per Benefit Period

BlueCare
For Large Groups
Health Benefit Plan 47

Summary of Benefits for Covered Services	*Amount Member Pays*
Other Special Services (Continued)	
Hospice In-Network Out-of-Network	 DED + 20% Coinsurance Not Covered
Hospital / Surgical	
Ambulatory Surgical Center Facility (ASC) In-Network Out-of-Network	 $200 Copayment Not Covered
Inpatient Hospital Facility and Rehabilitation Services (per admit) (PBP Max) In-Network Out-of-Network	Rehabilitation Services limit - 30 days DED + 20% Coinsurance Not Covered
Outpatient Hospital Facility Services (per visit) In-Network – Therapy Services In-Network – All other Services Out-of-Network	 $55 Copayment DED + 20% Coinsurance Not Covered
Emergency Room Facility Services (per visit) (copayment waived if admitted) In-Network and Out-of-Network	 $250 Copayment
Mental Health / Substance Dependency	
Inpatient Hospitalization Facility Services (per admit) In-Network Out-of-Network	 $0 Not Covered
Outpatient Hospitalization Facility Service (per visit) In-Network Out-of-Network	 $0 Not Covered
Emergency Room Facility Services (per visit) In-Network and Out-of-Network	 $0
Provider Services at Hospital and ER In-Network Family Physician / Specialist Out-of-Network ER Out-of-Network Hospital	 $0 $0 Not Covered
Provider Services at Locations other than Office, Hospital and ER In-Network Family Physician / Specialist Out-of-Network	 $0 Not Covered
Outpatient Office Visit In-Network Family Physician / Specialist Out-of-Network	 $0 Not Covered
Financial Features	
Deductible (DED) (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (DED is the amount the member is responsible for before Florida Blue HMO pays)	 $1,500 / $4,500 Not Covered
Coinsurance In-Network Out-of-Network (Coinsurance is the percentage the member pays for services)	 20% Not Covered

Summary of Benefits for Covered Services *Amount Member Pays*

Financial Features (Continued)	
Out-of-Pocket Maximum (PBP) (Per Person / Family Aggregate) In-Network Out-of-Network (Out-of-Pocket Maximum includes DED, Coinsurance, Copayments and Prescription Drugs)	$4,500 / $9,000 Not Covered
Total Lifetime Maximum Benefit	No Maximum

BlueCare Pharmacy Benefits - $20/$50/$80

	In-Network	Out-of-Network	Mail Order* (90 days)
Pharmacy Deductible**	$100		
Preferred Generic Prescription Drugs	$20	Not Covered	$40
Preferred Brand Name Prescription Drugs	$50	Not Covered	$100
Non-Preferred Prescription Drugs	$80	Not Covered	$160

Additional Benefits and Features

BlueCare Rx Prescription Drug Program

In the event your Group has purchased pharmacy coverage from Florida Blue HMO, you'll find a Pharmacy Program information sheet enclosed. Please review it carefully, as you'll find it contains an overview of your benefits and how to utilize them.

An Array of Value-Added Programs and Services

- **Access to valuable health information and resources**, including care decision support, our online provider directory at ***floridablue.com*** and other interactive web-based support tools.
- **Expert advice on call.** We encourage you to call our care consultants team at 1-888-476-2227 to find out how much they can help you SAVE. Whether comparing the cost of your medications between local pharmacies or researching the quality and cost of treatment options before you make a decision, we can help you shop for the best value for you and your family.
- Online access to everything about your health benefit plan as well as all of our self-service tools.
- Online access to participating physician offices for **e-office visits**, consultations, appointment scheduling or cancellation, prescription refills and much more.*
- BlueCare members receive a **Member Health Statement** that summarizes your health care activity for the preceding month.

Should it become necessary, a grievance procedure is available to all Members as detailed in the Master Policy.

Preauthorization for select services: You don't need a referral to see a participating specialist, however authorizations are required for certain office-based services such as CT/MRI scans and select injectables, as well as other medical services like hospitalization, rehabilitation services, home health care, and select durable medical equipment.

This summary is only a partial description of the many benefits and services covered by Florida Blue HMO, an HMO subsidiary of Blue Cross and Blue Shield of Florida, Inc. This does not constitute a contract. For a complete description of benefits and exclusions, please see the Florida Blue HMO BlueCare Benefit Booklet and Schedule of Benefits; its terms prevail.

BlueScript Prescription Drug Program
The BlueCare® health benefit plan your employer is offering you is paired with our BlueCare Rx® Pharmacy Program. With a large network of Participating Pharmacies statewide and nationally, you can obtain prescription drugs at a location convenient to you.You may also be able to receive more savings on prescription drugs by purchasing your drugs through the mail order program.

Advantages of our Pharmacy Program: With our BlueScript Pharmacy Program, you'll receive coverage for Preferred Generic, Preferred Brand Name, and Non-Preferred Prescription Drugs, as well as Self-administered Injectables and specialty medications. You have easy access to Participating Pharmacies throughout Florida and to National Network Pharmacies with over 60,000 locations.

Save when purchasing your Prescription Drugs: You can reduce your out-of-pocket costs by purchasing Covered Prescription Drugs listed on our Preferred Medication List. These Prescription Drugs should cost you less than Prescription Drugs not on the list.

Generic Prescription Drugs
You pay a lower cost for Generic Prescription Drugs that appear on the Preferred Medication List. If you request a Brand Name Prescription Drug when a Generic is available, you will be responsible for:
1. The copayment applicable to Brand Name Prescription Drugs; and
2. The difference in cost between the Generic Prescription Drug and the Brand Name Prescription Drug, as indicated in the BlueOptions Pharmacy Program Schedule of Benefits.

More convenient than ever:
Take your prescriptions to a participating pharmacy to have it filled. Or, if you are taking a prescription medication on an ongoing basis, you have a couple of convenient options:
1. Your doctor can prescribe a 3-month supply and you can have it filled at select participating retail pharmacies. A 3-month out-of-pocket cost (copay, coinsurance and/or deductible) applies.
2. For additional savings, fill prescriptions via our mail-order program. This program allows covered members taking Prescription Drugs to receive up to a 3-month supply for one Mail Order Copayment, after Pharmacy Deductible, if applicable. Prescription Drugs ordered through this program are provided by Prime Therapeutics'® mail order facility, PrimeMail®.

Diabetic Supplies
Diabetic supplies such as blood glucose testing strips and tablets, lancets, glucometers, and acetone test tablets and/
or syringes and needles are covered under your pharmacy benefit. Diabetic supplies require a prescription and can be
obtained from a participating pharmacy

Medication Guide
The Preferred Medication List, which is part of the Medication Guide, is available online at www.bcbsfl.com. Changes in the formulary can occur over time and the most up-to-date listing can always be found by viewing the Medication Guide online or by calling the customer service number listed on your identification card. For the hearing impaired, call Florida TTY Relay Service 711. The Medication Guide also identifies specialty drugs, and drugs
requiring prior authorization. When reviewing the Preferred Medication List with your doctor, ask your provider to consider a Prescription Drug from the Preferred Medication List, particularly a Preferred Generic Prescription Drug.

Pharmacy Options Affect Your Out of Pocket
There are two different types of pharmacies for you to be aware of as you decide where to get your prescriptions filled—retail pharmacies and specialty pharmacies. To save the most money, before you get a prescription filled you
should confirm which pharmacy is considered 'in-network' for that particular medication.

- **Retail Pharmacy Network** - Non-specialty 'Generic' medications and 'Brand Name' medications listed in the Medication Guide can be filled at these pharmacies at a lower cost to you than other pharmacies in your area. If you go to a non-participating pharmacy, your prescription will cost you more.
- **Specialty Pharmacy Network** - We have identified certain drugs as specialty drugsdue to requirements such as special handling, storage, training, distribution, and management of the therapy. These drugs are listed as a 'Specialty Drug' in the Medication Guide. To be covered under your pharmacy program at the In-Network cost share, they must be purchased at a participating Specialty Pharmacy. These pharmacies are different than the retail pharmacies and are identified in both the Provider Directory and the Medication Guide. Using an in-network Specialty Pharmacy to provide these Specialty Drugs lowers the amount you pay for these medications.
- **Non-Participating Pharmacy** - Choosing a non-participating pharmacy will cost you more money. You may have to pay the full cost of the medication.
- **The National Pharmacy Network** - The National Pharmacy Network includes more than 50,000 chain and independent Pharmacies across the United States. These National Network Pharmacies are available to our members traveling or residing outside of Florida. Simply present your member ID card at time of purchase.

Utilization Management / Responsible Rx Programs

Prior Coverage Authorization - Drugs selected for Prior Coverage Authorization (PA) may require that specific clinical criteria be met before the Drugs will be covered under your pharmacy benefit. The list of drugs requiring Prior Authorization is located in the Medication Guide and are designated with a "PA" following the product name, BCBSF reserves the right to change the Drugs that require PA at any time and for any reason.

Responsible Quantity - Drugs included in this program allow a maximum quantity per time period. Quantity limits are typically developed based upon FDA-approved Drug labeling and nation allyrecognized therapeutic clinical guidelines. The list of Drugs that have quantity limits are designated in the Formulary List with "QL" following the product name. BCBSF reserves the right to change the Drugs and the quantity limits subject to the Responsible Quantity Program at any time and for any reason. In cases where a larger quantity of a Responsible Quantity Drug is medically required, your doctor or health care provider can request an override. Responsible Quantity override forms are available at www.bcbsfl.com.

Responsible Steps - Drugs included in this program require that you try another designated or prerequisite Drug first before a Drug listed in the Responsible Steps Medication Chart will be covered. If due to medical reasons you cannot use the prerequisite Drug and require the Responsible Steps Medication, your doctor or health care provider may request prior authorization for an override. If the override request is approved, coverage will be provided for the Responsible Steps Medication. These medications are designated in the Formulary List with "RS" following the product name. Medications included in the Responsible Steps Program are listed in the Medication Guide. BCBSF reserves the right to change the Drugs subject to the Responsible Steps program at any time and for any reason.

Drugs That Are Not Covered
Your Pharmacy benefit may not cover select medications. The Medication Guide contains of a list of non-covered drugs. Some reasons a medication may not be covered are:

- The Drug has been shown to have excessive adverse effects and/or safer alternatives are available.
- The Drug has a preferred formulary alternative

Prescription Discounts - With the BlueSaver® prescription savings card program, you will receive special discounted pricing on non-covered prescription medications when you show your BlueSaver ID card at select participating pharmacies. This card provides savings for you or any of your covered family members on

medications that are not covered under your BlueScript pharmacy benefit. The BlueSaver savings program is not an insurance product or part of your health benefit plan.

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

* As a courtesy, Florida Blue has an arrangement with a vendor to provide secure online communication between its members and participating physicians as a value-added feature. The written terms of your policy, certificate or benefit booklet determine what is covered.

Item 2

Medical Rates and Monthly Contributions

The District School Board of Sumter County, FL
Historical rates

2013

BlueOptions Family Physician Plan 3359
Employee Only $ 373.87
Employee Spouse $ 773.90
Employee Child(ren) $ 702.87
Family $ 1,187.04

BlueOptions Health Plan 03160/03161
Employee Only $ 365.31
Employee Spouse $ 692.48
Employee Child(ren) $ 619.37
Family $ 1,062.15

BlueChoice Physician Copay Plan 727
Employee Only $ 505.19
Employee Spouse $ 1,045.71
Employee Child(ren) $ 949.74
Family $ 1,603.95

2014

BlueOptions Family Physician Plan 3359
Employee Only $ 429.60
Employee Spouse $ 889.25
Employee Child(ren) $ 807.64
Family $ 1,363.98

BlueOptions Health Plan 03160/03161
Employee Only $ 391.98
Employee Spouse $ 743.06
Employee Child(ren) $ 664.59
Family $ 1,139.69

2015

BlueOptions Family Physician Plan 03359
Employee Only $ 502.74
Employee Spouse $ 1,040.51
Employee Child(ren) $ 945.03
Family $ 1,595.99

BlueOptions Health Plan 03160/03161
Employee Only $ 449.60
Employee Spouse $ 852.20
Employee Child(ren) $ 762.20
Family $ 1,307.00

BlueCare Plan 47
Employee Only $ 393.40
Employee Spouse $ 814.30
Employee Child(ren) $ 739.60
Family $ 1,249.10

BLUE CROSS BLUE SHIELD HEALTH INSURANCE RATES
RATES EFFECTIVE 1/1/13-12/31/13

You have 30 days from your date of hire to choose a benefit plan. Please contact Leslie Paxton within your 30 day hire period to make a selection. If you have any questions please call 793-2315 ext: 229 or email leslie.paxton@sumter.k12.fl.us

"A-C-D-E" Annual Board Benefit - $4,148.00
Monthly Board Benefit - $345.67
Includes $36,000 Life Insurance with AD&D for All Employees

BlueChoice 727(Medical Only) Plan C

Coverage Selected	Monthly Board Benefit	Monthly Employee Premium	Per Check Deduction
C Employee	$345.67	$154.09	$77.05
C2 EE/Spouse	$345.67	$482.19	$241.10
C3 EE/Child(ren)	$345.67	$428.65	$214.33
C4 EE/Family	$345.67	$615.65	$307.83

BlueOptions 3359(Medical Only) Plan D

Coverage Selected	Monthly Board Benefit	Monthly Employee Premium	Per Check Deduction
D Employee	$345.67	$25.61	$12.81
D2 EE/Spouse	$345.67	$263.10	$131.55
D3 EE/Child(ren)	$345.67	$230.40	$115.20
D4 EE/Family	$345.67	$365.50	$182.75

2013 Alternative Plans

BlueOptions 3160 & 3161(Medical Only) W/HSA Plan E

Coverage Selected	Monthly Board Benefit	Monthly Employee Premium	Per Check Deduction
E Employee	$345.67	$31.42	$15.71
E2 EE/Spouse	$345.67	$369.14	$184.57
E3 EE/Child(ren)	$345.67	$303.54	$151.77
E4 EE/Family	$345.67	$750.73	$375.36

Plan A (No Medical Benefits)
Dental, Vision & Flexible Spending

Coverage Selected	Monthly Board Benefit	Monthly Employee Premium	Per Check Deduction
A Employee	$345.67	$0.00	$0.00
A2 EE/Spouse	$345.67	$26.70	$13.35
A3 EE/Children	$345.67	$23.70	$11.85
A4 EE/Family	$345.67	$31.70	$15.85

To Add Dental & Vision to Medical Plans

Coverage Selected	Monthly Premium	Employee Pays Mo.	Per Check Deduction
1 Employee	$37.42	$37.42	$18.71
5 EE/Spouse	$64.12	$64.12	$32.06
6 EE/Child(ren)	$61.12	$61.12	$30.56
7 EE/Family	$69.12	$69.12	$34.56

BLUE CROSS BLUE SHIELD HEALTH INSURANCE RATES
RETIREE RATES EFFECTIVE 1/1/13-12/31/13

Below are the 2013 insurance rates. Open enrollment is November 1 – 16, 2012. All changes are effective 1/1/2013. Contact Leslie Paxton for questions concerning your plan at: 352-793-2315 ext: 229 or email leslie.paxton@sumter.k12.fl.us.

BlueChoice 727 Plan C

Coverage Selected	Monthly Deduction
RC Retiree	$499.76
RC2 Retiree/Spouse	$827.86
RC3 Retiree/Child(ren)	$774.32
RC4 Retiree/Family	$961.32

BlueOptions 3359 Plan D

Coverage Selected	Monthly Deduction
RD Retiree	$371.28
RD2 Retiree/Spouse	$608.77
RD3 Retiree/Child(ren)	$576.07
RD4 Retiree/Family	$711.17

2013 Retiree Alternative Plans

BlueOptions 3160 & 3161 W/HSA Plan E

Coverage Selected	Monthly Deduction
RE Retiree	$377.09
RE2 RE/Spouse	$714.81
RE3 RE/Child(ren)	$649.21
RE4 RE/Family	$1096.40

Plan A (No Medical Benefits) Dental & Vision

Coverage Selected	Monthly Deduction
RA Retiree	$37.42
RA1 RE/Spouse	$64.12
RA2 RE/Child(ren)	$61.12
RA3 RE/Family	$69.12

To Add Dental & Vision to Medical Plans

Coverage Selected	Monthly Deduction
1 Retiree	$37.42
5 Retiree/Spouse	$64.12
6 Retiree/Child(ren)	$61.12
7 Retiree/Family	$69.12

Retiree Group Life Insurance

Coverage	$5,000	$10,000
Retiree	$.85 per month	$1.70 per month

Sumter School District
Blue Cross Blue Shield of Florida
Active Employee Benefits Plans
2014

This illustration is a SUMMARY of plan benefits.
All rates shown are in 24 payments.

Insurance Contact Information

Please contact Leslie Paxton for questions concerning your plan at: 352-793-2315, x50229 or email Leslie.Paxton@sumter.k12.fl.us

"A-D-E" Annual Board Benefit-$4,374.00

Plan A: alternate benefits for those employees who have medical coverage elsewhere.

Coverage		Amount
Life Insurance with AD&D		$36,000
Vision and Dental coverage (dental includes orthodontic benefits)		see schedule
Medical Flexible Spending Account		**$500/PCY**

Keep in mind that Option A does not include medical benefits. The cost shown is the amount deducted from your paycheck.

A	Employee coverage	no cost
A2	Employee (A) & spouse dental and vision	$13.35
A3	Employee (A) & children dental & vision	$11.85
A4	Employee (A) & spouse and children dental & vision	$15.85

*BCBS PCP providers include Family Practitioners, General Practitioners, Internal Medicine and Pediatricians.
❖Co-payment includes all covered services that occur at the time of the office visit and within the office visit only.

BENEFITS	Plan D/Plan 3359	Plan E/Plan 3160	Plan E/Plan 3161
Life Insurance with AD&D	$36,000	$36,000	$36,000
Medical Lifetime Maximum	No Maximum	No Maximum	No Maximum
❖Co-pay for visits to PPO *PCP doctors	$25.00	DED + 10%	DED + 10%
❖Co-pay for visits PPO Specialists	$35.00	DED + 10%	DED + 10%
Deductible PCY (Per person/Family Agg)	$1,000 / $3,000	$1,500/Not Applicable	Not Applicable/ $3,000
Co-payment per hospital confinement In-Network Out-of-Network	 Option 1 - $500/Option 2- $1,000 Deductible + 40%	 Deductible + 10% Deductible + 30%	 Deductible + 10% Deductible + 30%
Co-Insurance for PPO Providers	20%	10%	10%
Co-Insurance for NON PPO Providers	40%	30%	30%
Maximum out-of-pocket Co-insurance In-Network Of-Network	Includes DED, Coins, Copays $4,000 / $12,000 Combined w/In-Ntwk	Includes DED, Coins, Copays $3,000 $6,000	Includes, DED, ,Coins, Copays $6,000 $12,000
Prescription Medication – Retail Copay (See detail for mail order)	$100 DED PCY, then $20/$40/$60 (30 days)	In – Network DED then $15/$30/$50 (30 days)	In-Network DED then $15/$30/$50 (30 days)
Annual Physical Exam (for employees and spouses with medical coverage)	Family Physician/Specialist copay applies	$0 In-Network 30% Out-Of-Ntwk	$ 0 In-Network 30% Out-Of-Ntwk

Below are the 2014 insurance rates. The cost shown is reduced by the board contribution and is the amount deducted from your paycheck.

