Record Type	Work Status	Birthdate	Hire Date	Gender	Plan	Level
employee	Active	12/31/1972	08/03/1999	F	Plan 5781 PPO High a	Employee
employee	Active	10/07/1978	10/12/2004	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/29/1987	08/03/2021	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/01/1965	01/07/2019	F	Plan 54 HMO High a	Employee
employee	Active	11/10/1983	08/09/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/16/1985	01/07/2008	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/03/1984	08/13/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/07/1972	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/19/1974	08/18/2009	F	Plan 54 HMO High a	Employee
employee	Active	11/30/1957	09/21/2021	F	Plan 54 HMO High a	Employee
employee	Active	05/15/1971	08/14/2015	F	Plan 5781 PPO High a	Employee
employee	Active	04/09/1977	08/12/2008	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	03/12/1972	02/01/1990	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	06/02/1988	08/09/2016	M	Plan 54 HMO High a	Employee
employee	Active	06/17/1986	08/17/2010	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/20/1985	09/04/2019	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/18/1964	08/23/2010	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/28/1980	06/09/2014	F	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	05/23/2005		M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	03/31/2009		F	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	12/27/1972	10/15/2012	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	02/03/1988	10/03/2016	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/01/1977	05/01/2007	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/27/1959	08/17/2010	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	04/20/1972	08/03/1999	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/16/1956	11/15/1988	M	Plan 5781 PPO High b	Employee Only
employee	Active	07/09/1989	08/09/2018	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/19/1956	07/01/2010	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/23/1956	08/05/1999	F	Plan 5781 PPO High a	Employee
employee	Active	11/18/1968	01/15/2016	F	Plan 5781 PPO High a	Employee
employee	Active	08/27/1963	08/15/1988	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/25/1967	08/02/1993	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	07/31/1969	08/08/2002	F	Plan 54 HMO High b	Employee Only
employee	Active	03/10/1978	08/04/2003	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/27/1987	08/03/2021	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	03/19/1972	08/18/2009	F	Plan 5781 PPO High a	Employee
employee	Active	02/19/1976	08/04/2003	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	06/07/1976	08/01/2005	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	03/24/1970	12/07/2009	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/31/1963	08/02/2004	M	Plan 5781 PPO High b	Employee Only
employee	Active	03/26/1970	09/19/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/28/1975	08/19/2013	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/17/1994	09/02/2014	F	Plan 54 HMO High a	Employee
employee	Active	01/07/1968	08/01/2016	F	Plan 54 HMO High a	Employee
employee	Active	11/25/1969	08/07/2001	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	07/04/1976	08/03/2021	F	Plan 5781 PPO High a	Employee
employee	Active	12/17/1967	10/14/2008	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/13/1961	08/03/2015	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	05/08/1979	03/15/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/27/1972	08/18/2014	F	Plan 5781 PPO High a	Employee
employee	Active	09/22/1961	08/09/2016	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/19/1964	09/29/2020	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/10/1974	08/21/2009	F	Plan 54 HMO High a	Employee
employee	Active	07/18/1972	08/03/1999	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/18/1965	09/06/2007	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/27/1981	08/09/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/18/1979	07/01/2013	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/08/1966	07/11/2005	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
Child	Active	04/13/1997		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	11/04/1965	01/16/1996	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)

Child	Active	03/29/2000		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	07/28/1971	09/22/1994	F	Plan 54 HMO High a	Employee
employee	Active	06/04/1993	04/24/2017	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/25/1969	01/04/2016	F	Plan 5781 PPO High a	Employee
employee	Active	04/06/1964	10/09/2007	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/06/1962	08/09/2018	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/03/1965	08/17/2010	F	Plan 5781 PPO High a	Employee
employee	Active	01/21/1974	08/03/2018	F	Plan 54 HMO High a	Employee
employee	Active	01/19/1996	11/28/2016	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/21/1970	08/03/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	03/06/2003		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	07/10/1978	08/09/2018	F	Plan 5781 PPO High a	Employee
Child	Active	12/15/2007		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	04/17/1984	12/02/2019	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	09/03/2005		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	03/18/1971	08/09/2016	F	Plan 5781 PPO High a	Employee
employee	Active	12/17/1964	08/04/1998	F	Plan 54 HMO High a	Employee
employee	Active	01/09/1972	09/15/2014	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/17/1958	08/11/2011	F	Plan 5781 PPO High a	Employee
employee	Active	04/30/1962	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/01/2001	01/04/2022	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/29/1962	08/18/1994	F	Plan 5781 PPO High a	Employee
employee	Active	05/18/1994	08/03/2021	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/30/1977	08/13/2014	F	Plan 54 HMO High a	Employee
employee	Active	08/03/1960	01/25/1993	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/27/1980	11/29/2010	M	Plan 5781 PPO High a	Employee
employee	Active	10/26/1972	08/11/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/27/1982	08/09/2016	F	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	01/24/2011		M	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	07/12/2013		M	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	04/29/2008		F	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	04/14/1973	08/11/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/24/1971	09/18/2012	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/19/1971	08/12/2015	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/16/1992	06/06/2022	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/05/1959	08/13/2014	F	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	01/13/1971	07/01/2013	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	07/17/1962	08/03/2015	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/30/1960	09/02/1997	F	Plan 5781 PPO High a	Employee
employee	Active	05/31/1959	09/10/2012	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	06/11/1968	08/04/2005	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/21/1965	08/05/2002	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/15/1966	08/05/2002	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	05/05/1959	01/27/1997	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
Spouse	Active	03/21/1961		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
employee	Active	03/15/1978	08/04/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/07/1973	08/14/2007	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	07/12/1963	08/20/1996	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	01/15/1972	08/03/2020	F	Plan 54 HMO High a	Employee
employee	Active	10/18/1963	08/05/2002	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
Child	Active	11/23/2010		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	02/26/2007		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	05/24/1979	08/20/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	12/28/1978	06/03/2016	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/10/1969	08/07/2001	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	07/25/1998		M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	02/07/1962	08/03/1999	M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	04/03/1995		M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	08/24/1966	07/13/2020	M	Plan 5781 PPO High a	Employee
employee	Active	06/10/1990	08/05/2019	M	Plan 54 HMO High a	Employee
employee	Active	06/06/1963	02/20/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee

employee	Active	02/22/1977	03/06/2012	F	Plan 54 HMO High a	Employee
employee	Active	02/05/1966	08/15/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/06/1968	08/16/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/11/1967	07/28/2020	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/10/1971	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/17/1978	11/27/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/11/1990	07/26/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/23/1991	08/15/2016	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/07/1969	08/04/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/16/1983	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/28/1962	02/14/2005	F	Plan 54 HMO High a	Employee
employee	Active	11/14/1958	09/02/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/13/1970	11/18/2014	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	09/03/2021		F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	08/25/1987	08/17/2010	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	08/03/2017		F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	02/06/1981	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/02/1989	03/05/2008	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/02/1973	08/14/2007	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/25/1982	08/09/2012	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/19/1978	08/26/2003	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	09/20/1970	08/03/2018	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/12/1965	01/27/1997	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/30/1976	08/03/1999	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/06/1966	08/17/2010	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/09/1960	08/19/1993	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	05/18/1966	07/07/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/26/1955	03/05/2007	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	05/26/1964	07/30/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/02/1973	08/14/2007	F	Plan 54 HMO High a	Employee
Child (FT College Student)	Active	06/28/2002		F	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
Child (FT College Student)	Active	05/06/1998		M	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	05/07/1971	08/19/1997	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	01/16/1979	08/03/2017	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/24/1988	08/31/2020	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/28/1966	06/21/2010	F	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	03/08/1972	08/05/2019	F	Plan 5781 PPO High a	Employee
employee	Active	09/14/1990	08/11/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/06/1971	01/24/2011	M	Plan 5781 PPO High a	Employee
employee	Active	07/21/1963	05/24/1999	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	01/30/1985	03/23/2015	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/08/1965	03/21/1994	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/28/1971	08/04/2003	M	Plan 54 HMO High b	Employee Only
employee	Active	12/10/1985	08/09/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/06/1962	08/15/1983	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	01/14/1964	08/25/1997	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	03/10/1967	08/17/2007	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/06/1967	08/11/2015	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/26/1962	08/03/2018	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	02/28/1964	10/10/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/13/1960	07/15/2020	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/12/1983	01/25/2016	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	08/03/1963	02/24/1997	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	06/06/1968	01/03/2011	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/01/1962	06/19/2006	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	03/10/1980	08/28/2017	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	12/12/1988	08/27/2014	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/08/1977	08/11/2015	F	Plan 54 HMO High a	Employee
employee	Active	10/11/1972	08/03/2017	M	Plan 54 HMO High a	Employee
employee	Active	11/24/1981	08/06/2018	F	Plan 54 HMO High a	Employee
employee	Active	12/26/1967	10/27/2008	F	Plan 5781 PPO High a	Employee

employee	Active	01/26/1991	08/13/2014	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	09/11/1961	08/14/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/02/1982	11/26/2007	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	02/28/1962	09/01/2011	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	11/07/1968	08/20/1996	F	Plan 5781 PPO High a	Employee
employee	Active	07/13/1975	08/03/2018	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/20/1970	05/21/2003	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	01/13/1968	01/04/1989	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/05/1976	09/01/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/27/1964	09/07/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/21/1996	08/03/2020	F	Plan 54 HMO High a	Employee
employee	Active	07/11/1980	08/04/2003	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/26/1970	08/02/2004	F	Plan 5781 PPO High a	Employee
employee	Active	01/29/1968	08/20/1996	M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	01/10/2001		M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	09/24/2007		F	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child (FT College Student)	Active	10/07/1997		F	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	02/04/1977	08/03/2020	F	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	11/09/2015		M	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	01/19/2007		F	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	10/05/2004		M	Plan 54 HMO High a	Employee + Child(ren)
Child (FT College Student)	Active	07/18/2002		M	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	04/26/1964	11/19/1993	F	Plan 5781 PPO High b	Employee Only
employee	Active	01/06/1983	07/01/2019	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/14/1968	03/16/2015	F	Plan 54 HMO High a	Employee
employee	Active	09/21/1961	11/27/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	12/23/1993		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	12/08/1969	01/06/1992	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	02/05/2002		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child (FT College Student)	Active	04/17/1996		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	03/20/1993	08/03/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/05/1987	08/17/2012	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	06/10/1980	08/16/2021	F	Plan 54 HMO High a	Employee
employee	Active	11/11/1977	01/08/2008	F	Plan 54 HMO High a	Employee
employee	Active	04/02/1960	09/25/2009	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/17/1974	08/07/2018	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	06/28/1963	12/08/2011	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/21/1974	08/02/2004	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/31/1957	08/14/2007	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	01/16/2002	04/27/2022	M	Plan 54 HMO High a	Employee
employee	Active	03/20/1975	08/16/2011	F	Plan 5781 PPO High a	Employee
employee	Active	10/14/1957	01/01/1984	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/10/1968	08/17/2007	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/31/1986	10/19/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/02/1971	08/05/2019	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	09/27/1967	08/11/2015	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/04/1958	01/03/2011	F	Plan 5781 PPO High a	Employee
employee	Active	12/31/1988	06/12/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/05/1987	08/14/2012	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	09/15/1988	01/08/2020	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	02/25/1963	09/12/2016	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/31/1968	03/03/2011	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/18/1978	08/05/2019	M	Plan 54 HMO High a	Employee
employee	Active	03/16/1983	05/15/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/21/1995	08/03/2020	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/16/1967	11/04/2021	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/09/1979	08/03/2020	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/23/1978	02/28/2000	F	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	07/02/2008		M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	06/13/2004		M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	06/14/1966	08/14/2012	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only