Plan Coverage	Plan D/3359	Plan E/3160	Plan E/3161
Employee medical, as listed above	☐D $ 13.45	☐E $ 16.50	☐ N/A
EE Medical, dental & vision	☐D1 $ 32.16	☐E1 $ 35.21	☐ N/A
EE/Spouse medical coverage	☐D2 $138.13	☐ N/A	☐E2 $ 193.80
EE/Children medical coverage	☐D3 $120.96	☐ N/A	☐E3 $ 159.36
EE/Family medical coverage	☐D4 $191.89	☐ N/A	☐E4 $394.14
EE/Spouse, medical, dental & vision	☐D5 $170.19	☐ N/A	☐E5 $225.86
EE/Child medical, dental & vision	☐D6 $151.52	☐ N/A	☐E6 $189.92
EE/Family. Medical, dental & vision	☐D7 $226.45	☐ N/A	☐E7 $428.70
EE Medical & EE / Sp Den & Vision	☐D8 $ 45.51	☐E8 $ 48.56	☐ N/A
EE Medical & EE / Child Den & Vision	☐D9 $ 44.01	☐E9 $ 47.06	☐ N/A
EE Medical & EE / Family Den & Vision	☐D10 $ 48.01	☐E10 $ 51.06	☐ N/A

Sumter School District
Blue Cross Blue Shield of Florida
Retiree Employee Benefits Plans
2014

This illustration is a SUMMARY of plan benefits.
All rates shown are in 12 payments.

Please contact Leslie Paxton for questions concerning your plan at:
352-793-2315, x 229 or email Leslie.Paxton@sumter.k12.fl.us

Plan RA: alternate benefits for those retirees who have medical coverage elsewhere.

Coverage		Amount
Vision and Dental coverage (dental includes orthodontic benefits)		see schedule
Keep in mind that Option A does not include medical benefits. The cost shown is the amount deducted from your FRS check.		
$5,000	Retiree Life	$.85
$10,000	Retiree Life	$1.70
RA	Employee coverage	$37.42
RA1	Employee (A) & spouse dental and vision	$64.12
RA2	Employee (A) & children dental & vision	$61.12
RA3	Employee (A) & spouse and children dental & vision	$69.12

*BCBS PCP providers include Family Practitioners, General Practitioners, Internal Medicine and Pediatricians.
❖Co-payment includes all covered services that occur at the time of the office visit and within the office visit only.

BENEFITS	Plan D/Plan 3359	Plan E/Plan 3160	Plan E/Plan 3161
Life Insurance with AD&D	$36,000	$36,000	$36,000
Medical Lifetime Maximum	No Maximum	No Maximum	No Maximum
❖Co-pay for visits to PPO *PCP doctors	$25.00	DED + 10%	DED + 10%
❖Co-pay for visits PPO Specialists	$35.00	DED + 10%	DED + 10%
Deductible PCY (Per person/Family Agg)	$1,000 / $3,000	$1,500/Not Applicable	Not Applicable/ $3,000
Co-payment per hospital confinement In-Network Out-of-Network	 Option 1 - $500/Option 2- $1,000 Deductible + 40%	 Deductible + 10% Deductible + 30%	 Deductible + 10% Deductible + 30%
Co-Insurance for PPO Providers	20%	10%	10%
Co-Insurance for NON PPO Providers	40%	30%	30%
Maximum out-of-pocket Co-insurance In-Network Of-Network	Includes DED, Coins, Copays $4,000 / $12,000 Combined w/In-Ntwk	Includes DED, Coins, Copays $3,000 $6,000	Includes, DED, ,Coins, Copays $6,000 $12,000
Prescription Medication – Retail Copay (See detail for mail order)	$100 DED PCY, then $20/$40/$60 (30 days)	In – Network DED then $15/$30/$50 (30 days)	In-Network DED then $15/$30/$50 (30 days)
Annual Physical Exam (for employees and spouses with medical coverage)	Family Physician/Specialist copay applies	$0 In-Network 30% Out-Of-Ntwk	$ 0 In-Network 30% Out-Of-Ntwk

Below are the 2014 insurance rates . The cost shown is your monthly insurance premium.

Plan Coverage	Plan D/3359	Plan E/3160	Plan E/3161
Employee medical, as listed above	☐RD $391.40	☐RE $ 397.50	☐ N/A
EE Medical, dental & vision	☐RD1 $428.82	☐RE1 $ 434.92	☐ N/A
EE/Spouse medical coverage	☐RD2 $640.76	☐ N/A	☐RE2 $ 752.10
EE/Children medical coverage	☐RD3 $606.42	☐ N/A	☐RE3 $ 683.22
EE/Family medical coverage	☐RD4 $748.28	☐ N/A	☐RE4 $1152.78
EE/Spouse, medical, dental & vision	☐RD5 $704.88	☐ N/A	☐RE5 $ 816.22
EE/Child medical, dental & vision	☐RD6 $667.54	☐ N/A	☐RE6 $ 744.34
EE/Family. Medical, dental & vision	☐RD7 $817.40	☐ N/A	☐RE7 $1221.90
EE Medical & EE / Sp Den & Vision	☐RD8 $455.52	☐RE8 $ 461.62	☐ N/A
EE Medical & EE / Child Den & Vision	☐RD9 $452.52	☐RE9 $ 458.62	☐ N/A
EE Medical & EE / Family Den & Vision	☐RD10 $460.52	☐RE10 $ 466.62	☐ N/A

Sumter School District
Blue Cross Blue Shield of Florida
Active Employee Benefits Plans
2015

This illustration is a SUMMARY of plan benefits.
All rates shown are in 24 payments.

Insurance Contact Information

Please contact Leslie Paxton for questions concerning your plan at:
352-793-2315, x50229 or email Leslie.Paxton@sumter.k12.fl.us

"A-D-E-F" Annual Board Benefit-$5,072.24/Per Paycheck -$211.34

Plan A: alternate benefits for those employees who have medical coverage elsewhere.

Coverage		Amount
Life Insurance with AD&D		$36,000
Vision and Dental coverage (dental includes orthodontic benefits)		see schedule
Keep in mind that Option A does not include medical benefits. The cost shown is the amount deducted from your paycheck.		
A	Employee coverage	no cost
A2	Employee (A) & spouse dental and vision	$18.71
A3	Employee (A) & children dental & vision	$16.85
A4	Employee (A) & spouse and children dental & vision	$20.85

BENEFITS	BlueOptions (D)	BlueOptions (E)**	BlueCare (F)
Life Insurance with AD&D	$36,000	$36,000	$36,000
Medical Lifetime Maximum	No Maximum	No Maximum	No Maximum
❖Co-pay for visits to PPO *PCP doctors	$25.00	DED + 10%	$30.00
❖Co-pay for visits PPO Specialists	$35.00	DED + 10%	$55.00
Deductible PCY (Per person/Family Agg)	$1,000 / $3,000	$1,500 / $3,000	$1,500 / $4,500
Co-payment per hospital confinement In-Network Out-of-Network	 Option 1 - $500/Option 2- $1,000 Deductible + 40%	 Deductible + 10% Deductible + 30%	 Deductible + 20% Not Covered
Co-Insurance for PPO Providers	20%	10%	10%
Co-Insurance for NON PPO Providers	40%	30%	Not Covered
Maximum out-of-pocket Co-insurance In-Network Of-Network	Includes DED, Coins, Copays $4,000 / $12,000 Combined w/In-Ntwk	Includes DED, Coins, Copays $3,000 $6,000	Includes, DED, ,Coins, Copays $4,500/$9,000 N/A
Prescription Medication – Retail Copay (See detail for mail order)	$100 DED PCY, then $20/$40/$60 (30 days)	In – Network DED then $15/$30/$50 (30 days)	$100 DED PCY, then $20/$50/$80 (30 days)
Annual Physical Exam (for employees and spouses with medical coverage)	Family Physician/Specialist copay applies	$0 In-Network 30% Out-Of-Ntwk	Family Physician/Specialist copay applies

*BCBS PCP providers include Family Practitioners, General Practitioners, Internal Medicine and Pediatricians.
❖Co-payment includes all covered services that occur at the time of the office visit and within the office visit only.

Dental/Vision Package added to Medical Plan	
Employee Coverage	$23.71
Employee/Spouse Dental & Vision	$37.06
Employee/Child(ren) Dental & Vision	$35.56
Employee/Family Dental & Vision	$39.56

Below are the 2015 insurance rates. The cost shown is reduced by the board contribution and is the amount deducted from your paycheck.

Plan Coverage	Plan D	Plan E	Plan F
Employee medical, as listed above	☐D $ 40.32	☐E $ 48.10	☐F $ 19.00
EE Medical, dental & vision	☐D1 $ 64.03	☐E1 $ 71.81	☐F1 $ 42.71
EE/Spouse medical coverage	☐D2 $231.70	☐E2 $296.32	☐F2 $150.56
EE/Children medical coverage	☐D3 $231.70	☐E3 $296.32	☐F3 $150.56
EE/Family medical coverage	☐D4 $376.50	☐E4 $576.79	☐F4 $221.50
EE/Spouse, medical, dental & vision	☐D5 $268.76	☐E5 $333.38	☐F5 $187.62
EE/Child medical, dental & vision	☐D6 $267.26	☐E6 $331.88	☐F6 $186.12
EE/Family. Medical, dental & vision	☐D7 $416.06	☐E7 $616.35	☐F7 $261.06
EE Medical & EE / Sp Den & Vision	☐D8 $ 77.38	☐E8 $ 85.16	☐F8 $ 56.06
EE Medical & EE / Child Den & Vision	☐D9 $ 75.88	☐E9 $ 83.66	☐F9 $ 54.56
EE Medical & EE / Family Den & Vision	☐D10 $ 79.88	☐E10 $ 87.66	☐F10 $ 58.56

****Please note: Effective 1/1/2015, BlueOptions plan E is no longer available. Employees in Plan E prior to 1/1/2015 are grandfathered in.**

Sumter School District
Blue Cross Blue Shield of Florida
Retiree Employee Benefits Plans
2015

This illustration is a SUMMARY of plan benefits.
All rates shown are in 12 payments.

Insurance Contact Information

Please contact Leslie Paxton for questions concerning your plan at:
352-793-2315, x50229 or email Leslie.Paxton@sumter.k12.fl.us

Plan A: alternate benefits for those employees who have medical coverage elsewhere.

Coverage		Amount
Vision and Dental coverage (dental includes orthodontic benefits)		see schedule

Keep in mind that Option A does not include medical benefits. The cost shown is the amount deducted from your paycheck.

$5,000	**Retiree Life**	**$1.05**
$10,000	**Retiree Life**	**$2.10**
R**A**	Retiree coverage	$47.42
RA1	Employee (A) & spouse dental and vision	$74.12
RA2	Employee (A) & children dental & vision	$71.12
R**A3**	Employee (A) & spouse and children dental & vision	$79.12

*BCBS PCP providers include Family Practitioners, General Practitioners, Internal Medicine and Pediatricians.
❖Co-payment includes all covered services that occur at the time of the office visit and within the office visit only.

BENEFITS	BlueOptions (D)	BlueOptions (E)	BlueCare (F)
Life Insurance with AD&D	$36,000	$36,000	$36,000
Medical Lifetime Maximum	No Maximum	No Maximum	No Maximum
❖Co-pay for visits to PPO *PCP doctors	$25.00	DED + 10%	$30.00
❖Co-pay for visits PPO Specialists	$35.00	DED + 10%	$55.00
Deductible PCY (Per person/Family Agg)	$1,000 / $3,000	$1,500 / $3,000	$1,500 / $4,500
Co-payment per hospital confinement In-Network Out-of-Network	 Option 1 - $500/Option 2- $1,000 Deductible + 40%	 Deductible + 10% Deductible + 30%	 Deductible + 20% Not Covered
Co-Insurance for PPO Providers	20%	10%	10%
Co-Insurance for NON PPO Providers	40%	30%	Not Covered
Maximum out-of-pocket Co-insurance In-Network Of-Network	Includes DED, Coins, Copays $4,000 / $12,000 Combined w/In-Ntwk	Includes DED, Coins, Copays $3,000 $6,000	Includes, DED, ,Coins, Copays $4,500/$9,000 N/A
Prescription Medication – Retail Copay (See detail for mail order)	$100 DED PCY, then $20/$40/$60 (30 days)	In – Network DED then $15/$30/$50 (30 days)	$100 DED PCY, then $20/$50/$80 (30 days)
Annual Physical Exam (for employees and spouses with medical coverage)	Family Physician/Specialist copay applies	$0 In-Network 30% Out-Of-Ntwk	Family Physician/Specialist copay applies

Below are the 2015 insurance rates. The cost shown is the amount deducted from your monthly FRS pension check.

Plan Coverage	Plan D	Plan E	Plan F
Employee medical, as listed above	☐D $502.74	☐E $449.60	☐F $393.40
EE Medical, dental & vision	☐D1 $550.16	☐E1 $497.02	☐F1 $440.82
EE/Spouse medical coverage	☐D2 $886.09	☐E2 $852.20	☐F2 $814.30
EE/Children medical coverage	☐D3 $886.09	☐E3 $762.20	☐F3 $739.60
EE/Family medical coverage	☐D4 $1,175.69	☐E4 $1,307.00	☐F4 $1,249.10
EE/Spouse, medical, dental & vision	☐D5 $960.21	☐E5 $926.32	☐F5 $888.42
EE/Child medical, dental & vision	☐D6 $957.21	☐E6 $833.32	☐F6 $810.72
EE/Family. Medical, dental & vision	☐D7 $1,254.81	☐E7 $1,386.12	☐F7 $1,328.22
EE Medical & EE / Sp Den & Vision	☐D8 $576.86	☐E8 $523.72	☐F8 $467.52
EE Medical & EE / Child Den & Vision	☐D9 $573.86	☐E9 $520.72	☐F9 $464.52
EE Medical & EE / Family Den & Vision	☐D10 $581.86	☐E10 $528.72	☐F10 $472.52

Item 3

Experience Reports

Monitoring by Utilization and Enrollment

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
Current Paid Period: From 01/2013 to 12/2013

	Enrollment		Premium	Capitation			Fee for Service Claims							
Paid Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201301	614	1,133	$404,313.11	$0.00	$559.37	$559.37	$17,728.09	$92,322.06	$41,319.86	$20,397.66	$171,767.67	$39,163.41	$211,490.45	52.31%
201302	612	1,131	$323,130.58	$0.00	$596.58	$596.58	($30,002.56)	($15,551.03)	$15,730.74	$11,963.35	($17,859.50)	$32,895.48	$15,632.56	4.84%
201303	612	1,135	$388,192.98	$0.00	$542.29	$542.29	$40,491.15	$101,882.15	$68,751.96	$37,482.63	$248,607.89	$35,432.39	$284,582.57	73.31%
201304	613	1,136	$391,811.79	$0.00	$566.69	$566.69	$63,826.31	$70,993.78	$77,706.10	$17,448.68	$229,974.87	$43,285.32	$273,826.88	69.89%
201305	607	1,129	$395,054.28	$0.00	$569.74	$569.74	$36,181.17	$65,348.62	$48,976.32	$20,807.79	$171,313.90	$49,323.00	$221,206.64	55.99%
201306	590	1,103	$385,735.14	$0.00	$549.61	$549.61	$142,930.62	$67,939.00	$67,071.42	$30,078.99	$308,020.03	$37,332.44	$345,902.08	89.67%
201307	586	1,099	$369,496.16	$0.00	$534.36	$534.36	$137,041.89	$135,296.58	$133,379.28	$39,479.31	$445,197.06	$43,549.76	$489,281.18	132.42%
201308	577	1,081	$378,301.27	$0.00	$548.39	$548.39	$3,110.52	$58,018.78	$75,732.13	$27,644.80	$164,506.23	$32,143.23	$197,197.85	52.13%
201309	603	1,124	$374,065.61	$0.00	$567.91	$567.91	$67,182.51	$47,711.80	$76,387.74	$25,787.82	$217,069.87	$41,844.46	$259,482.24	69.37%
201310	618	1,157	$397,733.42	$0.00	$572.18	$572.18	$33,953.81	$86,304.10	$77,270.10	$40,275.24	$237,803.25	$49,609.67	$287,985.10	72.41%
201311	621	1,168	$410,627.85	$0.00	$593.53	$593.53	$138,308.47	$66,407.58	$96,977.75	$29,830.59	$331,524.39	$39,285.56	$371,403.48	90.45%
201312	622	1,174	$398,028.09	$0.00	$595.36	$595.36	$95,252.92	$89,449.69	$108,370.10	$26,145.28	$319,217.99	$49,082.65	$368,896.00	92.68%
Total	**7,275**	**13,570**	**$4,616,490.28**	**$0.00**	**$6,796.01**	**$6,796.01**	**$746,004.90**	**$866,123.11**	**$887,673.50**	**$327,342.14**	**$2,827,143.65**	**$492,947.37**	**$3,326,887.03**	**72.07%**
Grouping Avg	**606**	**1,131**	**$384,707.52**	**$0.00**	**$566.33**	**$566.33**	**$62,167.08**	**$72,176.93**	**$73,972.79**	**$27,278.51**	**$235,595.30**	**$41,078.95**	**$277,240.59**	**72.07%**
Monthly Avg	**606**	**1,131**	**$384,707.52**	**$0.00**	**$566.33**	**$566.33**	**$62,167.08**	**$72,176.93**	**$73,972.79**	**$27,278.51**	**$235,595.30**	**$41,078.95**	**$277,240.59**	**72.07%**

Notes:
- Grand Total includes Medical FFS, Pharmacy FFS and Capitation.
- Enrollment is recast to reflect retroactive adjustments.
- Grouping Avg – Average of the distinct groupings chosen by the user.
- Monthly Avg – Average of a measure over Service/Paid time period.
- FFS = Fee For Service.
- MLR = Medical Loss Ratio.

Monitoring by Utilization and Enrollment

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201301	360	96	51	107	0	0	0	614	1,133
201302	362	92	52	106	0	0	0	612	1,131
201303	361	90	53	108	0	0	0	612	1,135
201304	362	90	53	108	0	0	0	613	1,136
201305	357	88	53	109	0	0	0	607	1,129
201306	344	87	52	107	0	0	0	590	1,103
201307	342	86	50	108	0	0	0	586	1,099
201308	339	82	50	106	0	0	0	577	1,081
201309	360	83	47	113	0	0	0	603	1,124
201310	368	84	48	118	0	0	0	618	1,157
201311	369	83	49	120	0	0	0	621	1,168
201312	366	84	51	121	0	0	0	622	1,174
Total	**4,290**	**1,045**	**609**	**1,331**	**0**	**0**	**0**	**7,275**	**13,570**
Grouping Avg	**358**	**87**	**51**	**111**	**0**	**0**	**0**	**606**	**1,131**
Monthly Avg	**358**	**87**	**51**	**111**	**0**	**0**	**0**	**606**	**1,131**

Notes:

- Enrollment is recast to reflect retroactive adjustments.