employee	Active	04/08/1965	04/10/1995	F	Plan 54 HMO High a	Employee
employee	Active	08/04/1991	09/10/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/26/1964	08/01/2005	F	Plan 5781 PPO High a	Employee
employee	Active	07/14/1964	08/19/1997	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	01/21/1983	07/08/2013	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	05/27/1974	09/07/2018	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	09/05/1967	08/24/2021	F	Plan 54 HMO High a	Employee
employee	Active	05/30/1986	08/30/2021	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/13/1984	08/03/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/28/1959	08/09/2018	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/27/1987	11/19/2020	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/09/1975	08/02/2004	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/17/1962	08/14/2008	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
Spouse	Active	09/10/1959		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
employee	Active	12/05/1979	08/14/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/28/1961	03/15/1999	F	Plan 5781 PPO High a	Employee
employee	Active	04/20/1964	08/17/1993	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/27/1966	08/07/2001	F	Plan 5781 PPO High a	Employee
employee	Active	01/05/1958	03/27/2006	F	Plan 5781 PPO High a	Employee
employee	Active	09/05/1986	05/03/2021	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/01/1969	08/16/1994	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
Child (FT College Student)	Active	08/26/1999		F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	01/07/1960	09/07/2010	F	Plan 5781 PPO High a	Employee
employee	Active	02/03/1971	08/24/2005	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/24/1973	08/16/1995	F	Plan 5781 PPO High b	Employee Only
employee	Active	10/03/1958	01/20/2011	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	05/31/1974	08/14/2015	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
Child	Active	06/04/2016		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	02/26/2020		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	06/01/1985	08/14/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	09/24/2013		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	07/16/1975	08/14/2007	M	Plan 5781 PPO High a	Employee
Child (FT College Student)	Active	05/06/1998		M	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	04/06/2001		M	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	08/14/1969	11/19/2002	F	Plan 5192/93 PPO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	04/22/1968	01/03/2011	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	02/11/1969	11/01/2002	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	09/05/1967	08/14/2007	F	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	07/16/1991	02/11/2019	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/06/1996	07/12/2021	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/08/1979	08/04/2003	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/18/1977	10/10/2016	M	Plan 54 HMO High a	Employee
employee	Active	06/28/1969	08/01/2005	F	Plan 54 HMO High a	Employee + Family
Child	Active	09/19/2006		M	Plan 54 HMO High a	Employee + Family
Spouse	Active	10/29/1959		M	Plan 54 HMO High a	Employee + Family
employee	Active	04/27/1977	08/03/2021	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/08/1962	08/22/2016	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/04/1980	08/04/2003	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/14/1966	07/31/2017	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	08/21/1971	08/07/2001	F	Plan 54 HMO High a	Employee
employee	Active	04/06/1950	08/18/2009	F	Plan 5781 PPO High a	Employee
employee	Active	01/06/1969	08/14/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/16/1963	09/05/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/24/1967	09/05/1989	M	Plan 54 HMO High a	Employee
employee	Active	08/26/1966	08/23/2017	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/25/1966	08/03/1999	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/02/1984	08/17/2010	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/21/1980	12/08/2003	F	Plan 5781 PPO High a	Employee
employee	Active	05/08/1974	08/02/2004	F	Plan 5781 PPO High b	Employee + Child(ren)
Child	Active	07/13/2001		F	Plan 5781 PPO High b	Employee + Child(ren)
Child	Active	07/13/2001		F	Plan 5781 PPO High b	Employee + Child(ren)

employee	Active	04/08/1962	08/03/2021	F	Plan 5781 PPO High a	Employee
employee	Active	11/02/1972	08/01/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/15/1963	08/17/2010	M	Plan 5781 PPO High a	Employee
employee	Active	07/01/1963	08/04/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/27/1993	08/05/2019	F	Plan 5781 PPO High a	Employee
employee	Active	03/10/1982	08/04/2006	F	Plan 5781 PPO High a	Employee
employee	Active	08/27/1962	01/10/2005	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/11/1995	08/03/2020	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/29/1984	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	06/09/2007		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	09/25/2004		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	07/30/1981	08/14/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child (FT College Student)	Active	12/13/1994		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	07/02/1974	08/09/2016	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
Child	Active	04/01/2022		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	10/14/1988	08/23/2018	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	09/20/1991	01/25/2016	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/14/1971	08/03/1999	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/02/1980	08/14/2007	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/14/1970	03/21/2005	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/08/1976	08/04/2005	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/28/1992	01/05/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/02/1960	09/16/2004	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/27/1978	08/01/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
Child	Active	11/11/1998		M	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	09/23/1973	07/20/2020	F	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	08/06/2001		F	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	07/02/1975	08/16/2011	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/12/1996	05/23/2022	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/27/1981	08/13/2013	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/01/1999	08/03/2021	F	Plan 54 HMO High a	Employee
employee	Active	08/06/1989	08/03/2021	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/17/1995	08/16/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/09/1980	08/18/2014	F	Plan 5781 PPO High a	Employee
employee	Active	06/12/1963	02/25/2008	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	05/07/1963	08/22/1989	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/08/1983	08/13/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/13/1971	11/27/1995	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/04/1974	12/01/1999	F	Plan 54 HMO High a	Employee
employee	Active	07/29/1970	07/23/2001	F	Plan 5781 PPO High a	Employee
employee	Active	01/06/1986	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Family
Child	Active	12/09/2009		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Family
Spouse	Active	07/12/1983		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Family
Child	Active	01/24/2014		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Family
employee	Active	10/25/1970	08/13/1991	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/23/1995	12/14/2021	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/27/1974	04/11/2005	M	Plan 54 HMO High a	Employee
employee	Active	09/05/1969	08/17/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/23/1969	08/18/1992	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	02/06/1973	08/30/1999	M	Plan 54 HMO High a	Employee
employee	Active	08/23/1985	05/29/2007	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/11/1977	09/22/2014	F	Plan 5781 PPO High a	Employee
employee	Active	11/06/1970	08/05/2002	F	Plan 54 HMO High a	Employee
employee	Active	06/25/1968	08/21/1990	F	Plan 5781 PPO High a	Employee
employee	Active	03/14/1958	09/24/1999	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/08/1986	08/13/2013	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/19/1985	08/24/2020	F	Plan 54 HMO High a	Employee
employee	Active	04/11/1968	08/18/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/04/1979	10/03/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/15/1988	08/03/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/07/1964	08/08/2002	F	Plan 122/123 HMO Low (HSA Comp) a	Employee

employee	Active	06/14/1979	03/07/2013	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/04/1970	08/03/2020	F	Plan 54 HMO High a	Employee
employee	Active	08/22/1990	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/22/1970	11/16/2015	M	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
Child	Active	05/11/1995		F	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	12/06/1997		F	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
Child	Active	11/19/2007		F	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	12/06/1972	06/16/2003	M	Plan 122/123 HMO Low (HSA Comp) b	Employee + Child(ren)
employee	Active	12/21/1993	12/02/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/23/1966	08/05/2002	F	Plan 5781 PPO High a	Employee
employee	Active	05/01/1961	03/04/2019	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/19/1988	08/11/2015	F	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	10/28/1980	08/05/2004	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	12/21/1999		M	Plan 54 HMO High a	Employee + Family
Spouse	Active	03/27/1967		M	Plan 54 HMO High a	Employee + Family
employee	Active	11/24/1971	08/17/2010	F	Plan 54 HMO High a	Employee + Family
employee	Active	08/11/1954	08/20/1984	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/20/1967	08/09/2016	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	03/26/1987	07/01/2021	F	Plan 5781 PPO High a	Employee
employee	Active	05/28/1985	09/12/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/07/1976	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/16/1960	08/05/2019	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	03/17/1964	08/03/2020	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/14/1988	01/12/2015	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	03/21/1974	10/10/2016	F	Plan 5781 PPO High a	Employee
employee	Active	02/12/1971	01/03/2005	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/20/1965	09/16/2020	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	10/22/2004		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
Child (FT College Student)	Active	02/15/2002		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	01/02/1973	08/16/2013	F	Plan 54 HMO High a	Employee
employee	Active	08/29/1973	08/14/2007	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	06/08/1962	08/13/2013	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/29/1976	08/09/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/16/2002	03/07/2022	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/18/1983	02/14/2014	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	12/01/1986	08/05/2019	F	Plan 54 HMO High a	Employee
employee	Active	12/17/1967	10/21/2016	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	06/21/1982	12/12/2011	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/20/1961	08/15/2014	F	Plan 54 HMO High a	Employee
employee	Active	03/26/1976	10/18/2010	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/30/1979	08/23/2010	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/11/1958	03/23/2018	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	07/24/1990	01/21/2020	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	01/06/2003		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	07/17/2008		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	10/28/1970	09/17/2009	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	08/30/1999		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	11/24/1973	08/31/1998	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/31/1993	08/11/2015	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	11/27/2021		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	08/28/2019		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	12/06/1969	12/10/2019	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	09/01/1989	11/02/2021	F	Plan 54 HMO High a	Employee
employee	Active	06/27/1973	01/28/2019	F	Plan 54 HMO High a	Employee
employee	Active	11/26/1962	10/10/2006	F	Plan 54 HMO High a	Employee
employee	Active	10/24/1997	10/02/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/13/1980	05/13/2019	F	Plan 5781 PPO High a	Employee
employee	Active	04/18/1970	09/16/2004	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/22/1946	10/01/1999	M	Plan 5781 PPO High a	Employee
employee	Active	05/06/1988	02/19/2019	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/02/1995	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)

Child	Active	08/13/2020		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	03/01/2019		F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	11/17/1980	08/18/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/05/1998	07/06/2021	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/17/1965	11/09/2020	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/04/1959	02/19/2008	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/18/2001	01/13/2022	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/31/1984	10/07/2020	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/01/1973	08/08/2002	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/09/1972	08/13/2014	F	Plan 5781 PPO High a	Employee
employee	Active	05/10/1981	08/19/2011	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/25/1978	08/02/2004	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	03/31/1969	10/09/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/22/1977	10/04/2004	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	04/01/1964	08/01/2000	F	Plan 5781 PPO High a	Employee
employee	Active	08/07/1962	09/14/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	07/14/1966	11/10/1997	F	Plan 5781 PPO High a	Employee
employee	Active	01/01/1985	08/05/2019	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/28/1982	08/01/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	07/11/1997	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/27/1965	10/04/2021	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	01/24/1968	01/04/2017	F	Plan 54 HMO High a	Employee + Spouse
Spouse	Active	11/03/1965		M	Plan 54 HMO High a	Employee + Spouse
employee	Active	07/12/1962	08/11/2015	F	Plan 54 HMO High a	Employee
employee	Active	11/22/1996	01/12/2022	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	08/07/1970	01/24/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
Child	Active	02/02/2006		F	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	04/06/1971	08/17/2010	F	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	12/18/1979	04/26/2021	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/09/1994	03/16/2020	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/14/1961	12/01/2008	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
Spouse	Active	04/22/1958		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
employee	Active	04/13/1987	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Spouse	Active	04/04/1960		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
employee	Active	05/22/1960	08/14/1984	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Spouse
employee	Active	11/12/1977	01/23/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/23/1970	09/02/2003	F	Plan 5781 PPO High a	Employee
employee	Active	11/07/1968	02/12/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/28/1991	08/09/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/25/1980	10/05/2021	F	Plan 5781 PPO High a	Employee
employee	Active	11/30/1980	08/14/2008	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/26/1968	08/03/2020	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/06/1961	09/03/1996	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	02/06/1972	10/08/2014	F	Plan 5781 PPO High a	Employee
employee	Active	06/07/1976	08/03/2018	F	Plan 54 HMO High a	Employee
employee	Active	12/01/1971	08/15/2006	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/04/1961	08/16/2011	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/16/1967	08/07/2001	F	Plan 5192/93 PPO Low (HSA Comp) b	Employee Only
employee	Active	07/03/1990	08/03/2020	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/20/1977	08/01/2000	M	Plan 54 HMO High b	Employee Only
employee	Active	12/02/1980	05/23/2005	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	06/24/1969	09/10/2019	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/10/1990	08/13/2015	M	Plan 54 HMO High a	Employee
employee	Active	01/24/1978	08/13/2020	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	10/12/1984	08/18/2009	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/14/1975	07/07/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	07/08/1981	08/20/2012	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	09/09/1967	05/26/1994	F	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	03/27/1970	08/21/2009	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/30/1984	11/17/2014	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	10/02/1982	06/22/2015	M	Plan 122/123 HMO Low (HSA Comp) a	Employee