- Grouping Avg – Average of the distinct groupings chosen by the user.

- Monthly Avg – Average of a measure over Service/Paid time period.

Monitoring by Utilization and Enrollment

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
Current Paid Period: From 01/2014 to 12/2014

	Enrollment		Premium	Capitation			Fee for Service Claims							
Paid Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201401	636	1,216	$459,970.63	$0.00	$739.93	$739.93	$284,235.37	$70,257.61	$67,572.61	$25,468.14	$447,533.73	$39,592.54	$487,866.20	106.06%
201402	635	1,213	$455,918.94	$0.00	$728.95	$728.95	$4,546.20	$33,013.02	$21,331.68	$6,299.73	$65,190.63	$40,419.72	$106,339.30	23.32%
201403	631	1,215	$452,389.56	$0.00	$735.05	$735.05	$34,323.84	$145,316.87	$99,404.99	$30,371.02	$309,416.72	$53,432.59	$363,584.36	80.37%
201404	626	1,210	$450,750.91	$0.00	$732.61	$732.61	$322,824.89	$80,874.13	$74,290.17	$28,650.48	$506,639.67	$62,701.45	$570,073.73	126.47%
201405	622	1,208	$438,265.68	$0.00	$727.12	$727.12	$65,102.06	$129,629.36	$86,336.89	$30,724.63	$311,792.94	$55,964.65	$368,484.71	84.08%
201406	601	1,166	$445,427.73	$0.00	$716.75	$716.75	$197,786.21	$180,987.44	$149,917.08	$26,277.70	$554,968.43	$53,900.82	$609,586.00	136.85%
201407	594	1,163	$411,918.37	$0.00	$686.25	$686.25	$234,078.92	$93,501.63	$115,961.59	$28,054.34	$471,596.48	$73,924.83	$546,207.56	132.60%
201408	587	1,150	$428,606.05	$0.00	$714.84	$714.84	$52,421.87	$86,801.71	$89,632.67	$25,257.45	$254,113.70	$50,435.01	$305,263.55	71.22%
201409	623	1,212	$419,504.77	$0.00	$734.72	$734.72	$64,873.71	$159,739.37	$92,973.74	$32,598.14	$350,184.96	$51,517.21	$402,436.89	95.93%
201410	631	1,219	$468,904.45	$0.00	$749.58	$749.58	$89,281.69	$67,612.34	$102,354.84	$21,546.30	$280,795.17	$65,804.86	$347,349.61	74.08%
201411	635	1,230	$452,563.72	$0.00	$757.64	$757.64	$3,511.35	$70,438.64	$79,833.81	$32,725.80	$186,509.60	$55,341.75	$242,608.99	53.61%
201412	631	1,220	$459,287.50	$0.00	$747.10	$747.10	$153,730.35	$113,785.77	$112,773.87	$26,749.37	$407,039.36	$73,827.73	$481,614.19	104.86%
Total	**7,452**	**14,422**	**$5,343,508.31**	**$0.00**	**$8,770.54**	**$8,770.54**	**$1,506,716.46**	**$1,231,957.89**	**$1,092,383.94**	**$314,723.10**	**$4,145,781.39**	**$676,863.16**	**$4,831,415.09**	**90.42%**
Grouping Avg	**621**	**1,202**	**$445,292.36**	**$0.00**	**$730.88**	**$730.88**	**$125,559.71**	**$102,663.16**	**$91,032.00**	**$26,226.93**	**$345,481.78**	**$56,405.26**	**$402,617.92**	**90.42%**
Monthly Avg	**621**	**1,202**	**$445,292.36**	**$0.00**	**$730.88**	**$730.88**	**$125,559.71**	**$102,663.16**	**$91,032.00**	**$26,226.93**	**$345,481.78**	**$56,405.26**	**$402,617.92**	**90.42%**

Notes:
- **Grand Total includes Medical FFS, Pharmacy FFS and Capitation.**
- **Enrollment is recast to reflect retroactive adjustments.**
- **Grouping Avg – Average of the distinct groupings chosen by the user.**
- **Monthly Avg – Average of a measure over Service/Paid time period.**
- **FFS = Fee For Service.**
- **MLR = Medical Loss Ratio.**

Monitoring by Utilization and Enrollment

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201401	369	85	53	129	0	0	0	636	1,216
201402	367	87	54	127	0	0	0	635	1,213
201403	362	87	54	128	0	0	0	631	1,215
201404	358	86	53	129	0	0	0	626	1,210
201405	354	84	54	130	0	0	0	622	1,208
201406	341	82	53	125	0	0	0	601	1,166
201407	334	81	53	126	0	0	0	594	1,163
201408	329	80	54	124	0	0	0	587	1,150
201409	355	81	58	129	0	0	0	623	1,212
201410	364	80	58	129	0	0	0	631	1,219
201411	366	80	58	131	0	0	0	635	1,230
201412	365	79	57	130	0	0	0	631	1,220
Total	**4,264**	**992**	**659**	**1,537**	**0**	**0**	**0**	**7,452**	**14,422**
Grouping Avg	**355**	**83**	**55**	**128**	**0**	**0**	**0**	**621**	**1,202**
Monthly Avg	**355**	**83**	**55**	**128**	**0**	**0**	**0**	**621**	**1,202**

Notes:

- Enrollment is recast to reflect retroactive adjustments.

- Grouping Avg – Average of the distinct groupings chosen by the user.

- Monthly Avg – Average of a measure over Service/Paid time period.

Monitoring by Utilization and Enrollment

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
Current Paid Period: From 08/2014 to 07/2015

	Enrollment		Premium	Capitation			Fee for Service Claims							
Paid Year Month	Contracts	Members	Premium	PCP	Specialty	Total Capitation	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total	MLR
201408	587	1,150	$428,606.05	$0.00	$714.84	$714.84	$52,421.87	$86,801.71	$89,632.67	$25,257.45	$254,113.70	$50,435.01	$305,263.55	71.22%
201409	623	1,212	$419,504.77	$0.00	$734.72	$734.72	$64,873.71	$159,739.37	$92,973.74	$32,598.14	$350,184.96	$51,517.21	$402,436.89	95.93%
201410	631	1,219	$468,904.45	$0.00	$749.58	$749.58	$89,281.69	$67,612.34	$102,354.84	$21,546.30	$280,795.17	$65,804.86	$347,349.61	74.08%
201411	635	1,230	$452,563.72	$0.00	$757.64	$757.64	$3,511.35	$70,438.64	$79,833.81	$32,725.80	$186,509.60	$55,341.75	$242,608.99	53.61%
201412	631	1,220	$459,287.50	$0.00	$747.10	$747.10	$153,730.35	$113,785.77	$112,773.87	$26,749.37	$407,039.36	$73,827.73	$481,614.19	104.86%
201501	636	1,194	$446,926.21	$0.00	$743.38	$743.38	$402,406.11	$135,262.01	$76,538.43	$16,144.31	$630,350.86	$35,438.64	$666,532.88	149.14%
201502	636	1,191	$454,334.46	$0.00	$7,658.33	$7,658.33	$90,497.48	$79,274.08	$92,295.82	$34,165.27	$296,232.65	$54,709.93	$358,600.91	78.93%
201503	636	1,185	$446,162.06	$0.00	$4,222.68	$4,222.68	$41,605.07	$86,185.79	$75,962.34	$20,004.36	$223,757.56	$57,003.47	$284,983.71	63.87%
201504	635	1,181	$450,350.98	$0.00	$4,668.53	$4,668.53	$111,619.38	$76,826.23	$95,782.75	$7,521.80	$291,750.16	$65,951.46	$362,370.15	80.46%
201505	639	1,186	$433,993.25	$0.00	$4,956.91	$4,956.91	$82,344.06	$172,589.46	$72,220.22	$10,223.54	$337,377.28	$59,524.60	$401,858.79	92.60%
201506	606	1,138	$439,526.24	$0.00	$4,656.14	$4,656.14	$49,812.05	$73,162.44	$113,175.81	$23,925.57	$260,075.87	$56,820.02	$321,552.03	73.16%
201507	601	1,129	$408,544.90	$0.00	$4,599.88	$4,599.88	$117,349.65	$120,048.69	$102,352.09	$24,727.32	$364,477.75	$69,941.95	$439,019.58	107.46%
Total	**7,496**	**14,235**	**$5,308,704.59**	**$0.00**	**$35,209.73**	**$35,209.73**	**$1,259,452.77**	**$1,241,726.53**	**$1,105,896.39**	**$275,589.23**	**$3,882,664.92**	**$696,316.63**	**$4,614,191.28**	**86.92%**
Grouping Avg	**625**	**1,186**	**$442,392.05**	**$0.00**	**$2,934.14**	**$2,934.14**	**$104,954.40**	**$103,477.21**	**$92,158.03**	**$22,965.77**	**$323,555.41**	**$58,026.39**	**$384,515.94**	**86.92%**
Monthly Avg	**625**	**1,186**	**$442,392.05**	**$0.00**	**$2,934.14**	**$2,934.14**	**$104,954.40**	**$103,477.21**	**$92,158.03**	**$22,965.77**	**$323,555.41**	**$58,026.39**	**$384,515.94**	**86.92%**

Notes:
- **Grand Total includes Medical FFS, Pharmacy FFS and Capitation.**
- **Enrollment is recast to reflect retroactive adjustments.**
- **Grouping Avg – Average of the distinct groupings chosen by the user.**
- **Monthly Avg – Average of a measure over Service/Paid time period.**
- **FFS = Fee For Service.**
- **MLR = Medical Loss Ratio.**

Monitoring by Utilization and Enrollment

Paid Year Month	Employee Only	Employee & Spouse	Employee & Children	Family	Spouse Only	Spouse & Children	Children Only	Total Contracts	Total Members
201408	329	80	54	124	0	0	0	587	1,150
201409	355	81	58	129	0	0	0	623	1,212
201410	364	80	58	129	0	0	0	631	1,219
201411	366	80	58	131	0	0	0	635	1,230
201412	365	79	57	130	0	0	0	631	1,220
201501	379	84	49	124	0	0	0	636	1,194
201502	380	84	49	123	0	0	0	636	1,191
201503	381	85	50	120	0	0	0	636	1,185
201504	382	83	50	120	0	0	0	635	1,181
201505	386	82	51	120	0	0	0	639	1,186
201506	357	82	51	116	0	0	0	606	1,138
201507	354	80	51	116	0	0	0	601	1,129
Total	**4,398**	**980**	**636**	**1,482**	**0**	**0**	**0**	**7,496**	**14,235**
Grouping Avg	**367**	**82**	**53**	**124**	**0**	**0**	**0**	**625**	**1,186**
Monthly Avg	**367**	**82**	**53**	**124**	**0**	**0**	**0**	**625**	**1,186**

Notes:

- Enrollment is recast to reflect retroactive adjustments.

- Grouping Avg – Average of the distinct groupings chosen by the user.

- Monthly Avg – Average of a measure over Service/Paid time period.

High Cost Claims Summary

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
High Cost Claims Threshold: 50000
Current Paid Period: From 01/2015 to 07/2015
Prior Paid Period: From 01/2014 to 12/2014

CURRENT					Inpatient		Outpatient		Professional		Pharmacy			
Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
1	003	SUBSCRIBER	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY; ACUTE MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION; HEMOPTYSIS, UNSPECIFIED	41	1	$238,490.43	0	$732.75	122	$12,124.73	0	$0.00	$251,347.91	$447,264.00
2	006	SUBSCRIBER	ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL, INITIAL EPISODE OF CARE; OTHER SPECIFIED REHABILITATION PROCEDURE; CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY ARTERY	24	2	$119,933.72	3	$4,440.83	149	$16,413.15	47	$1,404.39	$142,192.09	$319,659.08
3	004	SUBSCRIBER	MALIGNANT NEOPLASM OF SIGMOID COLON; RADIOTHERAPY; SECONDARY MALIGNANT NEOPLASM OF LIVER	0	0	$0.00	15	$34,267.52	303	$63,632.91	23	$6,084.27	$103,984.70	$215,088.82
4	006	SUBSCRIBER	MALIGNANT NEOPLASM OF AMPULLA OF VATER; JAUNDICE, UNSPECIFIED, NOT OF NEWBORN; OBSTRUCTION OF BILE DUCT	26	1	$90,250.37	0	$0.00	100	$10,244.01	2	$3.37	$100,497.75	$228,605.29
5	005	SPOUSE	OTHER DISEASES OF LUNG, NOT ELSEWHERE CLASSIFIED; ACUTE AND CHRONIC RESPIRATORY FAILURE; POSTINFLAMMATORY PULMONARY FIBROSIS	19	2	$41,263.22	11	$27,590.70	124	$15,977.68	84	$2,469.69	$87,301.29	$322,587.01

Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
6	006	SUBSCRIBER	MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED SITE; RADIOTHERAPY; MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF FEMALE BREAST	0	0	$0.00	12	$31,427.86	113	$47,872.95	20	$219.96	$79,520.77	$211,413.31
7	006	SUBSCRIBER	OTHER PULMONARY EMBOLISM AND INFARCTION; CLOSED FRACTURE OF HEAD OF RADIUS; MALIGNANT MELANOMA OF SKIN OF UPPER LIMB, INCLUDING SHOULDER	8	2	$47,055.67	4	$2,946.37	189	$15,939.41	18	$1,921.80	$67,863.25	$200,895.92
8	006	SUBSCRIBER	ATRIAL FIBRILLATION; PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA; OTHER MALAISE AND FATIGUE	1	1	$1,814.68	2	$56,854.41	37	$5,966.08	10	$799.33	$65,434.50	$115,428.52
9	006	DEPENDENT	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS; REGIONAL ENTERITIS OF SMALL INTESTINE; ANKYLOSING SPONDYLITIS	0	0	$0.00	5	$58,023.15	10	$974.85	8	$187.84	$59,185.84	$119,025.98
Total				**119**	**9**	**$538,808.09**	**52**	**$216,283.59**	**1,147**	**$189,145.77**	**212**	**$13,090.65**	**$957,328.10**	**$2,179,967.93**

Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
PRIOR					Inpatient		Outpatient		Professional		Pharmacy			
Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
1	003	SUBSCRIBER	ACUTE MYELOID LEUKEMIA IN REMISSION; ACUTE MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION; MISSING OR UNKNOWN DIAGNOSIS CODE	58	5	$370,929.32	137	$198,578.90	436	$46,285.19	140	$20,000.69	$635,794.10	$1,263,510.72
2	003	DEPENDENT	GENERALIZED CONVULSIVE EPILEPSY WITHOUT MENTION OF INTRACTABLE EPILEPSY; EPILEPTIC GRAND MAL STATUS; OTHER SPECIFIED REHABILITATION PROCEDURE	34	2	$116,085.33	1	$1,171.48	105	$38,337.91	13	$1,358.92	$156,953.64	$418,520.73
3	R03	SUBSCRIBER	GASTROPARESIS; OTHER SPECIFIED REHABILITATION PROCEDURE; OBSTRUCTIVE CHRONIC BRONCHITIS, WITH (ACUTE) EXACERBATION	29	3	$128,766.36	6	$5,036.29	242	$20,132.36	75	$1,963.50	$155,898.51	$326,311.31
4	003	DEPENDENT	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED BY CESAREAN DELIVERY; COARCTATION OF AORTA (PREDUCTAL) (POSTDUCTAL); CONGENITAL INTERRUPTION OF AORTIC ARCH	21	1	$123,949.99	1	$755.74	78	$15,442.02	0	$0.00	$140,147.75	$258,438.80
5			ORBITAL FLOOR (BLOW-OUT), CLOSED FRACTURE; INJURY, OTHER AND UNSPECIFIED, OTHER SPECIFIED SITES, INCLUDING MULTIPLE; TRAUMATIC PNEUMOTHORAX WITHOUT MENTION OF OPEN WOUND INTO THORAX	8	1	$119,885.40	0	$0.00	13	$8,025.49	0	$0.00	$127,910.89	$35,775.83
6	003	SUBSCRIBER	MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED SITE; MISSING OR UNKNOWN DIAGNOSIS CODE; ENCOUNTER FOR ANTINEOPLASTIC IMMUNOTHERAPY	0	0	$0.00	19	$87,424.74	33	$3,682.76	43	$22,020.10	$113,127.60	$286,771.57

Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
7	006	DEPENDENT	OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS; ANKYLOSING SPONDYLITIS; MISSING OR UNKNOWN DIAGNOSIS CODE	0	0	$0.00	9	$91,371.20	21	$1,639.10	16	$2,137.95	$95,148.25	$180,531.68
8	003	SUBSCRIBER	HEADACHE; *****; ATRIAL FIBRILLATION	21	7	$57,502.76	5	$10,221.21	218	$18,430.01	119	$3,909.87	$90,063.85	$274,286.83
9	006	DEPENDENT	ACUTE OSTEOMYELITIS, SITE UNSPECIFIED; INFECTION AND INFLAMMATORY REACTION DUE TO OTHER INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT; INFECTION AND INFLAMMATORY REACTION DUE TO OTHER INTERNAL PROSTHETIC DEVICE, IMPLANT, AND GRAFT	7	1	$17,730.46	18	$55,396.56	68	$12,082.93	40	$524.40	$85,734.35	$327,898.70
10	003	SUBSCRIBER	LOCALIZED OSTEOARTHROSIS NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, PELVIC REGION AND THIGH; OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, PELVIC REGION AND THIGH; OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, UNSPECIFIED	3	1	$74,460.54	0	$0.00	47	$6,868.33	11	$4.35	$81,333.22	$182,207.86
11	006	SPOUSE	NONUNION OF FRACTURE; CLOSED MONTEGGIA'S FRACTURE; SPECIAL SCREENING FOR MALIGNANT NEOPLASMS, COLON	6	2	$65,822.70	2	$1,156.44	141	$11,001.77	18	$45.99	$78,026.90	$202,194.35
12	003	SPOUSE	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH INTERMITTENT CLAUDICATION; ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES, UNSPECIFIED; OTHER COMPLICATIONS DUE TO OTHER VASCULAR DEVICE, IMPLANT, AND GRAFT	3	1	$25,670.22	1	$34,618.67	21	$2,684.99	25	$144.46	$63,118.34	$140,799.94
13	R03	SUBSCRIBER	MULTIPLE MYELOMA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION; SYNCOPE AND COLLAPSE; OTHER VITAMIN B12 DEFICIENCY ANEMIA	1	1	$3,514.74	3	$1,353.00	176	$54,027.62	52	$371.06	$59,266.42	$187,239.79

Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
14	R03	SUBSCRIBER	RADIOTHERAPY; MALIGNANT NEOPLASM OF PROSTATE; SCLEROSING MESENTERITIS	0	0	$0.00	41	$50,362.01	81	$6,454.26	25	$1,576.53	$58,392.80	$126,003.47
15	006	SPOUSE	MISSING OR UNKNOWN DIAGNOSIS CODE; BASAL CELL CARCINOMA OF SKIN OF TRUNK, EXCEPT SCROTUM; OTHER BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF TRUNK, UNSPECIFIED	0	0	$0.00	3	$0.00	12	$1,638.24	33	$56,462.66	$58,100.90	$62,211.50
16	003	DEPENDENT	SWELLING, MASS, OR LUMP IN HEAD AND NECK; BENIGN NEOPLASM OF MAJOR SALIVARY GLANDS; ENLARGEMENT OF LYMPH NODES	6	1	$24,034.45	11	$14,389.24	121	$18,501.16	16	$865.48	$57,790.33	$165,371.39
17	003	SUBSCRIBER	MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED SITE; MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF FEMALE BREAST; ENLARGEMENT OF LYMPH NODES	0	0	$0.00	12	$14,885.80	132	$41,822.27	19	$25.05	$56,733.12	$125,656.16
18	004	SUBSCRIBER	MISSING OR UNKNOWN DIAGNOSIS CODE; MALIGNANT NEOPLASM OF SIGMOID COLON; MALIGNANT NEOPLASM OF COLON, UNSPECIFIED SITE	0	0	$0.00	3	$23,491.74	97	$7,792.66	19	$24,682.42	$55,966.82	$95,418.53
19	R03	SUBSCRIBER	MALIGNANT NEOPLASM OF PROSTATE; DIABETES WITH HYPEROSMOLARITY, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED; MISSING OR UNKNOWN DIAGNOSIS CODE	14	1	$7,905.72	0	$0.00	170	$43,957.96	105	$3,474.90	$55,338.58	$156,180.48
20	006	DEPENDENT	SINGLE LIVEBORN, BORN IN HOSPITAL, DELIVERED BY CESAREAN DELIVERY; OTHER PRETERM INFANTS, 1,250-1,499 GRAMS; OTHER RESPIRATORY PROBLEMS OF NEWBORN AFTER BIRTH	42	1	$18,183.02	1	$5,737.81	85	$30,574.55	0	$0.00	$54,495.38	$408,536.15

Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
21	003	SUBSCRIBER	MISSING OR UNKNOWN DIAGNOSIS CODE; RHEUMATOID ARTHRITIS; ABDOMINAL PAIN, UNSPECIFIED SITE	0	0	$0.00	0	$0.00	99	$25,126.13	128	$27,894.82	$53,020.95	$82,600.50
Total				**253**	**28**	**$1,154,441.01**	**273**	**$595,950.83**	**2,396**	**$414,507.71**	**897**	**$167,463.15**	**$2,332,362.70**	**$5,306,466.29**

High Cost Claims Summary

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
High Cost Claims Threshold: 50000
Current Paid Period: From 01/2013 to 12/2013
Prior Paid Period: From 01/2013 to 12/2013

CURRENT					Inpatient		Outpatient		Professional		Pharmacy			
Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
1	003	SUBSCRIBER	MALIGNANT NEOPLASM OF OVARY; ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY; ABDOMINAL OR PELVIC SWELLING, MASS OR LUMP, UNSPECIFIED SITE	6	1	$75,183.57	15	$11,635.76	339	$62,448.69	68	$389.29	$149,657.31	$314,669.81
2	006	SPOUSE	BENIGN NEOPLASM OF CEREBRAL MENINGES; CEREBROSPINAL FLUID RHINORRHEA; ENCEPHALOCELE	25	3	$110,664.67	9	$1,552.84	89	$26,053.97	29	$858.18	$139,129.66	$505,927.00
3	004	SUBSCRIBER	MALIGNANT NEOPLASM OF SIGMOID COLON; MISSING OR UNKNOWN DIAGNOSIS CODE; SECONDARY MALIGNANT NEOPLASM OF LIVER	3	1	$21,533.85	7	$23,420.97	143	$37,192.98	18	$23,055.77	$105,203.57	$220,333.22
4	003	SUBSCRIBER	ENCOUNTER FOR ANTINEOPLASTIC IMMUNOTHERAPY; SECONDARY MALIGNANT NEOPLASM OF BONE AND BONE MARROW; MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED SITE	0	0	$0.00	22	$98,374.55	41	$3,125.48	28	$1,704.59	$103,204.62	$212,740.44
5	006	SUBSCRIBER	OTHER POSTOPERATIVE INFECTION; TRIGEMINAL NEURALGIA; CENTRAL NERVOUS SYSTEM COMPLICATION	14	4	$79,271.86	3	$2,461.34	104	$18,485.86	40	$713.66	$100,932.72	$178,432.30
6	006	SPOUSE	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF LOWER LEG, WITHOUT MENTION OF LOSS OF A BODY PART; BURN (ANY DEGREE) INVOLVING LESS THAN 10% OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS	11	1	$55,432.85	13	$6,681.74	135	$21,986.49	39	$123.80	$84,224.88	$201,880.16

Rank	Div	Relationship	Diagnosis Description	Days	Admits	Paid Amt	Visits	Paid Amt	Services	Paid Amt	# of Rx	Paid Amt	Total Paid Amt	Total Billed Amt
7	R03	SPOUSE	MULTIPLE MYELOMA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION; RADIOTHERAPY; MALIGNANT NEOPLASM OF BREAST (FEMALE), UNSPECIFIED SITE	0	0	$0.00	22	$31,425.68	219	$38,099.18	73	$3,115.72	$72,640.58	$414,644.41
8	003	SUBSCRIBER	CORONARY ATHEROSCLEROSIS OF NATIVE CORONARY ARTERY; ACUTE CORONARY OCCLUSION WITHOUT MYOCARDIAL INFARCTION; CHEST PAIN, OTHER	15	1	$57,703.82	8	$3,640.64	99	$10,646.89	22	$0.00	$71,991.35	$148,426.79
9	006	SUBSCRIBER	EXCESSIVE OR FREQUENT MENSTRUATION; LEIOMYOMA OF UTERUS, UNSPECIFIED; ESOPHAGEAL REFLUX	0	0	$0.00	2	$64,881.38	23	$1,804.31	15	$2.16	$66,687.85	$104,560.62
10	R03	SUBSCRIBER	ACUTE APPENDICITIS WITH GENERALIZED PERITONITIS; CARCINOMA IN SITU OF BREAST; MALIGNANT NEOPLASM OF UPPER-OUTER QUADRANT OF FEMALE BREAST	10	1	$19,814.73	9	$8,841.67	155	$29,610.17	48	$599.76	$58,866.33	$199,703.17
11	R03	SPOUSE	RHEUMATOID ARTHRITIS; ROUTINE GYNECOLOGICAL EXAMINATION; OTHER SCREENING MAMMOGRAM	0	0	$0.00	0	$0.00	97	$50,403.37	10	$0.00	$50,403.37	$73,595.84
Total				**84**	**12**	**$419,605.35**	**110**	**$252,916.57**	**1,444**	**$299,857.39**	**390**	**$30,562.93**	**$1,002,942.24**	**$2,574,913.76**

Key Indicators

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
Current Paid Period: From 01/2014 to 12/2014
Prior Paid Period: From 01/2013 to 12/2013

	Current	Prior	Change	Change %
Payments Per Employee Per Year	$7,779.96	$5,487.60	$2,292.36	41.77%
Payments Per Member Per Year	$4,020.00	$2,941.92	$1,078.08	36.65%
Enrollment:				
Employees	621	606	15	2.43%
Members	1,202	1,131	71	6.28%
Payments:				
Inpatient Facility	$1,506,716.46	$746,004.90	$760,711.56	101.97%
Outpatient Facility	$1,231,957.89	$866,123.11	$365,834.78	42.24%
Total Facility	**$2,738,674.35**	**$1,612,128.01**	**$1,126,546.34**	**69.88%**
Professional	$1,407,107.04	$1,215,015.64	$192,091.40	15.81%
PCP	$273,904.27	$220,407.24	$53,497.03	24.27%
Specialist	$1,133,202.77	$994,608.40	$138,594.37	13.93%
Capitation	$8,770.54	$6,796.01	$1,974.53	29.05%
Pharmacy	$676,863.16	$492,947.37	$183,915.79	37.31%
Grand Total	**$4,831,415.09**	**$3,326,887.03**	**$1,504,528.06**	**45.22%**

	Current	Prior	Change	Change %
Payments Per Member Per Month:				
Inpatient Facility	$104.47	$54.97	$49.50	90.05%
Outpatient Facility	$85.42	$63.82	$21.60	33.85%
Total Facility	**$189.89**	**$118.80**	**$71.09**	**59.84%**
Professional	$97.56	$89.53	$8.03	8.97%
PCP	$18.99	$16.24	$2.75	16.93%
Specialist	$78.57	$73.29	$5.28	7.20%
Capitation	$0.60	$0.50	$0.10	20.00%
Pharmacy	$46.93	$36.32	$10.61	29.21%
Grand Total	**$335.00**	**$245.16**	**$89.84**	**36.65%**
Other Key Payment Indicators:				
Inpatient Payments/Day	$3,198.97	$3,147.70	$51.27	1.63%
Inpatient Payments/Admissions	$15,694.96	$10,219.24	$5,475.72	53.58%
Outpatient Payments/Visit	$1,324.68	$1,023.78	$300.90	29.39%
Professional Payments/Service	$73.37	$68.24	$5.13	7.52%
PCP Payments/Service	$44.07	$47.37	($3.30)	-6.97%
Specialist Payments/Service	$87.42	$75.62	$11.80	15.60%
Pharmacy Payments/Script	$48.08	$38.22	$9.86	25.80%

	Current	Prior	Change	Change %
Key Utilization Indicators:				
Inpatient Facility				
Inpatient Days/1000 Members	392	210	182	86.99%
Inpatient Admissions/1000 Members	80	65	15	23.74%
Average Length of Inpatient Stay	4.91	3.25	1.66	51.12%
% Facility Admissions > 10	12.50%	5.48%		
Outpatient Facility				
Outpatient Visits/1000 Members	774	748	26	3.43%
Emer Rm Visits/1000 Members	177	135	42	30.99%
Other Visits/1000 Members	597	613	(16)	-2.65%
Professional				
Professional Services/1000 Members	15,956	15,744	212	1.35%
PCP Services/1000 Members	5,171	4,114	1,057	25.71%
Specialist Services/1000 Members	10,785	11,630	(845)	-7.27%
Mental Health Services/1000 Members	310	294	16	5.43%
Pharmacy:				
Pharmacy Scripts/1000 Members	11,713	11,405	308	2.70%

Top Drugs by Paid/Prescription

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
Current Paid Period: From 08/2014 to 07/2015
Prior Paid Period: From 08/2013 to 07/2014
Rank: 50
Rx Sort By: PRESCRIPTION

Total																						
	Rank		Paid Amt			Member Paid Amt			Total Paid Amt			Copay Amt		Deductible Amt		Co-Insurance Amt		Ingredient Cost		Dispense Fee	
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior
LISINOPRIL	1	1	$11.43	$2.27	450.00%	$1,058.70	$1,325.02	-20.08%	$1,070.13	$1,327.29	-19.37%	$1,049.05	$1,287.50	$9.65	$37.52	$0.00	$0.00	$878.23	$1,094.69	$191.90	$232.60
LEVOTHYROXINE SODIUM	2	2	$128.77	$20.87	535.00%	$5,466.25	$3,873.50	41.11%	$5,595.02	$3,894.37	43.66%	$5,423.45	$3,843.53	$42.80	$29.97	$0.00	$0.00	$5,462.92	$3,762.27	$132.10	$132.10
AMLODIPINE BESYLATE	3	3	$6.34	$0.00	0.00%	$1,014.43	$1,251.80	-18.94%	$1,020.77	$1,251.80	-18.47%	$954.45	$1,217.75	$59.98	$34.05	$0.00	$0.00	$925.67	$1,045.55	$95.10	$206.25
HYDROCODONE/ACETAMINOPHEN	4	4	$1,480.85	$395.03	274.68%	$3,625.13	$3,097.32	17.02%	$5,105.98	$3,492.35	46.19%	$3,625.13	$3,097.32	$0.00	$0.00	$0.00	$0.00	$4,807.18	$3,163.75	$298.80	$328.60
SIMVASTATIN	5	7	$3.43	$0.00	0.00%	$1,014.77	$1,150.12	-11.74%	$1,018.20	$1,150.12	-11.39%	$984.79	$1,131.07	$29.98	$19.05	$0.00	$0.00	$861.40	$979.07	$156.80	$171.05
AZITHROMYCIN	6	5	$178.45	$163.65	8.59%	$2,439.55	$3,002.87	-18.75%	$2,618.00	$3,166.52	-17.31%	$2,404.89	$2,984.64	$34.66	$18.23	$0.00	$0.00	$2,332.40	$2,852.52	$285.60	$314.00
OMEPRAZOLE	7	6	$92.83	$51.31	80.39%	$2,777.60	$3,068.89	-9.49%	$2,870.43	$3,120.20	-7.98%	$2,724.89	$2,960.19	$52.71	$108.70	$0.00	$0.00	$2,702.38	$2,902.55	$168.05	$217.65
AMOXICILLIN	8	10	$8.38	$0.00	0.00%	$947.10	$989.74	-4.25%	$955.48	$989.74	-3.44%	$947.10	$986.02	$0.00	$3.72	$0.00	$0.00	$747.73	$763.09	$207.75	$226.65
HYDROCHLOROTHIAZIDE	9	11	$0.00	$0.00	0.00%	$599.28	$608.44	-1.48%	$599.28	$608.44	-1.48%	$599.28	$608.44	$0.00	$0.00	$0.00	$0.00	$464.33	$501.19	$134.95	$107.25
ATORVASTATIN CALCIUM	10	17	$123.31	$55.29	123.64%	$2,824.26	$2,098.45	34.56%	$2,947.57	$2,153.74	36.83%	$2,802.70	$2,002.92	$21.56	$95.53	$0.00	$0.00	$2,793.82	$2,027.44	$153.75	$126.30
ALPRAZOLAM	11	9	$12.34	$0.00	0.00%	$735.78	$833.07	-11.64%	$748.12	$833.07	-10.08%	$735.78	$833.07	$0.00	$0.00	$0.00	$0.00	$508.47	$593.97	$239.65	$239.10
METFORMIN HCL	12	12	$0.00	$30.64	-100.00%	$853.27	$970.24	-11.96%	$853.27	$1,000.88	-14.70%	$830.78	$942.61	$22.49	$27.63	$0.00	$0.00	$773.62	$894.83	$79.65	$106.05
PRAVASTATIN SODIUM	13	8	$51.27	$24.34	108.33%	$4,033.83	$3,407.44	18.37%	$4,085.10	$3,431.78	19.03%	$4,033.83	$3,407.44	$0.00	$0.00	$0.00	$0.00	$3,947.40	$3,296.28	$137.70	$135.50
FLUTICASONE PROPIONATE	14	13	$97.86	$55.73	76.36%	$1,830.23	$2,935.22	-37.61%	$1,928.09	$2,990.95	-35.52%	$1,830.23	$2,855.54	$0.00	$79.68	$0.00	$0.00	$1,769.44	$2,806.90	$158.65	$184.05
METOPROLOL TARTRATE	15	16	$22.13	$20.19	5.00%	$606.27	$654.82	-7.34%	$628.40	$675.01	-6.81%	$603.87	$647.47	$2.40	$7.35	$0.00	$0.00	$548.25	$563.11	$80.15	$111.90
TRAMADOL HCL	16	15	$2.40	$1.94	0.00%	$760.28	$1,117.07	-31.87%	$762.68	$1,119.01	-31.81%	$747.37	$1,104.50	$12.91	$12.57	$0.00	$0.00	$590.03	$908.71	$172.65	$210.30
LOSARTAN POTASSIUM	17	21	$7.34	$0.00	0.00%	$1,037.74	$1,039.03	-0.10%	$1,045.08	$1,039.03	0.58%	$1,037.74	$1,039.03	$0.00	$0.00	$0.00	$0.00	$958.23	$953.53	$86.85	$85.50
GABAPENTIN	18	22	$677.70	$192.86	252.08%	$1,601.06	$1,252.18	27.80%	$2,278.76	$1,445.04	57.65%	$1,601.06	$1,252.18	$0.00	$0.00	$0.00	$0.00	$2,147.42	$1,312.94	$130.80	$130.95
LISINOPRIL/HYDROCHLOROTHIAZIDE	19	18	$0.00	$0.00	0.00%	$724.41	$909.50	-20.35%	$724.41	$909.50	-20.35%	$724.41	$909.50	$0.00	$0.00	$0.00	$0.00	$631.91	$792.85	$92.50	$116.65
MELOXICAM	20	14	$6.40	$2.47	150.00%	$358.56	$581.35	-38.21%	$364.96	$583.82	-37.39%	$348.30	$573.64	$10.26	$7.71	$0.00	$0.00	$237.31	$404.67	$127.65	$179.00
PREDNISONE	21	23	$82.76	$1.72	8100.00%	$837.34	$735.15	13.88%	$920.10	$736.87	24.86%	$656.23	$441.70	$181.11	$293.45	$0.00	$0.00	$797.90	$624.07	$122.20	$112.80
METHYLPREDNISOLONE DOSE PACK	22	20	$27.39	$372.03	-92.47%	$2,535.93	$2,839.74	-10.67%	$2,563.32	$3,211.77	-20.18%	$2,496.51	$2,839.74	$39.42	$0.00	$0.00	$0.00	$2,424.52	$3,046.87	$138.80	$164.90
MONTELUKAST SODIUM	23	33	$334.85	$1,155.30	-71.00%	$1,517.14	$1,861.41	-18.48%	$1,851.99	$3,016.71	-38.59%	$1,517.14	$1,820.62	$0.00	$40.79	$0.00	$0.00	$1,746.39	$2,932.11	$105.60	$84.60
METOPROLOL SUCCINATE ER	24	25	$893.58	$1,971.67	-54.69%	$3,166.87	$3,060.38	3.46%	$4,060.45	$5,032.05	-19.30%	$3,166.87	$3,060.38	$0.00	$0.00	$0.00	$0.00	$3,974.00	$4,943.25	$86.45	$88.80
SERTRALINE HCL	25	19	$29.72	$18.80	55.56%	$509.05	$768.93	-33.72%	$538.77	$787.73	-31.51%	$509.05	$757.65	$0.00	$11.28	$0.00	$0.00	$458.32	$667.53	$80.45	$120.20
AMOXICILLIN/CLAVULANATE POTASSIUM	26	26	$371.01	$197.87	87.82%	$1,808.17	$1,834.93	-1.42%	$2,179.18	$2,032.80	7.19%	$1,808.17	$1,834.93	$0.00	$0.00	$0.00	$0.00	$2,062.44	$1,908.50	$115.65	$124.30
TOPIRAMATE	27	29	$3.23	$0.00	0.00%	$911.61	$742.42	22.78%	$914.84	$742.42	23.18%	$911.61	$742.42	$0.00	$0.00	$0.00	$0.00	$828.54	$640.77	$86.30	$101.65
CYCLOBENZAPRINE HCL	27	24	$11.04	$6.96	66.67%	$322.50	$381.70	-15.49%	$333.54	$388.66	-14.18%	$322.50	$381.70	$0.00	$0.00	$0.00	$0.00	$233.54	$279.91	$100.00	$108.75
FLUOXETINE HCL	29	37	$66.31	$0.00	0.00%	$731.66	$502.30	45.62%	$797.97	$502.30	58.76%	$731.66	$502.30	$0.00	$0.00	$0.00	$0.00	$734.07	$437.20	$63.90	$65.10
CIPROFLOXACIN HCL	30	32	$10.37	$44.46	-77.27%	$397.13	$379.01	4.75%	$407.50	$423.47	-3.55%	$397.13	$379.01	$0.00	$0.00	$0.00	$0.00	$325.30	$328.47	$82.20	$95.00
ESCITALOPRAM OXALATE	31	45	$0.00	$0.00	0.00%	$1,035.64	$681.38	51.98%	$1,035.64	$681.38	51.98%	$1,035.64	$681.38	$0.00	$0.00	$0.00	$0.00	$958.34	$605.93	$77.30	$75.45
PANTOPRAZOLE SODIUM	31	28	$87.02	$31.89	177.42%	$668.43	$674.36	-0.74%	$755.45	$706.25	6.94%	$668.43	$659.06	$0.00	$15.30	$0.00	$0.00	$673.80	$600.70	$81.65	$105.55
ATENOLOL	31	26	$0.00	$0.00	0.00%	$399.05	$335.26	18.81%	$399.05	$335.26	18.81%	$399.05	$335.26	$0.00	$0.00	$0.00	$0.00	$365.80	$299.11	$33.25	$36.15
IBUPROFEN	34	40	$0.00	$0.00	0.00%	$534.65	$453.39	17.88%	$534.65	$453.39	17.88%	$534.65	$442.61	$0.00	$10.78	$0.00	$0.00	$441.00	$369.84	$93.65	$83.55
CITALOPRAM HYDROBROMIDE	35	31	$0.00	$0.00	0.00%	$267.38	$336.12	-20.24%	$267.38	$336.12	-20.24%	$267.38	$336.12	$0.00	$0.00	$0.00	$0.00	$197.08	$254.27	$70.30	$81.85
DULOXETINE HCL	36	66	$5,102.32	$13,065.10	-60.94%	$2,468.45	$1,560.00	58.21%	$7,570.77	$14,625.10	-48.23%	$2,468.45	$1,560.00	$0.00	$0.00	$0.00	$0.00	$7,498.32	$14,587.35	$72.45	$37.75
FUROSEMIDE	37	30	$0.00	$0.00	0.00%	$161.37	$209.07	-22.49%	$161.37	$209.07	-22.49%	$156.35	$202.80	$5.02	$6.27	$0.00	$0.00	$102.52	$115.12	$58.85	$93.95
ZOLPIDEM TARTRATE	38	38	$6.03	$6.60	0.00%	$168.13	$190.05	-11.05%	$174.16	$196.65	-11.22%	$168.13	$185.71	$0.00	$4.34	$0.00	$0.00	$97.51	$110.20	$76.65	$86.45
TRI-SPRINTEC	39	35	$450.05	$0.00	0.00%	$369.32	$973.07	-61.97%	$819.37	$973.07	-15.72%	$369.32	$973.07	$0.00	$0.00	$0.00	$0.00	$799.67	$942.07	$19.70	$31.00
FLUCONAZOLE	39	48	$215.97	$17.08	1164.71%	$548.46	$509.05	7.66%	$764.43	$526.13	45.25%	$548.46	$509.05	$0.00	$0.00	$0.00	$0.00	$682.28	$443.13	$82.15	$83.00
BENZONATATE	41	43	$0.00	$0.00	0.00%	$547.75	$451.91	21.06%	$547.75	$451.91	21.06%	$547.75	$451.91	$0.00	$0.00	$0.00	$0.00	$460.30	$367.46	$87.45	$84.45
LEVOFLOXACIN	42	43	$7.61	$9.04	-11.11%	$334.12	$357.24	-6.44%	$341.73	$366.28	-6.56%	$330.82	$343.78	$3.30	$13.46	$0.00	$0.00	$258.08	$282.63	$83.65	$83.65
CEPHALEXIN	42	51	$41.83	$5.47	720.00%	$486.87	$347.68	40.06%	$528.70	$353.15	49.58%	$481.02	$344.12	$5.85	$3.56	$0.00	$0.00	$462.30	$295.05	$66.40	$58.10
CARVEDILOL	44	57	$23.78	$0.00	0.00%	$471.99	$401.69	17.46%	$495.77	$401.69	23.44%	$471.99	$401.69	$0.00	$0.00	$0.00	$0.00	$445.22	$366.24	$50.55	$35.45
SULFAMETHOXAZOLE/TRIMETHOPRIM DS	45	35	$3.46	$0.00	0.00%	$167.97	$261.71	-35.63%	$171.43	$261.71	-34.48%	$167.97	$261.71	$0.00	$0.00	$0.00	$0.00	$111.68	$165.66	$59.75	$96.05
LORAZEPAM	46	69	$9.60	$3.59	200.00%	$221.53	$166.22	33.13%	$231.13	$169.81	36.09%	$221.53	$166.22	$0.00	$0.00	$0.00	$0.00	$161.68	$124.66	$69.45	$45.15
VENLAFAXINE HCL ER	47	69	$49.26	$508.07	-90.16%	$1,098.83	$823.44	33.41%	$1,148.09	$1,331.51	-13.75%	$1,098.83	$823.44	$0.00	$0.00	$0.00	$0.00	$1,085.89	$1,276.86	$62.20	$54.65
CLONIDINE HCL	48	47	$320.62	$69.20	363.77%	$251.59	$267.44	-5.62%	$572.21	$336.64	69.94%	$251.59	$267.44	$0.00	$0.00	$0.00	$0.00	$509.01	$267.64	$63.20	$69.00
UNKNOWN	49	40	$1,903.10	$1,115.94	70.58%	$1,927.50	$2,398.83	-19.64%	$3,830.60	$3,514.77	8.96%	$1,301.54	$2,207.66	$625.96	$191.17	$0.00	$0.00	$3,792.50	$3,442.22	$38.10	$72.55
LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE	50	61	$0.00	$0.00	0.00%	$633.81	$492.49	28.66%	$633.81	$492.49	28.66%	$633.81	$492.49	$0.00	$0.00	$0.00	$0.00	$595.71	$454.34	$38.10	$38.15
CLONAZEPAM	50	48	$7.73	$10.26	-20.00%	$215.50	$218.48	-0.92%	$223.23	$228.74	-2.19%	$215.50	$218.48	$0.00	$0.00	$0.00	$0.00	$162.18	$163.14	$61.05	$65.60
ALL OTHER			$683,748.62	$572,844.43	19.36%	$186,359.31	$199,869.10	-6.76%	$870,107.93	$772,713.53	12.60%	$148,678.34	$148,980.15	$25,544.75	$28,783.10	$12,136.22	$22,105.85	$864,105.81	$767,377.95	$5,405.90	$6,193.15
Total			**$696,316.63**	**$591,902.17**	**17.64%**	**$240,513.26**	**$252,911.65**	**-4.90%**	**$936,829.89**	**$844,813.82**	**10.89%**	**$201,711.65**	**$200,950.59**	**$26,665.39**	**$29,855.21**	**$12,136.22**	**$22,105.85**	**$925,813.58**	**$833,971.94**	**$10,419.55**	**$11,698.15**