employee	Active	09/18/1979	08/04/2003	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	07/14/1968	08/16/1994	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	05/03/1963	08/01/2005	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	04/28/1957	10/15/2018	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/06/1980	08/03/2015	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	03/19/1958	10/15/1996	F	Plan 5781 PPO High a	Employee
employee	Active	02/11/1998	10/05/2021	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	05/20/1974	08/19/1997	F	Plan 54 HMO High a	Employee
employee	Active	02/18/1969	08/02/2004	F	Plan 54 HMO High a	Employee
employee	Active	07/08/1957	11/12/2002	F	Plan 54 HMO High a	Employee
employee	Active	01/02/1975	09/29/2020	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	08/12/1957	01/26/2010	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/29/1975	08/04/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/20/1967	08/09/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	10/16/1999		M	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	03/18/2002		F	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	06/17/2005		M	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	07/28/1972	10/25/2004	F	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	01/18/1982	08/03/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/05/1955	08/17/2010	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	10/11/1976	09/28/2021	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	01/08/1970	01/12/2006	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	12/12/1974	08/19/2011	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	04/21/1974	08/04/2006	F	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	11/30/2008		M	Plan 54 HMO High a	Employee + Child(ren)
Child (FT College Student)	Active	05/09/1998		M	Plan 54 HMO High a	Employee + Child(ren)
Child (FT College Student)	Active	02/09/2000		F	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	10/27/2003		M	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	01/29/1972	03/03/2011	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/17/1978	08/03/2020	F	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	12/17/2001		M	Plan 54 HMO High a	Employee + Child(ren)
Child	Active	08/07/1999		F	Plan 54 HMO High a	Employee + Child(ren)
employee	Active	01/02/1981	08/17/2007	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	05/03/1991	08/11/2014	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
Child	Active	09/26/2017		F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	03/02/1988	08/14/2012	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
Child	Active	09/21/2015		F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Child(ren)
employee	Active	10/26/1956	02/01/2001	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	01/06/1960	01/20/1995	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/15/1960	08/19/2011	M	Plan 122/123 HMO Low (HSA Comp) b	Employee Only
employee	Active	07/13/1969	08/17/2010	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	06/20/1961	08/09/2016	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/09/1992	08/03/2020	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	11/13/1970	08/07/2001	F	Plan 54 HMO High a	Employee
employee	Active	04/01/1958	08/04/2003	F	Plan 5781 PPO High a	Employee
employee	Active	02/14/1957	08/16/1994	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/23/1979	08/04/2003	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee
Spouse	Active	03/14/1961		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Family
Child	Active	07/10/2001		M	Plan 122/123 HMO Low (HSA Comp) a	Employee + Family
employee	Active	09/14/1963	01/03/2005	F	Plan 122/123 HMO Low (HSA Comp) a	Employee + Family
employee	Active	11/27/1989	08/03/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	03/17/1969	12/01/1991	M	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	05/14/1967	08/20/1991	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee
employee	Active	11/09/1971	08/18/2006	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Family
Child (FT College Student)	Active	12/18/1998		F	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Family
Spouse	Active	11/05/1970		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Family
Child (FT College Student)	Active	02/12/1997		M	Plan 5192/93 PPO Low (HSA Comp) a	Employee + Family
employee	Active	12/02/1969	08/16/2011	F	Plan 5781 PPO High a	Employee
employee	Active	02/27/1959	08/17/2010	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Active	12/14/1958	08/21/1990	F	Plan 122/123 HMO Low (HSA Comp) a	Employee
employee	Retiree	11/07/1957	01/01/2010	F	Plan 5781 PPO High a	Employee + Spouse

Spouse	Retiree			M	Plan 5781 PPO High a	Employee + Spouse
employee	Retiree	05/22/1959	08/30/1982	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	09/20/1962	05/28/2021	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	08/05/1959	06/28/2006	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	09/01/1964	08/18/1987	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	09/23/1959	08/09/2016	F	Plan 54 HMO High a	Employee Only
employee	Retiree	11/15/1958	08/07/2017	F	Plan 122/123 HMO Low (HSA Comp) a	Employee Only
employee	Retiree	07/28/1957	01/06/1986	M	Plan 122/123 HMO Low (HSA Comp) a	Employee Only
employee	Retiree	10/17/1958	11/03/2000	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	12/29/1958	10/03/2005	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	11/17/1940	01/01/2010	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	01/21/1962	12/15/1986	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	12/04/1962	08/04/2006	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	10/19/1960	05/24/1993	M	Plan 5781 PPO High a	Employee Only
employee	Retiree	07/23/1959	11/16/1992	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	11/17/1956	07/05/2016	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	04/24/1960	08/19/1993	F	Plan 122/123 HMO Low (HSA Comp) a	Employee Only
employee	Retiree	12/08/1957	08/03/1987	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	03/21/1960	08/17/1982	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	11/28/1957	09/16/1985	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	08/03/1957	08/22/1996	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	01/16/1959	08/22/1989	M	Plan 54 HMO High a	Employee Only
employee	Retiree	02/11/1961	08/27/1990	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	03/27/1962	08/03/2018	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	06/25/1962	08/20/1985	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	11/05/1959	08/04/1998	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	09/01/1959	08/03/2017	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	04/06/1964	08/01/1994	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	06/14/1958	07/01/1979	M	Plan 5781 PPO High a	Employee Only
employee	Retiree	10/28/1957	08/28/2000	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	06/15/1959	08/22/1989	F	Plan 54 HMO High a	Employee Only
employee	Retiree	04/11/1959	01/22/1996	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	09/10/1935	05/01/2012	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	06/01/1951	08/19/1997	M	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	04/29/1959	08/21/1997	F	Plan 5781 PPO High a	Employee Only
employee	Retiree	11/25/1967	03/20/1995	F	Plan 122/123 HMO Low (HSA Comp) a	Employee Only
employee	Retiree	05/08/1974	08/07/1998	F	Plan 5192/93 PPO Low (HSA Comp) a	Employee Only
employee	Retiree	09/20/1975	08/07/2001	F	Plan 122/123 HMO Low (HSA Comp) a	Employee Only

Monitoring by Utilization and Enrollment

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2020 to 04/2021
Current Paid Period: From 05/2020 to 07/2021

	Enrollment		Premium			Capitation				Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Value Based Programs	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
202005	543	654	$64,538.52	$0.00	$64,538.52	$0.00	$859.29	$859.29	$0.00	$30,944.49	$11,193.31	$16,454.40	$6,960.23	$65,552.43	$82,893.04	$149,304.76
202006	541	651	$63,505.80	$0.00	$63,505.80	$0.00	$10,371.53	$10,371.53	$0.00	$43,174.07	$56,338.68	$77,819.13	$18,262.39	$195,594.27	$78,340.57	$284,306.37
202007	534	640	$58,375.77	$0.00	$58,375.77	$0.00	$5,515.02	$5,515.02	$12.95	$87,320.65	$101,041.54	$64,623.67	$29,043.91	$282,029.77	$151,210.64	$438,768.38
202008	523	628	$63,311.36	$0.00	$63,311.36	$0.00	$5,377.15	$5,377.15	$7.94	$2,816.00	$27,910.09	$44,244.03	$23,878.52	$98,848.64	$92,560.88	$196,794.61
202009	526	634	$61,272.10	$0.00	$61,272.10	$0.00	$5,452.47	$5,452.47	$215.31	$86,654.93	$81,169.22	$55,084.77	$23,506.56	$246,415.48	$141,915.15	$393,998.41
202010	545	663	$63,378.56	$0.00	$63,378.56	$0.00	$5,767.90	$5,767.90	$221.67	$35,160.41	$53,408.62	$43,626.20	$19,056.68	$151,251.91	$85,660.32	$242,901.80
202011	548	666	$65,331.56	$0.00	$65,331.56	$0.00	$5,833.51	$5,833.51	$199.14	$118,045.08	$161,504.23	$68,765.29	$25,542.28	$373,856.88	$104,670.80	$484,560.33
202012	546	664	$63,528.08	$0.00	$63,528.08	$0.00	$5,805.51	$5,805.51	$213.22	$124,726.99	$108,155.89	$139,733.42	$27,588.03	$400,204.33	$123,579.15	$529,802.21
202101	544	660	$63,232.20	$0.00	$63,232.20	$0.00	$951.04	$951.04	$210.75	$7,617.98	$46,767.15	$73,944.83	$24,739.92	$153,069.88	$94,377.33	$248,609.00
202102	540	655	$64,962.86	$0.00	$64,962.86	$0.00	$896.20	$896.20	$210.75	$195,813.46	$14,875.22	$26,428.79	$18,947.21	$256,064.68	$62,618.91	$319,790.54
202103	539	653	$63,767.62	$0.00	$63,767.62	$0.00	$923.66	$923.66	$329.03	$33,175.56	$59,390.41	$25,780.07	$20,728.56	$139,074.60	$108,967.65	$249,294.94
202104	535	649	$63,958.72	$0.00	$63,958.72	$0.00	$938.70	$938.70	$336.81	$25,208.08	$56,331.81	$23,220.63	$14,303.91	$119,064.43	$103,970.61	$224,310.55
202105	0	0	$0.00	$0.00	$0.00	$0.00	($0.28)	($0.28)	$363.13	$8,028.00	$135,396.96	$20,450.32	$7,988.43	$171,863.71	$36,469.95	$208,696.51
202106	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$663.98	$25,040.20	$99.35	$2,437.44	$3,343.97	$30,920.96	($50.00)	$31,534.94
202107	0	0	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$680.85	$0.00	$4,854.36	$839.99	$1,549.40	$7,243.75	$0.00	$7,924.60
Total	**6,464**	**7,817**	**$759,163.15**	**$0.00**	**$759,163.15**	**$0.00**	**$48,691.70**	**$48,691.70**	**$3,665.53**	**$823,725.90**	**$918,436.84**	**$683,452.98**	**$265,440.00**	**$2,691,055.72**	**$1,267,185.00**	**$4,010,597.95**
Grouping Avg	**431**	**521**	**$50,610.88**	**$0.00**	**$50,610.88**	**$0.00**	**$3,246.11**	**$3,246.11**	**$244.37**	**$54,915.06**	**$61,229.12**	**$45,563.53**	**$17,696.00**	**$179,403.71**	**$84,479.00**	**$267,373.20**
Monthly Avg	**431**	**521**	**$50,610.88**	**$0.00**	**$50,610.88**	**$0.00**	**$3,246.11**	**$3,246.11**	**$244.37**	**$54,915.06**	**$61,229.12**	**$45,563.53**	**$17,696.00**	**$179,403.71**	**$84,479.00**	**$267,373.20**

Notes:
- **Grand Total includes Medical FFS, Pharmacy FFS, Incentives and Capitation.**
- **Grouping Avg – Average of the distinct groupings chosen by the user.**
- **Monthly Avg – Average of a measure over Service/Paid time period.**
- **Enrollment is recast to reflect retroactive adjustments.**
- **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
202005	487	14	35	7	0	0	0	543	654
202006	486	13	35	7	0	0	0	541	651
202007	480	13	34	7	0	0	0	534	640
202008	470	13	33	7	0	0	0	523	628
202009	471	14	34	7	0	0	0	526	634
202010	486	14	38	7	0	0	0	545	663
202011	488	14	39	7	0	0	0	548	666
202012	487	14	37	8	0	0	0	546	664
202101	486	13	37	8	0	0	0	544	660
202102	482	13	37	8	0	0	0	540	655
202103	482	12	37	8	0	0	0	539	653
202104	478	12	37	8	0	0	0	535	649
Total	**5,783**	**159**	**433**	**89**	**0**	**0**	**0**	**6,464**	**7,817**
Grouping Avg	**482**	**13**	**36**	**7**	**0**	**0**	**0**	**539**	**651**
Monthly Avg	**482**	**13**	**36**	**7**	**0**	**0**	**0**	**539**	**651**

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.

Key Indicators

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2020 to 04/2021
Prior Service Period: From 05/2019 to 04/2020
Current Paid Period: From 05/2020 to 07/2021
Prior Paid Period: From 05/2019 to 07/2020

	Current	Prior	Change	Change %
Payments Per Employee Per Year	$7,445.40	$5,440.68	$2,004.72	36.85%
Payments Per Member Per Year	$6,156.72	$4,540.68	$1,616.04	35.59%
Enrollment:				
Employees	539	545	(7)	-1.21%
Members	651	653	(2)	-0.29%
Payments:				
Inpatient Facility	$823,725.90	$379,745.92	$443,979.98	116.92%
Outpatient Facility	$918,436.84	$702,451.18	$215,985.66	30.75%
Total Facility	**$1,742,162.74**	**$1,082,197.10**	**$659,965.64**	**60.98%**
Professional	$948,892.98	$672,449.32	$276,443.66	41.11%
PCP	$99,490.42	$73,446.04	$26,044.38	35.46%
Specialist	$849,402.56	$599,003.28	$250,399.28	41.80%
Capitation	$48,691.70	$8,842.03	$39,849.67	450.68%
Value Based Programs	$3,665.53	$2,544.17	$1,121.36	44.08%
Pharmacy	$1,267,185.00	$1,200,547.61	$66,637.39	5.55%
Grand Total	**$4,010,597.95**	**$2,966,580.23**	**$1,044,017.72**	**35.19%**

	Current	Prior	Change	Change %
Payments Per Member Per Month:				
Inpatient Facility	$105.37	$48.43	$56.94	117.57%
Outpatient Facility	$117.49	$89.59	$27.90	31.14%
Total Facility	**$222.86**	**$138.03**	**$84.83**	**61.46%**
Professional	$121.38	$85.77	$35.61	41.52%
PCP	$12.72	$9.36	$3.36	35.90%
Specialist	$108.66	$76.40	$32.26	42.23%
Capitation	$6.22	$1.12	$5.10	455.36%
Value Based Programs	$0.46	$0.31	$0.15	$0.48
Pharmacy	$162.10	$153.13	$8.97	5.86%
Grand Total	**$513.06**	**$378.39**	**$134.67**	**35.59%**
Other Key Payment Indicators:				
Inpatient Payments/Day	$4,627.67	$3,164.54	$1,463.13	46.24%
Inpatient Payments/Admissions	$19,156.41	$11,168.99	$7,987.42	71.51%
Outpatient Payments/Visit	$1,572.66	$1,340.55	$232.11	17.31%
Professional Payments/Service	$91.59	$68.61	$22.98	33.49%
PCP Payments/Service	$41.40	$36.77	$4.63	12.59%
Specialist Payments/Service	$106.74	$76.76	$29.98	39.06%
Pharmacy Payments/Script	$153.97	$136.13	$17.84	13.11%