Average																						
	Rank		Plan Avg Paid Amt			Member Avg Paid Amt			Total Avg Paid Amt			Copay Avg Amt		Deductible Avg Amt		Co-Insurance Avg Amt		Ingredient Avg Cost		Dispense Avg Fee	
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior
LISINOPRIL	1	1	$0.02	$0.00	0.00%	$2.62	$3.53	0.00%	$2.65	$3.53	0.00%	$2.60	$3.43	$0.02	$0.10	$0.00	$0.00	$2.17	$2.91	$0.47	$0.62
LEVOTHYROXINE SODIUM	2	2	$0.37	$0.06	0.00%	$15.93	$11.80	36.36%	$16.31	$11.87	36.36%	$15.81	$11.71	$0.12	$0.09	$0.00	$0.00	$15.92	$11.47	$0.38	$0.40
AMLODIPINE BESYLATE	3	3	$0.02	$0.00	0.00%	$3.58	$4.30	0.00%	$3.60	$4.30	0.00%	$3.37	$4.18	$0.21	$0.11	$0.00	$0.00	$3.27	$3.59	$0.33	$0.70
HYDROCODONE/ACETAMINOPHEN	4	4	$5.50	$1.41	400.00%	$13.47	$11.10	18.18%	$18.98	$12.51	50.00%	$13.47	$11.10	$0.00	$0.00	$0.00	$0.00	$17.87	$11.33	$1.11	$1.17
SIMVASTATIN	5	7	$0.01	$0.00	0.00%	$3.96	$4.61	0.00%	$3.97	$4.61	0.00%	$3.84	$4.54	$0.11	$0.07	$0.00	$0.00	$3.36	$3.93	$0.61	$0.68
AZITHROMYCIN	6	5	$0.70	$0.62	0.00%	$9.68	$11.54	-9.09%	$10.38	$12.17	-8.33%	$9.54	$11.47	$0.13	$0.07	$0.00	$0.00	$9.25	$10.97	$1.13	$1.20
OMEPRAZOLE	7	6	$0.38	$0.19	0.00%	$11.38	$11.94	0.00%	$11.76	$12.14	0.00%	$11.16	$11.51	$0.21	$0.42	$0.00	$0.00	$11.07	$11.29	$0.68	$0.84
AMOXICILLIN	8	10	$0.03	$0.00	0.00%	$3.96	$4.54	0.00%	$3.99	$4.54	0.00%	$3.96	$4.52	$0.00	$0.01	$0.00	$0.00	$3.12	$3.50	$0.86	$1.03
HYDROCHLOROTHIAZIDE	9	11	$0.00	$0.00	0.00%	$2.51	$2.99	0.00%	$2.51	$2.99	0.00%	$2.51	$2.99	$0.00	$0.00	$0.00	$0.00	$1.95	$2.46	$0.56	$0.52
ATORVASTATIN CALCIUM	10	17	$0.52	$0.32	0.00%	$12.01	$12.49	0.00%	$12.54	$12.81	0.00%	$11.92	$11.92	$0.09	$0.56	$0.00	$0.00	$11.88	$12.06	$0.65	$0.75
ALPRAZOLAM	11	9	$0.05	$0.00	0.00%	$3.28	$3.75	0.00%	$3.33	$3.75	0.00%	$3.28	$3.75	$0.00	$0.00	$0.00	$0.00	$2.26	$2.67	$1.06	$1.07
METFORMIN HCL	12	12	$0.00	$0.15	0.00%	$3.98	$4.82	0.00%	$3.98	$4.97	0.00%	$3.88	$4.68	$0.10	$0.13	$0.00	$0.00	$3.61	$4.45	$0.37	$0.52
PRAVASTATIN SODIUM	13	8	$0.25	$0.10	0.00%	$20.16	$14.94	35.71%	$20.42	$15.05	33.33%	$20.16	$14.94	$0.00	$0.00	$0.00	$0.00	$19.73	$14.45	$0.68	$0.59
FLUTICASONE PROPIONATE	14	13	$0.55	$0.28	0.00%	$10.34	$14.89	-28.57%	$10.89	$15.18	-26.67%	$10.34	$14.49	$0.00	$0.40	$0.00	$0.00	$9.99	$14.24	$0.89	$0.93
METOPROLOL TARTRATE	15	16	$0.13	$0.11	0.00%	$3.58	$3.78	0.00%	$3.71	$3.90	0.00%	$3.57	$3.74	$0.01	$0.04	$0.00	$0.00	$3.24	$3.25	$0.47	$0.64
TRAMADOL HCL	16	15	$0.01	$0.01	0.00%	$4.84	$6.27	-16.67%	$4.85	$6.28	-16.67%	$4.76	$6.20	$0.08	$0.07	$0.00	$0.00	$3.75	$5.10	$1.09	$1.18
LOSARTAN POTASSIUM	17	21	$0.04	$0.00	0.00%	$6.73	$7.81	-14.29%	$6.78	$7.81	-14.29%	$6.73	$7.81	$0.00	$0.00	$0.00	$0.00	$6.22	$7.16	$0.56	$0.64
GABAPENTIN	18	22	$4.42	$1.48	200.00%	$10.46	$9.63	0.00%	$14.89	$11.11	27.27%	$10.46	$9.63	$0.00	$0.00	$0.00	$0.00	$14.03	$10.09	$0.85	$1.00
LISINOPRIL/HYDROCHLOROTHIAZIDE	19	18	$0.00	$0.00	0.00%	$4.96	$5.44	0.00%	$4.96	$5.44	0.00%	$4.96	$5.44	$0.00	$0.00	$0.00	$0.00	$4.32	$4.74	$0.63	$0.69
MELOXICAM	20	14	$0.04	$0.01	0.00%	$2.50	$3.07	0.00%	$2.55	$3.08	0.00%	$2.43	$3.03	$0.07	$0.04	$0.00	$0.00	$1.65	$2.14	$0.89	$0.94
PREDNISONE	21	23	$0.59	$0.01	0.00%	$6.06	$6.17	0.00%	$6.66	$6.19	0.00%	$4.75	$3.71	$1.31	$2.46	$0.00	$0.00	$5.78	$5.24	$0.88	$0.94
METHYLPREDNISOLONE DOSE PACK	22	20	$0.21	$2.61	-100.00%	$19.81	$19.99	0.00%	$20.02	$22.61	-9.09%	$19.50	$19.99	$0.30	$0.00	$0.00	$0.00	$18.94	$21.45	$1.08	$1.16
MONTELUKAST SODIUM	23	33	$2.70	$12.55	-75.00%	$12.23	$20.23	-40.00%	$14.93	$32.79	-53.13%	$12.23	$19.78	$0.00	$0.44	$0.00	$0.00	$14.08	$31.87	$0.85	$0.91
METOPROLOL SUCCINATE ER	24	25	$7.63	$18.77	-61.11%	$27.06	$29.14	-6.90%	$34.70	$47.92	-27.66%	$27.06	$29.14	$0.00	$0.00	$0.00	$0.00	$33.96	$47.07	$0.73	$0.84
SERTRALINE HCL	25	19	$0.26	$0.11	0.00%	$4.50	$4.86	0.00%	$4.76	$4.98	0.00%	$4.50	$4.79	$0.00	$0.07	$0.00	$0.00	$4.05	$4.22	$0.71	$0.76
AMOXICILLIN/CLAVULANATE POTASSIUM	26	26	$3.43	$1.92	100.00%	$16.74	$17.81	-5.88%	$20.17	$19.73	0.00%	$16.74	$17.81	$0.00	$0.00	$0.00	$0.00	$19.09	$18.52	$1.07	$1.20
TOPIRAMATE	27	29	$0.03	$0.00	0.00%	$8.51	$7.49	14.29%	$8.54	$7.49	14.29%	$8.51	$7.49	$0.00	$0.00	$0.00	$0.00	$7.74	$6.47	$0.80	$1.02
CYCLOBENZAPRINE HCL	27	24	$0.10	$0.06	0.00%	$3.01	$3.56	0.00%	$3.11	$3.63	0.00%	$3.01	$3.56	$0.00	$0.00	$0.00	$0.00	$2.18	$2.61	$0.93	$1.01
FLUOXETINE HCL	29	37	$0.62	$0.00	0.00%	$6.90	$6.12	0.00%	$7.52	$6.12	16.67%	$6.90	$6.12	$0.00	$0.00	$0.00	$0.00	$6.92	$5.33	$0.60	$0.79
CIPROFLOXACIN HCL	30	32	$0.09	$0.46	0.00%	$3.81	$3.98	0.00%	$3.91	$4.45	0.00%	$3.81	$3.98	$0.00	$0.00	$0.00	$0.00	$3.12	$3.45	$0.79	$1.00
ESCITALOPRAM OXALATE	31	45	$0.00	$0.00	0.00%	$10.78	$9.59	11.11%	$10.78	$9.59	11.11%	$10.78	$9.59	$0.00	$0.00	$0.00	$0.00	$9.98	$8.53	$0.80	$1.06
PANTOPRAZOLE SODIUM	31	28	$0.90	$0.31	0.00%	$6.96	$6.61	0.00%	$7.86	$6.92	0.00%	$6.96	$6.46	$0.00	$0.15	$0.00	$0.00	$7.01	$5.88	$0.85	$1.03
ATENOLOL	31	26	$0.00	$0.00	0.00%	$4.15	$3.25	0.00%	$4.15	$3.25	0.00%	$4.15	$3.25	$0.00	$0.00	$0.00	$0.00	$3.81	$2.90	$0.34	$0.35
IBUPROFEN	34	40	$0.00	$0.00	0.00%	$5.74	$6.04	0.00%	$5.74	$6.04	0.00%	$5.74	$5.90	$0.00	$0.14	$0.00	$0.00	$4.74	$4.93	$1.00	$1.11
CITALOPRAM HYDROBROMIDE	35	31	$0.00	$0.00	0.00%	$3.03	$3.50	0.00%	$3.03	$3.50	0.00%	$3.03	$3.50	$0.00	$0.00	$0.00	$0.00	$2.23	$2.64	$0.79	$0.85
DULOXETINE HCL	36	66	$60.74	$266.63	-77.07%	$29.38	$31.83	-6.45%	$90.12	$298.47	-69.80%	$29.38	$31.83	$0.00	$0.00	$0.00	$0.00	$89.26	$297.70	$0.86	$0.77
FUROSEMIDE	37	30	$0.00	$0.00	0.00%	$1.99	$2.15	0.00%	$1.99	$2.15	0.00%	$1.93	$2.09	$0.06	$0.06	$0.00	$0.00	$1.26	$1.18	$0.72	$0.96
ZOLPIDEM TARTRATE	38	38	$0.07	$0.08	0.00%	$2.12	$2.37	0.00%	$2.20	$2.45	0.00%	$2.12	$2.32	$0.00	$0.05	$0.00	$0.00	$1.23	$1.37	$0.97	$1.08
TRI-SPRINTEC	39	35	$5.76	$0.00	0.00%	$4.73	$10.93	-60.00%	$10.50	$10.93	0.00%	$4.73	$10.93	$0.00	$0.00	$0.00	$0.00	$10.25	$10.58	$0.25	$0.34
FLUCONAZOLE	39	48	$2.76	$0.24	0.00%	$7.03	$7.37	0.00%	$9.80	$7.62	28.57%	$7.03	$7.37	$0.00	$0.00	$0.00	$0.00	$8.74	$6.42	$1.05	$1.20
BENZONATATE	41	43	$0.00	$0.00	0.00%	$7.11	$6.27	0.00%	$7.11	$6.27	0.00%	$7.11	$6.27	$0.00	$0.00	$0.00	$0.00	$5.97	$5.10	$1.13	$1.17
LEVOFLOXACIN	42	43	$0.10	$0.12	0.00%	$4.39	$4.96	0.00%	$4.49	$5.08	0.00%	$4.35	$4.77	$0.04	$0.18	$0.00	$0.00	$3.39	$3.92	$1.10	$1.16
CEPHALEXIN	42	51	$0.55	$0.08	0.00%	$6.40	$5.18	20.00%	$6.95	$5.27	20.00%	$6.32	$5.13	$0.07	$0.05	$0.00	$0.00	$6.08	$4.40	$0.87	$0.86
CARVEDILOL	44	57	$0.31	$0.00	0.00%	$6.29	$6.92	0.00%	$6.61	$6.92	0.00%	$6.29	$6.92	$0.00	$0.00	$0.00	$0.00	$5.93	$6.31	$0.67	$0.61
SULFAMETHOXAZOLE/TRIMETHOPRIM DS	45	35	$0.04	$0.00	0.00%	$2.30	$2.94	0.00%	$2.34	$2.94	0.00%	$2.30	$2.94	$0.00	$0.00	$0.00	$0.00	$1.52	$1.86	$0.81	$1.07
LORAZEPAM	46	69	$0.13	$0.07	0.00%	$3.07	$3.53	0.00%	$3.21	$3.61	0.00%	$3.07	$3.53	$0.00	$0.00	$0.00	$0.00	$2.24	$2.65	$0.96	$0.96
VENLAFAXINE HCL ER	47	69	$0.69	$10.81	-100.00%	$15.47	$17.52	-11.76%	$16.17	$28.33	-42.86%	$15.47	$17.52	$0.00	$0.00	$0.00	$0.00	$15.29	$27.16	$0.87	$1.16
CLONIDINE HCL	48	47	$4.64	$0.98	0.00%	$3.64	$3.82	0.00%	$8.29	$4.80	75.00%	$3.64	$3.82	$0.00	$0.00	$0.00	$0.00	$7.37	$3.82	$0.91	$0.98
UNKNOWN	49	40	$27.98	$14.87	92.86%	$28.34	$31.98	-9.68%	$56.33	$46.86	19.57%	$19.14	$29.43	$9.20	$2.54	$0.00	$0.00	$55.77	$45.89	$0.56	$0.96
LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE	50	61	$0.00	$0.00	0.00%	$9.45	$9.12	0.00%	$9.45	$9.12	0.00%	$9.45	$9.12	$0.00	$0.00	$0.00	$0.00	$8.89	$8.41	$0.56	$0.70
CLONAZEPAM	50	48	$0.11	$0.14	0.00%	$3.21	$3.16	0.00%	$3.33	$3.31	0.00%	$3.21	$3.16	$0.00	$0.00	$0.00	$0.00	$2.42	$2.36	$0.91	$0.95
ALL OTHER			$99.29	$82.64	19.51%	$27.06	$28.83	-3.57%	$126.35	$111.48	12.61%	$21.59	$21.49	$3.70	$4.15	$1.76	$3.18	$125.48	$110.71	$0.78	$0.89
Total			**$50.91**	**$43.92**	**13.95%**	**$17.58**	**$18.76**	**-5.56%**	**$68.50**	**$62.69**	**8.06%**	**$14.75**	**$14.91**	**$1.94**	**$2.21**	**$0.88**	**$1.64**	**$67.70**	**$61.89**	**$0.76**	**$0.86**