	Current	Prior	Change	Change %
Key Utilization Indicators:				
Inpatient Facility				
Inpatient Days/1000 Members	273	184	90	48.77%
Inpatient Admissions/1000 Members	66	52	14	26.84%

Average Length of Inpatient Stay	4.14	3.53	0.61	17.29%
% Facility Admissions > 10	13.95%	5.88%		
Outpatient Facility				
Outpatient Visits/1000 Members	897	802	94	11.78%
Emer Rm Visits/1000 Members	189	207	(18)	-8.62%
Other Visits/1000 Members	708	595	112	18.86%
Professional				
Professional Services/1000 Members	15,904	15,000	904	6.03%
PCP Services/1000 Members	3,689	3,057	632	20.68%
Specialist Services/1000 Members	12,215	11,943	272	2.27%
Pharmacy:				
Pharmacy Scripts/1000 Members	12,634	13,498	(864)	-6.40%

Value Based Programs line includes earned incentives for managing quality with cost efficiencies. Supplemental detail included on MBI EBP report.

Included in the Valued Based Program line are CBF Care Coordination Fees and Shared Savings that members have incurred outside of Florida

Brand Vs Generic

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2020 to 04/2021
Current Paid Period: From 05/2020 to 07/2021

Utilization	Retail	Retail 90 Day	Mail Order	Total
Total Rx Users	543	336	7	571
Total Rx	5,454	2,705	71	8,230
Generic	4,762	2,595	71	7,428
Multi-Source Brand Generic Available	81	30	0	111
Multi-Source Brand w/o Generic Available	32	5	0	37
Single Source Brand	579	75	0	654
Acute Rx %	49.23%	7.10%	22.54%	35.15%
Maintenance Rx %	50.77%	92.90%	77.46%	64.85%
Member Utilization				
Rx/1000	8,373	4,152	109	12,634
Member PMPM	$11.89	$8.69	$0.15	$20.74
Member PMPY	$142.68	$104.28	$1.80	$248.88
Generic %	87.31%	95.93%	100.00%	90.26%
Multi-Source Brand %	0.59%	0.18%	0.00%	0.45%
Multi-Source Brand Generic Available %	1.49%	1.11%	0.00%	1.35%
Single Source Brand %	10.62%	2.77%	0.00%	7.95%
Generic Substitution %	98.33%	98.86%	0.00%	98.53%
Formulary %	97.51%	99.19%	100.00%	98.08%
Days Supply				
Total Days Supply	118,524	243,454	5,972	367,950
Average Days Supply	21.73	90.00	84.11	44.71
Cost				
Plan Paid PMPM	$132.46	$28.94	$0.69	$162.10
Member Paid PMPM	$11.89	$8.69	$0.15	$20.74
Total PMPM	$144.35	$37.64	$0.85	$182.85
Generic PMPM	$11.70	$9.17	$0.85	$21.72
Brand PMPM	$132.65	$28.46	$0.00	$161.12
Total PMPY	$1,732.29	$451.70	$10.22	$2,194.21

Notes:
- Retail 90 Days = Prescription filled for a days supply greater than 31 up to a maximum of 93.
- Member Submitted = Manually submitted paper claim. Member Submitted amounts are included in Retail, Retail 90 Days and Mail Order.
- Total for Total Rx Users does not represent a summation of Retail, Retail 90 Days and Mail Order. A member's Rx may be filled in more than one category.
- Utilization counts are determined by scripts written. Retail, Mail Order and Retail 90 Days count as 1 unit.

TOTAL COST	Retail	Retail 90 Day	Mail Order	Total
Total Cost	$1,128,443.25	$294,246.55	$6,656.48	$1,429,346.28
Total Ingredient Cost	$1,121,553.10	$294,248.00	$6,656.48	$1,422,457.58
Total Ingredient Cost - Generic	$90,342.17	$71,620.98	$6,656.48	$168,619.63
Total Ingredient Cost - Multi-Source Brand	$4,670.67	$1,693.14	$0.00	$6,363.81
Total Ingredient Cost - Single Source Brand	$997,203.24	$213,546.28	$0.00	$1,210,749.52
Total Ingredient Cost - Brand Generic Available	$29,337.02	$7,387.60	$0.00	$36,724.62
Total Cost - Formulary	$940,241.92	$280,066.52	$6,656.48	$1,226,964.92
Total Cost - Non-Formulary	$188,201.33	$14,180.03	$0.00	$202,381.36
Avg Total Cost / Claim	$206.90	$108.77	$93.75	$173.67
Avg Total Cost / Day	$9.52	$1.20	$1.11	$3.88
Total Cost PMPY	$1,732.29	$451.70	$10.22	$2,194.21
Total Cost PMPM	$144.35	$37.64	$0.85	$182.85
Avg Total Cost - Generic	$19.21	$27.62	$93.75	$22.86
Avg Total Cost - Multi-Source Brand	$146.10	$338.67	$0.00	$172.12
Avg Total Cost - Single Source Brand	$1,732.09	$2,847.70	$0.00	$1,860.03
Avg Total Cost - Brand Generic Available	$362.66	$242.55	$0.00	$330.20
Avg Total Cost - Formulary	$176.80	$104.38	$93.75	$152.00
Avg Total Cost - Non-Formulary	$1,383.83	$644.54	$0.00	$1,280.89
PLAN PAID				
Total Plan Paid Amount	$1,035,473.08	$226,275.46	$5,436.46	$1,267,185.00
Plan Paid - Generic	$55,062.73	$26,435.98	$5,436.46	$86,935.17
Plan Paid - Multi-Source Brand	$3,425.47	$1,423.39	$0.00	$4,848.86
Plan Paid - Single Source Brand	$950,118.35	$193,895.83	$0.00	$1,144,014.18
Plan Paid - Brand Generic Available	$26,866.53	$4,520.26	$0.00	$31,386.79
Plan Paid - Formulary	$854,660.71	$215,297.25	$5,436.46	$1,075,394.42
Plan Paid - Non-Formulary	$180,812.37	$10,978.21	$0.00	$191,790.58
Avg Total Plan Paid / Claim	$189.85	$83.65	$76.56	$153.97
Avg Total Plan Paid / Day	$8.73	$0.92	$0.91	$3.44
Plan Paid PMPY	$1,589.57	$347.36	$8.35	$1,945.28
Plan Paid PMPM	$132.46	$28.94	$0.69	$162.10
Plan Cost Share Contribution %	91.00%	76.00%	81.00%	88.00%
Avg Plan Paid - Generic	$11.56	$10.18	$76.56	$11.70
Avg Plan Paid - Multi-Source Brand	$107.04	$284.67	$0.00	$131.05
Avg Plan Paid - Single Source Brand	$1,640.96	$2,585.27	$0.00	$1,749.25
Avg Plan Paid - Brand Generic Available	$331.68	$150.67	$0.00	$282.76
Avg Plan Paid - Formulary	$160.71	$80.24	$76.56	$133.22
Avg Plan Paid - Non-Formulary	$1,329.50	$499.00	$0.00	$1,213.86
MEMBER PAID				
Total Member Paid Amount	$92,970.17	$67,971.09	$1,220.02	$162,161.28
Member Paid - Generic	$36,443.72	$45,263.00	$1,220.02	$82,926.74
Member Paid - Multi-Source Brand	$1,249.75	$270.00	$0.00	$1,519.75
Member Paid - Single Source Brand	$52,767.07	$19,681.70	$0.00	$72,448.77
Member Paid - Brand Generic Available	$2,509.63	$2,756.39	$0.00	$5,266.02
Member Paid - Formulary	$85,581.21	$64,769.27	$1,220.02	$151,570.50
Member Paid - Non-Formulary	$7,388.96	$3,201.82	$0.00	$10,590.78
Avg Total Member Paid / Claim	$17.04	$25.12	$17.18	$19.70
Avg Total Member Paid / Day	$0.78	$0.27	$0.20	$0.44
Member Paid PMPY	$142.72	$104.34	$1.87	$248.94
Member Paid PMPM	$11.89	$8.69	$0.15	$20.74
Member Cost Share Contribution %	8.00%	23.00%	18.00%	11.00%
Avg Member Paid - Generic	$7.65	$17.44	$17.18	$11.16
Avg Member Paid - Multi-Source Brand	$39.05	$54.00	$0.00	$41.07