Utilization																					
	Rank		Number of Rx			Rx Users			Rx Per User		Avg Quantity		Avg Days Supply		Plan Paid PMPM Amt			Util/1000		
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %
LISINOPRIL	1	1	403	375	7.47%	86	79	8.86%	4.69	4.75	55.34	54.82	50.00	50.00	$0.00	$0.00	0.00%	339.73	319.26	6.41%
LEVOTHYROXINE SODIUM	2	2	343	328	4.57%	72	69	4.35%	4.76	4.75	58.44	57.10	58.00	56.00	$0.00	$0.00	0.00%	289.15	279.25	3.54%
AMLODIPINE BESYLATE	3	3	283	291	-2.75%	71	64	10.94%	3.99	4.55	61.77	57.14	58.00	53.00	$0.00	$0.00	0.00%	238.57	247.75	-3.71%
HYDROCODONE/ACETAMINOPHEN	4	4	269	279	-3.58%	123	112	9.82%	2.19	2.49	64.74	68.84	17.00	17.00	$0.10	$0.02	400.00%	226.77	237.53	-4.53%
SIMVASTATIN	5	7	256	249	2.81%	62	58	6.90%	4.13	4.29	54.84	55.00	55.00	54.00	$0.00	$0.00	0.00%	215.81	211.99	1.80%
AZITHROMYCIN	6	5	252	260	-3.08%	198	206	-3.88%	1.27	1.26	8.57	9.91	5.00	6.00	$0.01	$0.01	0.00%	212.43	221.36	-4.03%
OMEPRAZOLE	7	6	244	257	-5.06%	77	69	11.59%	3.17	3.72	52.98	47.63	47.00	43.00	$0.00	$0.00	0.00%	205.69	218.80	-5.99%
AMOXICILLIN	8	10	239	218	9.63%	181	175	3.43%	1.32	1.25	56.62	59.44	8.00	8.00	$0.00	$0.00	0.00%	201.48	185.60	8.55%
HYDROCHLOROTHIAZIDE	9	11	238	203	17.24%	57	59	-3.39%	4.18	3.44	54.98	59.01	56.00	60.00	$0.00	$0.00	0.00%	200.63	172.83	16.09%
ATORVASTATIN CALCIUM	10	17	235	168	39.88%	53	42	26.19%	4.43	4.00	49.91	47.32	49.00	47.00	$0.00	$0.00	0.00%	198.10	143.03	38.51%
ALPRAZOLAM	11	9	224	222	0.90%	56	52	7.69%	4.00	4.27	72.55	72.30	29.00	31.00	$0.00	$0.00	0.00%	188.83	189.00	-0.09%
METFORMIN HCL	12	12	214	201	6.47%	51	41	24.39%	4.20	4.90	108.15	96.49	49.00	45.00	$0.00	$0.00	0.00%	180.40	171.12	5.42%
PRAVASTATIN SODIUM	13	8	200	228	-12.28%	42	44	-4.55%	4.76	5.18	45.60	43.42	44.00	43.00	$0.00	$0.00	0.00%	168.60	194.11	-13.14%
FLUTICASONE PROPIONATE	14	13	177	197	-10.15%	115	107	7.48%	1.54	1.84	18.25	18.19	36.00	37.00	$0.00	$0.00	0.00%	149.21	167.72	-11.04%
METOPROLOL TARTRATE	15	16	169	173	-2.31%	44	40	10.00%	3.84	4.33	95.62	92.16	59.00	54.00	$0.00	$0.00	0.00%	142.47	147.29	-3.27%
TRAMADOL HCL	16	15	157	178	-11.80%	57	62	-8.06%	2.75	2.87	105.54	102.47	25.00	24.00	$0.00	$0.00	0.00%	132.35	151.54	-12.67%
LOSARTAN POTASSIUM	17	21	154	133	15.79%	34	28	21.43%	4.53	4.75	56.00	54.81	56.00	54.00	$0.00	$0.00	0.00%	129.82	113.23	14.65%
GABAPENTIN	18	22	153	130	17.69%	42	28	50.00%	3.64	4.64	97.05	91.61	40.00	35.00	$0.04	$0.01	300.00%	128.98	110.68	16.53%
LISINOPRIL/HYDROCHLOROTHIAZIDE	19	18	146	167	-12.57%	27	31	-12.90%	5.41	5.39	54.24	54.97	49.00	49.00	$0.00	$0.00	0.00%	123.08	142.18	-13.43%
MELOXICAM	20	14	143	189	-24.34%	56	60	-6.67%	2.55	3.15	44.22	49.35	39.00	42.00	$0.00	$0.00	0.00%	120.55	160.91	-25.08%
PREDNISONE	21	23	138	119	15.97%	95	79	20.25%	1.45	1.51	32.76	30.78	19.00	19.00	$0.00	$0.00	0.00%	116.33	101.31	14.83%
METHYLPREDNISOLONE DOSE PACK	22	20	128	142	-9.86%	109	117	-6.84%	1.17	1.21	21.00	21.14	6.00	6.00	$0.00	$0.02	-100.00%	107.90	120.89	-10.75%
MONTELUKAST SODIUM	23	33	124	92	34.78%	36	30	20.00%	3.44	3.07	38.22	42.21	38.00	42.00	$0.02	$0.08	-75.00%	104.53	78.33	33.46%
METOPROLOL SUCCINATE ER	24	25	117	105	11.43%	25	24	4.17%	4.68	4.38	57.14	64.30	50.00	45.00	$0.06	$0.13	-53.85%	98.63	89.39	10.33%
SERTRALINE HCL	25	19	113	158	-28.48%	30	35	-14.29%	3.77	4.51	46.32	47.24	45.00	47.00	$0.00	$0.00	0.00%	95.26	134.52	-29.18%
AMOXICILLIN/CLAVULANATE POTASSIUM	26	26	108	103	4.85%	93	89	4.49%	1.16	1.16	41.40	44.72	9.00	9.00	$0.02	$0.01	100.00%	91.04	87.69	3.82%
TOPIRAMATE	27	29	107	99	8.08%	26	23	13.04%	4.12	4.30	71.92	65.67	41.00	38.00	$0.00	$0.00	0.00%	90.20	84.29	7.02%
CYCLOBENZAPRINE HCL	27	24	107	107	0.00%	50	52	-3.85%	2.14	2.06	61.11	60.28	31.00	28.00	$0.00	$0.00	0.00%	90.20	91.10	-0.98%
FLUOXETINE HCL	29	37	106	82	29.27%	22	16	37.50%	4.82	5.13	59.61	55.32	49.00	48.00	$0.00	$0.00	0.00%	89.36	69.81	28.00%
CIPROFLOXACIN HCL	30	32	104	95	9.47%	88	77	14.29%	1.18	1.23	16.32	15.48	8.00	8.00	$0.00	$0.00	0.00%	87.67	80.88	8.40%
ESCITALOPRAM OXALATE	31	45	96	71	35.21%	28	16	75.00%	3.43	4.44	47.18	40.14	47.00	38.00	$0.00	$0.00	0.00%	80.93	60.45	33.88%
PANTOPRAZOLE SODIUM	31	28	96	102	-5.88%	27	23	17.39%	3.56	4.43	46.15	41.19	42.00	39.00	$0.00	$0.00	0.00%	80.93	86.84	-6.81%
ATENOLOL	31	26	96	103	-6.80%	27	27	0.00%	3.56	3.81	76.87	76.11	69.00	70.00	$0.00	$0.00	0.00%	80.93	87.69	-7.71%
IBUPROFEN	34	40	93	75	24.00%	68	52	30.77%	1.37	1.44	62.09	73.45	20.00	25.00	$0.00	$0.00	0.00%	78.40	63.85	22.78%
CITALOPRAM HYDROBROMIDE	35	31	88	96	-8.33%	21	18	16.67%	4.19	5.33	40.22	43.12	39.00	42.00	$0.00	$0.00	0.00%	74.18	81.73	-9.23%
DULOXETINE HCL	36	66	84	49	71.43%	17	15	13.33%	4.94	3.27	46.98	56.32	45.00	46.00	$0.35	$0.92	-61.96%	70.81	41.72	69.74%
FUROSEMIDE	37	30	81	97	-16.49%	23	20	15.00%	3.52	4.85	56.62	43.23	46.00	41.00	$0.00	$0.00	0.00%	68.28	82.58	-17.32%
ZOLPIDEM TARTRATE	38	38	79	80	-1.25%	22	25	-12.00%	3.59	3.20	33.22	32.87	33.00	32.00	$0.00	$0.00	0.00%	66.60	68.11	-2.22%
TRI-SPRINTEC	39	35	78	89	-12.36%	14	12	16.67%	5.57	7.42	28.71	28.62	28.00	28.00	$0.03	$0.00	0.00%	65.75	75.77	-13.22%
FLUCONAZOLE	39	48	78	69	13.04%	55	52	5.77%	1.42	1.33	4.16	3.47	5.00	5.00	$0.01	$0.00	0.00%	65.75	58.74	11.93%
BENZONATATE	41	43	77	72	6.94%	72	59	22.03%	1.07	1.22	27.62	29.93	9.00	9.00	$0.00	$0.00	0.00%	64.91	61.30	5.89%
LEVOFLOXACIN	42	43	76	72	5.56%	62	57	8.77%	1.23	1.26	8.68	8.69	8.00	8.00	$0.00	$0.00	0.00%	64.07	61.30	4.52%
CEPHALEXIN	42	51	76	67	13.43%	67	63	6.35%	1.13	1.06	40.51	38.61	9.00	7.00	$0.00	$0.00	0.00%	64.07	57.04	12.32%
CARVEDILOL	44	57	75	58	29.31%	13	12	8.33%	5.77	4.83	97.97	91.55	46.00	46.00	$0.00	$0.00	0.00%	63.22	49.38	28.04%
SULFAMETHOXAZOLE/TRIMETHOPRIM DS	45	35	73	89	-17.98%	51	55	-7.27%	1.43	1.62	17.65	18.65	10.00	9.00	$0.00	$0.00	0.00%	61.54	75.77	-18.78%
LORAZEPAM	46	69	72	47	53.19%	22	15	46.67%	3.27	3.13	67.44	75.36	30.00	32.00	$0.00	$0.00	0.00%	60.70	40.01	51.69%
VENLAFAXINE HCL ER	47	69	71	47	51.06%	13	7	85.71%	5.46	6.71	46.69	38.42	39.00	33.00	$0.00	$0.03	-100.00%	59.85	40.01	49.58%
CLONIDINE HCL	48	47	69	70	-1.43%	14	15	-6.67%	4.93	4.67	49.14	48.27	35.00	33.00	$0.02	$0.00	0.00%	58.17	59.60	-2.40%
UNKNOWN	49	40	68	75	-9.33%	36	25	44.00%	1.89	3.00	96.60	99.01	42.00	39.00	$0.13	$0.07	85.71%	57.32	63.85	-10.23%
LOSARTAN POTASSIUM/HYDROCHLOROTHIAZIDE	50	61	67	54	24.07%	15	14	7.14%	4.47	3.86	60.44	57.22	59.00	54.00	$0.00	$0.00	0.00%	56.48	45.97	22.85%
CLONAZEPAM	50	48	67	69	-2.90%	13	16	-18.75%	5.15	4.31	64.19	61.69	36.00	32.00	$0.00	$0.00	0.00%	56.48	58.74	-3.85%
ALL OTHER			6,886	6,931	-0.65%	868	841	3.21%	7.93	8.24	60.30	61.62	34.00	34.00	$48.03	$40.64	18.18%	5,804.85	5,900.82	-1.63%
Total			**13,675**	**13,475**	**1.48%**	**1,007**	**953**	**5.67%**	**13.58**	**14.14**	**57.96**	**58.18**	**37.00**	**36.00**	**$48.91**	**$41.99**	**16.48%**	**11,527.92**	**11,472.15**	**0.49%**

Notes:

- * = Drug not found in prior period.

- TOTAL represents the summation of all Prescriptions for analysis period (including claims not ranked).

- ALL OTHER represents the difference between all prescriptions and prescriptions ranked for analysis period.

- Brand/Generic = (G) Generic, (MS) Multi-Source Brand, (SS) Single Source Brand.

- Plan Paid Amount does not include sales tax.

Top Drugs by Paid/Prescription

Company: THE SCHOOL DISTRICT OF SUMTER
Group: 60406
Current Paid Period: From 08/2014 to 07/2015
Prior Paid Period: From 08/2013 to 07/2014
Rank: 50
Rx Sort By: PAID

Total																						
	Rank		Paid Amt			Member Paid Amt			Total Paid Amt			Copay Amt		Deductible Amt		Co-Insurance Amt		Ingredient Cost		Dispense Fee	
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior
AUBAGIO	1	1	$65,452.91	$36,181.46	80.90%	$1,040.00	$580.00	79.31%	$66,492.91	$36,761.46	80.88%	$940.00	$480.00	$100.00	$100.00	$0.00	$0.00	$66,492.91	$36,761.46	$0.00	$0.00
CIMZIA	2	3	$37,068.33	$30,888.25	20.01%	$880.00	$820.00	7.32%	$37,948.33	$31,708.25	19.68%	$780.00	$720.00	$100.00	$100.00	$0.00	$0.00	$37,948.33	$31,708.25	$0.00	$0.00
ORENCIA	3	4	$36,880.26	$27,357.00	34.81%	$880.00	$760.00	15.79%	$37,760.26	$28,117.00	34.30%	$780.00	$660.00	$100.00	$100.00	$0.00	$0.00	$37,760.26	$28,117.00	$0.00	$0.00
LANTUS SOLOSTAR	4	9	$22,717.62	$10,655.98	113.20%	$3,460.10	$2,430.03	42.39%	$26,177.72	$13,086.01	100.04%	$2,560.00	$1,940.00	$900.10	$490.03	$0.00	$0.00	$26,156.77	$13,080.96	$20.95	$5.05
CAPECITABINE	5	18	$18,181.33	$8,186.34	122.09%	$145.45	$45.00	222.22%	$18,326.78	$8,231.34	122.65%	$30.00	$45.00	$0.00	$0.00	$115.45	$0.00	$18,325.93	$8,231.34	$0.85	$0.00
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	6	10	$16,550.96	$10,500.12	57.62%	$1,203.94	$720.00	67.08%	$17,754.90	$11,220.12	58.24%	$920.00	$520.00	$283.94	$200.00	$0.00	$0.00	$17,748.25	$11,218.67	$6.65	$1.45
TRUVADA	7	5	$15,498.10	$15,044.22	3.01%	$580.00	$480.00	20.83%	$16,078.10	$15,524.22	3.56%	$480.00	$480.00	$100.00	$0.00	$0.00	$0.00	$16,066.10	$15,510.17	$12.00	$14.05
REYATAZ	8	6	$14,567.43	$13,469.61	8.14%	$480.00	$580.00	-17.24%	$15,047.43	$14,049.61	7.10%	$480.00	$480.00	$0.00	$100.00	$0.00	$0.00	$15,035.43	$14,035.56	$12.00	$14.05
NOVOLOG FLEXPEN	9	16	$13,391.01	$8,486.06	57.79%	$1,200.00	$760.00	57.89%	$14,591.01	$9,246.06	57.80%	$1,100.00	$660.00	$100.00	$100.00	$0.00	$0.00	$14,572.41	$9,243.66	$18.60	$2.40
ABILIFY	10	14	$12,212.03	$9,367.52	30.36%	$1,340.00	$940.00	42.55%	$13,552.03	$10,307.52	31.47%	$1,040.00	$840.00	$300.00	$100.00	$0.00	$0.00	$13,536.63	$10,294.42	$15.40	$13.10
XELODA	11	2	$12,020.75	$34,799.41	-65.46%	$12,020.77	$15,337.63	-21.62%	$24,041.52	$50,137.04	-52.05%	$0.00	$0.00	$0.00	$116.66	$12,020.77	$15,220.97	$24,030.47	$50,121.74	$11.05	$15.30
TACLONEX	12	0	$10,685.78	$0.00	0.00%	$580.00	$0.00	0.00%	$11,265.78	$0.00	0.00%	$480.00	$0.00	$100.00	$0.00	$0.00	$0.00	$11,258.83	$0.00	$6.95	$0.00
LEVEMIR FLEXPEN	13	15	$9,514.62	$8,811.10	7.98%	$1,000.00	$1,160.00	-13.79%	$10,514.62	$9,971.10	5.45%	$800.00	$960.00	$200.00	$200.00	$0.00	$0.00	$10,495.42	$9,951.45	$19.20	$19.65
CLOMIPRAMINE HCL	14	8	$9,218.84	$11,470.55	-19.63%	$130.00	$210.00	-38.10%	$9,348.84	$11,680.55	-19.96%	$130.00	$210.00	$0.00	$0.00	$0.00	$0.00	$9,348.84	$11,679.30	$0.00	$1.25
JANUVIA	15	11	$8,568.61	$10,331.11	-17.06%	$1,090.00	$2,410.05	-54.77%	$9,658.61	$12,741.16	-24.19%	$1,090.00	$1,750.00	$0.00	$660.05	$0.00	$0.00	$9,636.61	$12,697.71	$22.00	$43.45
ADVAIR DISKUS	16	23	$8,034.55	$6,879.70	16.78%	$1,803.28	$1,566.32	15.07%	$9,837.83	$8,446.02	16.47%	$1,350.00	$1,160.00	$453.28	$406.32	$0.00	$0.00	$9,815.68	$8,418.92	$22.15	$27.10
LANTUS	17	96	$7,715.77	$1,252.29	516.21%	$1,580.00	$240.00	558.33%	$9,295.77	$1,492.29	522.99%	$1,280.00	$240.00	$300.00	$0.00	$0.00	$0.00	$9,289.52	$1,489.04	$6.25	$3.25
SPIRIVA HANDIHALER	18	24	$7,172.05	$6,818.09	5.18%	$1,200.00	$1,280.00	-6.25%	$8,372.05	$8,098.09	3.37%	$1,000.00	$1,080.00	$200.00	$200.00	$0.00	$0.00	$8,353.65	$8,077.84	$18.40	$20.25
METHYLPHENIDATE HCL ER	19	12	$7,027.37	$10,295.80	-31.74%	$2,319.32	$1,500.00	54.60%	$9,346.69	$11,795.80	-20.76%	$1,763.56	$1,500.00	$555.76	$0.00	$0.00	$0.00	$9,318.44	$11,735.25	$28.25	$60.55
VORICONAZOLE	20	25	$6,845.92	$6,610.74	3.56%	$80.00	$120.00	-33.33%	$6,925.92	$6,730.74	2.90%	$80.00	$120.00	$0.00	$0.00	$0.00	$0.00	$6,922.52	$6,725.64	$3.40	$5.10
TROKENDI XR	21	0	$6,546.29	$0.00	0.00%	$1,080.00	$0.00	0.00%	$7,626.29	$0.00	0.00%	$780.00	$0.00	$300.00	$0.00	$0.00	$0.00	$7,614.64	$0.00	$11.65	$0.00
HUMALOG KWIKPEN	22	13	$6,092.32	$9,486.18	-35.77%	$560.00	$980.00	-42.86%	$6,652.32	$10,466.18	-36.43%	$560.00	$880.00	$0.00	$100.00	$0.00	$0.00	$6,640.52	$10,443.33	$11.80	$22.85
JANUMET	23	31	$6,000.77	$4,414.60	35.93%	$1,210.00	$1,200.00	0.83%	$7,210.77	$5,614.60	28.43%	$910.00	$1,000.00	$300.00	$200.00	$0.00	$0.00	$7,196.37	$5,600.20	$14.40	$14.40
METFORMIN HCL ER	24	435	$5,960.60	$0.00	0.00%	$503.47	$303.37	66.01%	$6,464.07	$303.37	2033.00%	$503.47	$303.37	$0.00	$0.00	$0.00	$0.00	$6,451.07	$287.37	$13.00	$16.00
CRESTOR	25	35	$5,767.25	$3,862.08	49.33%	$1,491.60	$1,677.49	-11.03%	$7,258.85	$5,539.57	31.03%	$1,440.00	$1,190.00	$51.60	$487.49	$0.00	$0.00	$7,225.45	$5,516.12	$33.40	$23.45
EFFEXOR XR	26	28	$5,543.20	$5,393.05	2.78%	$720.00	$820.00	-12.20%	$6,263.20	$6,213.05	0.80%	$720.00	$720.00	$0.00	$100.00	$0.00	$0.00	$6,263.20	$6,213.05	$0.00	$0.00
NOVOLOG MIX 70/30	27	42	$5,367.30	$3,229.96	66.18%	$500.00	$640.00	-21.88%	$5,867.30	$3,869.96	51.62%	$400.00	$440.00	$100.00	$200.00	$0.00	$0.00	$5,861.30	$3,856.76	$6.00	$13.20
TECFIDERA	28	22	$5,330.92	$6,884.88	-22.56%	$140.00	$6,884.88	-97.97%	$5,470.92	$13,769.76	-60.27%	$40.00	$0.00	$100.00	$0.00	$0.00	$6,884.88	$5,470.92	$13,766.76	$0.00	$3.00
ZETIA	29	37	$5,328.37	$3,835.91	38.90%	$1,700.00	$1,675.80	1.43%	$7,028.37	$5,511.71	27.51%	$1,300.00	$1,185.10	$400.00	$490.70	$0.00	$0.00	$7,021.82	$5,504.56	$6.55	$7.15
NEXIUM	30	19	$5,300.03	$8,084.16	-34.44%	$1,220.00	$1,920.00	-36.46%	$6,520.03	$10,004.16	-34.83%	$1,020.00	$1,620.00	$200.00	$300.00	$0.00	$0.00	$6,501.73	$9,971.16	$18.30	$33.00
SYMBICORT	31	40	$5,291.53	$3,643.92	45.21%	$1,921.49	$1,380.78	39.13%	$7,213.02	$5,024.70	43.55%	$1,030.00	$660.00	$891.49	$720.78	$0.00	$0.00	$7,187.72	$5,002.80	$25.30	$21.90
PENTASA	32	29	$5,172.10	$5,366.23	-3.62%	$460.00	$600.00	-23.33%	$5,632.10	$5,966.23	-5.60%	$360.00	$400.00	$100.00	$200.00	$0.00	$0.00	$5,622.85	$5,954.93	$9.25	$11.30
DULOXETINE HCL	33	7	$5,102.32	$13,065.10	-60.94%	$2,468.45	$1,560.00	58.21%	$7,570.77	$14,625.10	-48.23%	$2,468.45	$1,560.00	$0.00	$0.00	$0.00	$0.00	$7,498.32	$14,587.35	$72.45	$37.75
GUANFACINE ER	34	0	$5,042.06	$0.00	0.00%	$500.00	$0.00	0.00%	$5,542.06	$0.00	0.00%	$500.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5,529.81	$0.00	$12.25	$0.00
ELMIRON	35	27	$4,818.65	$5,713.92	-15.67%	$300.00	$400.00	-25.00%	$5,118.65	$6,113.92	-16.28%	$300.00	$400.00	$0.00	$0.00	$0.00	$0.00	$5,118.65	$6,113.92	$0.00	$0.00
JARDIANCE	36	0	$4,672.64	$0.00	0.00%	$1,008.20	$0.00	0.00%	$5,680.84	$0.00	0.00%	$808.20	$0.00	$200.00	$0.00	$0.00	$0.00	$5,668.69	$0.00	$12.15	$0.00
CLOBETASOL PROPIONATE	37	69	$4,426.02	$1,951.81	126.81%	$560.00	$429.10	30.30%	$4,986.02	$2,380.91	109.45%	$560.00	$429.10	$0.00	$0.00	$0.00	$0.00	$4,970.32	$2,347.31	$15.70	$33.60
NIACIN ER	38	33	$4,364.29	$4,083.05	6.88%	$560.00	$530.00	5.66%	$4,924.29	$4,613.05	6.74%	$560.00	$530.00	$0.00	$0.00	$0.00	$0.00	$4,907.29	$4,602.65	$17.00	$10.40
EMEND	39	0	$4,353.45	$0.00	0.00%	$702.15	$0.00	0.00%	$5,055.60	$0.00	0.00%	$120.00	$0.00	$582.15	$0.00	$0.00	$0.00	$5,054.40	$0.00	$1.20	$0.00
CELLCEPT	40	51	$4,335.35	$2,881.84	50.43%	$720.00	$600.00	20.00%	$5,055.35	$3,481.84	45.19%	$720.00	$600.00	$0.00	$0.00	$0.00	$0.00	$5,043.95	$3,472.09	$11.40	$9.75
LEVEMIR	41	73	$4,031.67	$1,739.87	131.74%	$860.00	$480.00	79.17%	$4,891.67	$2,219.87	120.37%	$760.00	$480.00	$100.00	$0.00	$0.00	$0.00	$4,878.82	$2,207.92	$12.85	$11.95
PREMARIN	42	41	$3,959.44	$3,252.21	21.74%	$2,752.54	$4,148.18	-33.63%	$6,711.98	$7,400.39	-9.30%	$2,252.54	$2,999.88	$500.00	$1,148.30	$0.00	$0.00	$6,684.43	$7,353.29	$27.55	$47.10
STRATTERA	43	58	$3,809.02	$2,467.11	54.36%	$1,080.00	$540.00	100.00%	$4,889.02	$3,007.11	62.55%	$980.00	$440.00	$100.00	$100.00	$0.00	$0.00	$4,873.57	$2,994.46	$15.45	$12.65
BYETTA	44	50	$3,582.28	$2,892.20	23.86%	$400.00	$400.00	0.00%	$3,982.28	$3,292.20	20.96%	$300.00	$300.00	$100.00	$100.00	$0.00	$0.00	$3,982.28	$3,292.20	$0.00	$0.00
DULERA	45	32	$3,564.03	$4,298.73	-17.08%	$840.00	$890.00	-5.62%	$4,404.03	$5,188.73	-15.11%	$640.00	$790.00	$200.00	$100.00	$0.00	$0.00	$4,400.03	$5,185.83	$4.00	$2.90
URSODIOL	46	170	$3,474.28	$416.95	734.86%	$240.00	$160.00	50.00%	$3,714.28	$576.95	544.62%	$240.00	$160.00	$0.00	$0.00	$0.00	$0.00	$3,712.43	$569.45	$1.85	$7.50
SUBOXONE	47	20	$3,305.65	$7,487.83	-55.86%	$590.00	$1,452.32	-59.37%	$3,895.65	$8,940.15	-56.42%	$490.00	$1,052.32	$100.00	$400.00	$0.00	$0.00	$3,883.35	$8,911.35	$12.30	$28.80
INTUNIV	48	30	$3,186.38	$4,427.10	-28.01%	$840.00	$1,640.00	-48.78%	$4,026.38	$6,067.10	-33.62%	$840.00	$1,440.00	$0.00	$200.00	$0.00	$0.00	$4,012.08	$6,039.00	$14.30	$28.10
NAMENDA	49	52	$3,144.39	$2,708.47	16.06%	$440.00	$440.00	0.00%	$3,584.39	$3,148.47	13.82%	$440.00	$440.00	$0.00	$0.00	$0.00	$0.00	$3,573.69	$3,137.52	$10.70	$10.95
ZENATANE	50	107	$3,074.40	$1,115.21	175.70%	$180.00	$60.00	200.00%	$3,254.40	$1,175.21	176.94%	$180.00	$60.00	$0.00	$0.00	$0.00	$0.00	$3,244.05	$1,171.46	$10.35	$3.75
ALL OTHER			$233,596.35	$222,294.57	5.08%	$182,156.44	$189,880.70	-4.07%	$415,752.79	$412,175.27	0.87%	$163,325.43	$167,545.82	$18,831.01	$22,334.88	$0.00	$0.00	$405,355.08	$401,989.39	$9,800.95	$11,042.15
Total			**$696,316.63**	**$591,902.17**	**17.64%**	**$240,513.26**	**$252,911.65**	**-4.90%**	**$936,829.89**	**$844,813.82**	**10.89%**	**$201,711.65**	**$200,950.59**	**$26,665.39**	**$29,855.21**	**$12,136.22**	**$22,105.85**	**$925,813.58**	**$833,971.94**	**$10,419.55**	**$11,698.15**

Average																						
	Rank		Plan Avg Paid Amt			Member Avg Paid Amt			Total Avg Paid Amt			Copay Avg Amt		Deductible Avg Amt		Co-Insurance Avg Amt		Ingredient Avg Cost		Dispense Avg Fee	
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Current	Prior
AUBAGIO	1	1	$5,034.83	$4,522.68	11.32%	$80.00	$72.50	9.72%	$5,114.83	$4,595.18	11.29%	$72.30	$60.00	$7.69	$12.50	$0.00	$0.00	$5,114.83	$4,595.18	$0.00	$0.00
CIMZIA	2	3	$2,851.41	$2,574.02	10.76%	$67.69	$68.33	0.00%	$2,919.10	$2,642.35	10.45%	$60.00	$60.00	$7.69	$8.33	$0.00	$0.00	$2,919.10	$2,642.35	$0.00	$0.00
ORENCIA	3	4	$2,836.94	$2,487.00	14.03%	$67.69	$69.09	-1.45%	$2,904.63	$2,556.09	13.62%	$60.00	$60.00	$7.69	$9.09	$0.00	$0.00	$2,904.63	$2,556.09	$0.00	$0.00
LANTUS SOLOSTAR	4	9	$631.04	$507.42	24.26%	$96.11	$115.71	-16.52%	$727.15	$623.14	16.69%	$71.11	$92.38	$25.00	$23.33	$0.00	$0.00	$726.57	$622.90	$0.58	$0.24
CAPECITABINE	5	18	$2,272.66	$2,728.78	-16.72%	$18.18	$15.00	20.00%	$2,290.84	$2,743.78	-16.48%	$3.75	$15.00	$0.00	$0.00	$14.43	$0.00	$2,290.74	$2,743.78	$0.10	$0.00
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	6	10	$1,273.15	$2,100.02	-39.33%	$92.61	$144.00	-35.42%	$1,365.76	$2,244.02	-39.13%	$70.76	$104.00	$21.84	$40.00	$0.00	$0.00	$1,365.25	$2,243.73	$0.51	$0.29
TRUVADA	7	5	$1,291.50	$1,253.68	2.95%	$48.33	$40.00	20.00%	$1,339.84	$1,293.68	3.56%	$40.00	$40.00	$8.33	$0.00	$0.00	$0.00	$1,338.84	$1,292.51	$1.00	$1.17
REYATAZ	8	6	$1,213.95	$1,122.46	8.11%	$40.00	$48.33	-16.67%	$1,253.95	$1,170.80	7.09%	$40.00	$40.00	$0.00	$8.33	$0.00	$0.00	$1,252.95	$1,169.63	$1.00	$1.17
NOVOLOG FLEXPEN	9	16	$637.66	$1,212.29	-47.36%	$57.14	$108.57	-47.22%	$694.81	$1,320.86	-47.42%	$52.38	$94.28	$4.76	$14.28	$0.00	$0.00	$693.92	$1,320.52	$0.88	$0.34
ABILIFY	10	14	$718.35	$669.10	7.32%	$78.82	$67.14	16.42%	$797.17	$736.25	8.15%	$61.17	$60.00	$17.64	$7.14	$0.00	$0.00	$796.27	$735.31	$0.90	$0.93
XELODA	11	2	$924.67	$1,391.97	-33.57%	$924.67	$613.50	50.73%	$1,849.34	$2,005.48	-7.78%	$0.00	$0.00	$0.00	$4.66	$924.67	$608.83	$1,848.49	$2,004.86	$0.85	$0.61
TACLONEX	12	0	$1,335.72	$0.00	0.00%	$72.50	$0.00	0.00%	$1,408.22	$0.00	0.00%	$60.00	$0.00	$12.50	$0.00	$0.00	$0.00	$1,407.35	$0.00	$0.86	$0.00
LEVEMIR FLEXPEN	13	15	$475.73	$400.50	18.75%	$50.00	$52.72	-3.85%	$525.73	$453.23	15.89%	$40.00	$43.63	$10.00	$9.09	$0.00	$0.00	$524.77	$452.33	$0.96	$0.89
CLOMIPRAMINE HCL	14	8	$3,072.94	$1,911.75	60.75%	$43.33	$35.00	22.86%	$3,116.28	$1,946.75	60.07%	$43.33	$35.00	$0.00	$0.00	$0.00	$0.00	$3,116.28	$1,946.55	$0.00	$0.20
JANUVIA	15	11	$372.54	$271.87	36.90%	$47.39	$63.42	-25.40%	$419.93	$335.29	25.07%	$47.39	$46.05	$0.00	$17.36	$0.00	$0.00	$418.98	$334.15	$0.95	$1.14
ADVAIR DISKUS	16	23	$309.02	$264.60	16.67%	$69.35	$60.24	15.00%	$378.37	$324.84	16.36%	$51.92	$44.61	$17.43	$15.62	$0.00	$0.00	$377.52	$323.80	$0.85	$1.04
LANTUS	17	96	$482.23	$313.07	53.99%	$98.75	$60.00	63.33%	$580.98	$373.07	55.50%	$80.00	$60.00	$18.75	$0.00	$0.00	$0.00	$580.59	$372.26	$0.39	$0.81
SPIRIVA HANDIHALER	18	24	$358.60	$324.67	10.19%	$60.00	$60.95	0.00%	$418.60	$385.62	8.31%	$50.00	$51.42	$10.00	$9.52	$0.00	$0.00	$417.68	$384.65	$0.92	$0.96
METHYLPHENIDATE HCL ER	19	12	$159.71	$166.06	-3.61%	$52.71	$24.19	116.67%	$212.42	$190.25	11.58%	$40.08	$24.19	$12.63	$0.00	$0.00	$0.00	$211.78	$189.27	$0.64	$0.97
VORICONAZOLE	20	25	$1,711.48	$1,101.79	55.31%	$20.00	$20.00	0.00%	$1,731.48	$1,121.79	54.33%	$20.00	$20.00	$0.00	$0.00	$0.00	$0.00	$1,730.63	$1,120.94	$0.85	$0.85
TROKENDI XR	21	0	$503.56	$0.00	0.00%	$83.07	$0.00	0.00%	$586.63	$0.00	0.00%	$60.00	$0.00	$23.07	$0.00	$0.00	$0.00	$585.74	$0.00	$0.89	$0.00
HUMALOG KWIKPEN	22	13	$468.64	$431.19	8.58%	$43.07	$44.54	-2.27%	$511.71	$475.73	7.37%	$43.07	$40.00	$0.00	$4.54	$0.00	$0.00	$510.80	$474.69	$0.90	$1.03
JANUMET	23	31	$375.04	$259.68	44.40%	$75.62	$70.58	7.14%	$450.67	$330.27	36.36%	$56.87	$58.82	$18.75	$11.76	$0.00	$0.00	$449.77	$329.42	$0.90	$0.84
METFORMIN HCL ER	24	435	$192.27	$0.00	0.00%	$16.24	$13.19	23.08%	$208.51	$13.19	1500.00%	$16.24	$13.19	$0.00	$0.00	$0.00	$0.00	$208.09	$12.49	$0.41	$0.69
CRESTOR	25	35	$174.76	$167.91	3.59%	$45.20	$72.93	-37.50%	$219.96	$240.85	-8.33%	$43.63	$51.73	$1.56	$21.19	$0.00	$0.00	$218.95	$239.83	$1.01	$1.01
EFFEXOR XR	26	28	$1,385.80	$1,348.26	2.74%	$180.00	$205.00	-12.20%	$1,565.80	$1,553.26	0.77%	$180.00	$180.00	$0.00	$25.00	$0.00	$0.00	$1,565.80	$1,553.26	$0.00	$0.00
NOVOLOG MIX 70/30	27	42	$766.75	$293.63	161.43%	$71.42	$58.18	22.41%	$838.18	$351.81	138.46%	$57.14	$40.00	$14.28	$18.18	$0.00	$0.00	$837.32	$350.61	$0.85	$1.20
TECFIDERA	28	22	$5,330.92	$2,294.96	132.30%	$140.00	$2,294.96	-93.90%	$5,470.92	$4,589.92	19.20%	$40.00	$0.00	$100.00	$0.00	$0.00	$2,294.96	$5,470.92	$4,588.92	$0.00	$1.00
ZETIA	29	37	$333.02	$255.72	30.20%	$106.25	$111.72	-4.50%	$439.27	$367.44	19.35%	$81.25	$79.00	$25.00	$32.71	$0.00	$0.00	$438.86	$366.97	$0.40	$0.47
NEXIUM	30	19	$240.91	$244.97	-1.64%	$55.45	$58.18	-3.45%	$296.36	$303.15	-1.98%	$46.36	$49.09	$9.09	$9.09	$0.00	$0.00	$295.53	$302.15	$0.83	$1.00
SYMBICORT	31	40	$203.52	$182.19	11.54%	$73.90	$69.03	5.80%	$277.42	$251.23	10.36%	$39.61	$33.00	$34.28	$36.03	$0.00	$0.00	$276.45	$250.14	$0.97	$1.09
PENTASA	32	29	$646.51	$536.62	20.34%	$57.50	$60.00	-3.33%	$704.01	$596.62	17.95%	$45.00	$40.00	$12.50	$20.00	$0.00	$0.00	$702.85	$595.49	$1.15	$1.13
DULOXETINE HCL	33	7	$60.74	$266.63	-77.07%	$29.38	$31.83	-6.45%	$90.12	$298.47	-69.80%	$29.38	$31.83	$0.00	$0.00	$0.00	$0.00	$89.26	$297.70	$0.86	$0.77
GUANFACINE ER	34	0	$296.59	$0.00	0.00%	$29.41	$0.00	0.00%	$326.00	$0.00	0.00%	$29.41	$0.00	$0.00	$0.00	$0.00	$0.00	$325.28	$0.00	$0.72	$0.00
ELMIRON	35	27	$1,606.21	$1,428.48	12.39%	$100.00	$100.00	0.00%	$1,706.21	$1,528.48	11.58%	$100.00	$100.00	$0.00	$0.00	$0.00	$0.00	$1,706.21	$1,528.48	$0.00	$0.00
JARDIANCE	36	0	$359.43	$0.00	0.00%	$77.55	$0.00	0.00%	$436.98	$0.00	0.00%	$62.16	$0.00	$15.38	$0.00	$0.00	$0.00	$436.05	$0.00	$0.93	$0.00
CLOBETASOL PROPIONATE	37	69	$158.07	$75.06	110.67%	$20.00	$16.50	18.75%	$178.07	$91.57	94.51%	$20.00	$16.50	$0.00	$0.00	$0.00	$0.00	$177.51	$90.28	$0.56	$1.29
NIACIN ER	38	33	$207.82	$255.19	-18.43%	$26.66	$33.12	-18.18%	$234.49	$288.31	-18.40%	$26.66	$33.12	$0.00	$0.00	$0.00	$0.00	$233.68	$287.66	$0.80	$0.65
EMEND	39	0	$395.76	$0.00	0.00%	$63.83	$0.00	0.00%	$459.60	$0.00	0.00%	$10.90	$0.00	$52.92	$0.00	$0.00	$0.00	$459.49	$0.00	$0.10	$0.00
CELLCEPT	40	51	$361.27	$288.18	25.35%	$60.00	$60.00	0.00%	$421.27	$348.18	20.98%	$60.00	$60.00	$0.00	$0.00	$0.00	$0.00	$420.32	$347.20	$0.95	$0.97
LEVEMIR	41	73	$251.97	$144.98	73.61%	$53.75	$40.00	32.50%	$305.72	$184.98	65.22%	$47.50	$40.00	$6.25	$0.00	$0.00	$0.00	$304.92	$183.99	$0.80	$0.99
PREMARIN	42	41	$96.57	$53.31	81.13%	$67.13	$68.00	0.00%	$163.70	$121.31	34.71%	$54.94	$49.17	$12.19	$18.82	$0.00	$0.00	$163.03	$120.54	$0.67	$0.77
STRATTERA	43	58	$253.93	$224.28	12.95%	$72.00	$49.09	44.90%	$325.93	$273.37	19.05%	$65.33	$40.00	$6.66	$9.09	$0.00	$0.00	$324.90	$272.22	$1.03	$1.15
BYETTA	44	50	$1,194.09	$964.06	23.86%	$133.33	$133.33	0.00%	$1,327.42	$1,097.40	20.97%	$100.00	$100.00	$33.33	$33.33	$0.00	$0.00	$1,327.42	$1,097.40	$0.00	$0.00
DULERA	45	32	$396.00	$477.63	-16.98%	$93.33	$98.88	-5.10%	$489.33	$576.52	-15.10%	$71.11	$87.77	$22.22	$11.11	$0.00	$0.00	$488.89	$576.20	$0.44	$0.32
URSODIOL	46	170	$289.52	$52.11	455.77%	$20.00	$20.00	0.00%	$309.52	$72.11	329.17%	$20.00	$20.00	$0.00	$0.00	$0.00	$0.00	$309.36	$71.18	$0.15	$0.93
SUBOXONE	47	20	$275.47	$267.42	3.00%	$49.16	$51.86	-3.92%	$324.63	$319.29	1.57%	$40.83	$37.58	$8.33	$14.28	$0.00	$0.00	$323.61	$318.26	$1.02	$1.02
INTUNIV	48	30	$227.59	$184.46	23.37%	$60.00	$68.33	-11.76%	$287.59	$252.79	13.49%	$60.00	$60.00	$0.00	$8.33	$0.00	$0.00	$286.57	$251.62	$1.02	$1.17
NAMENDA	49	52	$285.85	$246.22	15.85%	$40.00	$40.00	0.00%	$325.85	$286.22	13.64%	$40.00	$40.00	$0.00	$0.00	$0.00	$0.00	$324.88	$285.22	$0.97	$0.99
ZENATANE	50	107	$341.60	$371.73	-8.09%	$20.00	$20.00	0.00%	$361.60	$391.73	-7.67%	$20.00	$20.00	$0.00	$0.00	$0.00	$0.00	$360.45	$390.48	$1.15	$1.25
ALL OTHER			$18.20	$17.49	0.00%	$14.19	$14.94	0.00%	$32.39	$32.43	0.00%	$12.72	$13.18	$1.46	$1.75	$0.00	$0.00	$31.58	$31.63	$0.76	$0.86
Total			**$50.91**	**$43.92**	**13.95%**	**$17.58**	**$18.76**	**-5.56%**	**$68.50**	**$62.69**	**8.06%**	**$14.75**	**$14.91**	**$1.94**	**$2.21**	**$0.88**	**$1.64**	**$67.70**	**$61.89**	**$0.76**	**$0.86**

Utilization																					
	Rank		Number of Rx			Rx Users			Rx Per User		Avg Quantity		Avg Days Supply		Plan Paid PMPM Amt			Util/1000		
Drug Name	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %	Current	Prior	Current	Prior	Current	Prior	Current	Prior	Chg %	Current	Prior	Chg %
AUBAGIO	1	1	13	8	62.50%	1	1	0.00%	13.00	8.00	28.00	28.00	28.00	28.00	$4.59	$2.56	79.30%	10.96	6.81	60.90%
CIMZIA	2	3	13	12	8.33%	1	1	0.00%	13.00	12.00	1.00	1.00	28.00	28.00	$2.60	$2.19	18.72%	10.96	10.22	7.27%
ORENCIA	3	4	13	11	18.18%	1	2	-50.00%	13.00	5.50	4.00	4.00	28.00	28.00	$2.59	$1.94	33.51%	10.96	9.37	17.02%
LANTUS SOLOSTAR	4	9	36	21	71.43%	10	11	-9.09%	3.60	1.91	30.00	31.42	51.00	67.00	$1.59	$0.75	112.00%	30.35	17.88	69.74%
CAPECITABINE	5	18	8	3	166.67%	2	1	100.00%	4.00	3.00	72.75	84.00	21.00	21.00	$1.27	$0.58	118.97%	6.74	2.55	164.05%
NOVOLOG MIX 70/30 PREFILLED FLEXPEN	6	10	13	5	160.00%	4	3	33.33%	3.25	1.67	53.07	111.00	47.00	74.00	$1.16	$0.74	56.76%	10.96	4.26	157.44%
TRUVADA	7	5	12	12	0.00%	1	1	0.00%	12.00	12.00	30.00	30.00	30.00	30.00	$1.08	$1.06	1.89%	10.12	10.22	-0.98%
REYATAZ	8	6	12	12	0.00%	1	1	0.00%	12.00	12.00	30.00	30.00	30.00	30.00	$1.02	$0.95	7.37%	10.12	10.22	-0.98%
NOVOLOG FLEXPEN	9	16	21	7	200.00%	9	5	80.00%	2.33	1.40	26.42	60.00	37.00	72.00	$0.94	$0.60	56.67%	17.70	5.96	197.05%
ABILIFY	10	14	17	14	21.43%	3	2	50.00%	5.67	7.00	27.35	30.00	30.00	30.00	$0.85	$0.66	28.79%	14.33	11.92	20.23%
XELODA	11	2	13	25	-48.00%	1	2	-50.00%	13.00	12.50	58.15	63.84	28.00	26.00	$0.84	$2.46	-65.85%	10.96	21.28	-48.51%
TACLONEX	12	0	8	0	0.00%	2	0	0.00%	4.00	0.00	120.00	0.00	30.00	0.00	$0.75	$0.00	0.00%	6.74	0.00	0.00%
LEVEMIR FLEXPEN	13	15	20	22	-9.09%	3	3	0.00%	6.67	7.33	23.25	22.50	30.00	31.00	$0.66	$0.62	6.45%	16.86	18.73	-9.99%
CLOMIPRAMINE HCL	14	8	3	6	-50.00%	1	2	-50.00%	3.00	3.00	360.00	225.00	90.00	60.00	$0.64	$0.81	-20.99%	2.53	5.11	-50.49%
JANUVIA	15	11	23	38	-39.47%	5	7	-28.57%	4.60	5.43	40.43	36.31	40.00	36.00	$0.60	$0.73	-17.81%	19.39	32.35	-40.07%
ADVAIR DISKUS	16	23	26	26	0.00%	8	9	-11.11%	3.25	2.89	78.46	69.23	39.00	34.00	$0.56	$0.48	16.67%	21.92	22.14	-0.98%
LANTUS	17	96	16	4	300.00%	4	4	0.00%	4.00	1.00	25.00	17.50	53.00	42.00	$0.54	$0.08	575.00%	13.49	3.41	296.07%
SPIRIVA HANDIHALER	18	24	20	21	-4.76%	4	4	0.00%	5.00	5.25	42.00	41.42	42.00	41.00	$0.50	$0.48	4.17%	16.86	17.88	-5.70%
METHYLPHENIDATE HCL ER	19	12	44	62	-29.03%	7	9	-22.22%	6.29	6.89	40.22	39.67	35.00	37.00	$0.49	$0.73	-32.88%	37.09	52.78	-29.73%
VORICONAZOLE	20	25	4	6	-33.33%	1	1	0.00%	4.00	6.00	60.00	60.00	30.00	30.00	$0.48	$0.46	4.35%	3.37	5.11	-33.99%
TROKENDI XR	21	0	13	0	0.00%	3	0	0.00%	4.33	0.00	30.00	0.00	30.00	0.00	$0.45	$0.00	0.00%	10.96	0.00	0.00%
HUMALOG KWIKPEN	22	13	13	22	-40.91%	5	3	66.67%	2.60	7.33	20.76	21.81	30.00	27.00	$0.42	$0.67	-37.31%	10.96	18.73	-41.49%
JANUMET	23	31	16	17	-5.88%	3	2	50.00%	5.33	8.50	85.00	74.11	43.00	47.00	$0.42	$0.31	35.48%	13.49	14.47	-6.81%
METFORMIN HCL ER	24	435	31	23	34.78%	10	8	25.00%	3.10	2.88	124.83	127.82	62.00	56.00	$0.41	$0.00	0.00%	26.13	19.58	33.46%
CRESTOR	25	35	33	23	43.48%	5	7	-28.57%	6.60	3.29	32.96	40.43	33.00	40.00	$0.40	$0.27	48.15%	27.82	19.58	42.07%
EFFEXOR XR	26	28	4	4	0.00%	1	1	0.00%	4.00	4.00	180.00	225.00	90.00	90.00	$0.38	$0.38	0.00%	3.37	3.41	-0.98%
NOVOLOG MIX 70/30	27	42	7	11	-36.36%	3	1	200.00%	2.33	11.00	38.57	20.00	38.00	25.00	$0.37	$0.22	68.18%	5.90	9.37	-36.99%
TECFIDERA	28	22	1	3	-66.67%	1	1	0.00%	1.00	3.00	60.00	60.00	30.00	30.00	$0.37	$0.48	-22.92%	0.84	2.55	-67.00%
ZETIA	29	37	16	15	6.67%	4	4	0.00%	4.00	3.75	63.75	66.00	63.00	66.00	$0.37	$0.27	37.04%	13.49	12.77	5.62%
NEXIUM	30	19	22	33	-33.33%	6	5	20.00%	3.67	6.60	37.50	39.09	37.00	39.00	$0.37	$0.57	-35.09%	18.55	28.10	-33.99%
SYMBICORT	31	40	26	20	30.00%	9	5	80.00%	2.89	4.00	10.85	10.38	34.00	33.00	$0.37	$0.25	48.00%	21.92	17.03	28.72%
PENTASA	32	29	8	10	-20.00%	2	2	0.00%	4.00	5.00	172.50	168.00	30.00	30.00	$0.36	$0.38	-5.26%	6.74	8.51	-20.79%
DULOXETINE HCL	33	7	84	49	71.43%	17	15	13.33%	4.94	3.27	46.98	56.32	45.00	46.00	$0.35	$0.92	-61.96%	70.81	41.72	69.74%
GUANFACINE ER	34	0	17	0	0.00%	4	0	0.00%	4.25	0.00	44.11	0.00	44.00	0.00	$0.35	$0.00	0.00%	14.33	0.00	0.00%
ELMIRON	35	27	3	4	-25.00%	1	1	0.00%	3.00	4.00	270.00	270.00	90.00	90.00	$0.33	$0.40	-17.50%	2.53	3.41	-25.74%
JARDIANCE	36	0	13	0	0.00%	3	0	0.00%	4.33	0.00	39.23	0.00	39.00	0.00	$0.32	$0.00	0.00%	10.96	0.00	0.00%
CLOBETASOL PROPIONATE	37	69	28	26	7.69%	13	17	-23.53%	2.15	1.53	49.46	53.26	20.00	20.00	$0.31	$0.13	138.46%	23.60	22.14	6.63%
NIACIN ER	38	33	21	16	31.25%	4	4	0.00%	5.25	4.00	61.42	69.37	44.00	52.00	$0.30	$0.28	7.14%	17.70	13.62	29.96%
EMEND	39	0	11	0	0.00%	3	0	0.00%	3.67	0.00	2.81	0.00	2.00	0.00	$0.30	$0.00	0.00%	9.27	0.00	0.00%
CELLCEPT	40	51	12	10	20.00%	1	1	0.00%	12.00	10.00	60.00	54.00	30.00	27.00	$0.30	$0.20	50.00%	10.12	8.51	18.82%
LEVEMIR	41	73	16	12	33.33%	2	1	100.00%	8.00	12.00	12.50	10.00	29.00	28.00	$0.28	$0.12	133.33%	13.49	10.22	32.02%
PREMARIN	42	41	41	61	-32.79%	12	14	-14.29%	3.42	4.36	44.63	39.83	44.00	43.00	$0.27	$0.23	17.39%	34.56	51.93	-33.45%
STRATTERA	43	58	15	11	36.36%	2	2	0.00%	7.50	5.50	30.00	30.00	30.00	30.00	$0.26	$0.17	52.94%	12.64	9.37	35.02%
BYETTA	44	50	3	3	0.00%	1	1	0.00%	3.00	3.00	7.20	7.20	90.00	90.00	$0.25	$0.20	25.00%	2.53	2.55	-0.98%
DULERA	45	32	9	9	0.00%	4	4	0.00%	2.25	2.25	26.00	33.22	63.00	76.00	$0.25	$0.30	-16.67%	7.59	7.66	-0.98%
URSODIOL	46	170	12	8	50.00%	2	2	0.00%	6.00	4.00	87.50	86.25	30.00	30.00	$0.24	$0.02	1,100.00%	10.12	6.81	48.53%
SUBOXONE	47	20	12	28	-57.14%	2	3	-33.33%	6.00	9.33	45.00	48.57	27.00	25.00	$0.23	$0.53	-56.60%	10.12	23.84	-57.56%
INTUNIV	48	30	14	24	-41.67%	3	2	50.00%	4.67	12.00	28.85	30.00	28.00	30.00	$0.22	$0.31	-29.03%	11.80	20.43	-42.24%
NAMENDA	49	52	11	11	0.00%	1	1	0.00%	11.00	11.00	60.00	60.00	30.00	30.00	$0.22	$0.19	15.79%	9.27	9.37	-0.98%
ZENATANE	50	107	9	3	200.00%	2	1	100.00%	4.50	3.00	40.00	43.33	30.00	30.00	$0.21	$0.07	200.00%	7.59	2.55	197.06%
ALL OTHER			12,832	12,709	0.97%	1,004	947	6.02%	12.78	13.42	58.65	58.71	36.00	36.00	$16.41	$15.77	4.06%	10,817.28	10,820.01	-0.03%
Total			**13,675**	**13,475**	**1.48%**	**1,007**	**953**	**5.67%**	**13.58**	**14.14**	**57.96**	**58.18**	**37.00**	**36.00**	**$48.91**	**$41.99**	**16.48%**	**11,527.92**	**11,472.15**	**0.49%**

Notes:
- * = Drug not found in prior period.
- TOTAL represents the summation of all Prescriptions for analysis period (including claims not ranked).
- ALL OTHER represents the difference between all prescriptions and prescriptions ranked for analysis period.
- Brand/Generic = (G) Generic, (MS) Multi-Source Brand, (SS) Single Source Brand.
- Plan Paid Amount does not include sales tax.

Item 4

Benefits Match-Up – a,b,c

Please return these documents as a part of your proposal in Word format.

If not provided previously, the following Exhibit can be provided in Word format via email request, directed to:

Theresa Conley
tconley@siver.com

Item 5

Most Utilized Provider Comparison Match-Up

Please return this documents as a part of your proposal in Excel format.

If not provided previously, the following Exhibit can be provided in Excel format via email request, directed to:

Theresa Conley
tconley@siver.com

Item 6

Medical Census – 2 Tabs

If not provided previously, the following Exhibit can be provided in Excel format via email request, directed to:

Theresa Conley
tconley@siver.com