Avg Member Paid - Single Source Brand	$91.13	$262.42	$0.00	$110.77
Avg Member Paid - Brand Generic Available	$30.98	$91.87	$0.00	$47.44
Avg Member Paid - Formulary	$16.09	$24.14	$17.18	$18.77
Avg Member Paid - Non-Formulary	$54.33	$145.53	$0.00	$67.03
PRICING / NETWORK PERFORMANCE				
Avg Ingredient Cost / Rx	$205.63	$108.77	$93.75	$172.83
Avg Ingredient Cost / Generic Rx	$18.97	$27.59	$93.75	$22.70
Avg Ingredient Cost / Multi-Source Brand Rx	$145.95	$338.62	$0.00	$171.99
Avg Ingredient Cost / Single Source Brand Rx	$1,722.28	$2,847.28	$0.00	$1,851.29
Avg Ingredient Cost / Brand Generic Available Rx	$362.18	$246.25	$0.00	$330.85
Avg Ingredient Cost / Formulary	$175.75	$104.38	$93.75	$151.31
Avg Ingredient Cost / Non-Formulary	$1,374.22	$644.49	$0.00	$1,272.62
Avg Dispense Fee / Rx	$0.22	$0.03	$0.00	$0.16
Avg Dispense Fee / Generic Rx	$0.24	$0.03	$0.00	$0.16
Avg Dispense Fee / Multi-Source Brand Rx	$0.14	$0.05	$0.00	$0.12
Avg Dispense Fee / Single Source Brand Rx	$0.11	$0.01	$0.00	$0.10
Avg Dispense Fee / Brand Generic Available Rx	$0.17	$0.06	$0.00	$0.14
Avg Dispense Fee / Formulary	$0.22	$0.02	$0.00	$0.16
Avg Dispense Fee / Non-Formulary	$0.21	$0.05	$0.00	$0.19

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Top Drug Classes by Paid/Prescription

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2020 to 04/2021
Prior Service Period: From 05/2019 to 04/2020
Current Paid Period: From 05/2020 to 07/2021
Prior Paid Period: From 05/2019 to 07/2020
Rank: 10
Rx Sort By: PAID

Drug Class	Drug	Current Rank	Prior Rank	Current Plan Paid Amt	Plan Paid Chg Pct	Formulary Pct	Substitution Pct	Avg Ingredient/ Rx	Avg Ingredient/ Brand	Avg Ingredient/ Generic	Cost Share Pct	# of Rx's	Rx Chg Pct	Total Rx Users	Current Util/1000	Current Util Chg Pct	Current Plan Paid PMPM	Plan Paid Chg	Paid PMPM Chg Pct
ANALGESICS - ANTI-INFLAMMATORY	HUMIRA PEN			$149,305.07	19.40%			$10,711.79	$10,711.79	$0.00	0.44%	14	7.69%	1	21.49	8.01%	$19.10	$3.15	19.75%
ANALGESICS - ANTI-INFLAMMATORY	XELJANZ XR			$45,164.30	0.00%			$4,669.02	$4,669.02	$0.00	3.38%	10	0.00%	1	15.35	0.00%	$5.78	$5.78	0.00%
ANALGESICS - ANTI-INFLAMMATORY	ENBREL SURECLICK			$41,879.01	-56.63%			$4,610.91	$4,610.91	$0.00	10.10%	10	-54.55%	3	15.35	-54.41%	$5.36	($6.96)	-56.50%
ANALGESICS - ANTI-INFLAMMATORY	ENBREL			$29,061.97	-7.54%			$5,432.09	$5,432.09	$0.00	12.15%	6	-14.29%	1	9.21	-14.03%	$3.72	($0.29)	-7.27%
ANALGESICS - ANTI-INFLAMMATORY	CELECOXIB			$234.76	145.46%			$33.09	$0.00	$33.09	268.47%	26	-3.70%	11	39.91	-3.42%	$0.03	$0.02	146.18%
ANALGESICS - ANTI-INFLAMMATORY	ALL OTHER			$720.52	-2.15%			$11.58	$0.00	$11.58	207.10%	188	-14.16%	95	288.60	-13.90%	$0.09	($0.00)	-1.86%
ANALGESICS - ANTI-INFLAMMATORY	**ANALGESICS - ANTI-INFLAMMATORY**	**1**	**1**	**$266,365.63**	**4.92%**	**100.00%**	**100.00%**	**$1,096.04**	**$6,883.92**	**$14.20**	**4.53%**	**254**	**-11.81%**	**106**	**389.92**	**-11.55%**	**$34.08**	**$1.69**	**5.23%**
ANTIVIRALS	BIKTARVY			$52,442.18	95.00%			$4,851.84	$4,851.84	$0.00	1.77%	11	22.22%	2	16.89	22.58%	$6.71	$3.28	95.58%
ANTIVIRALS	TRIUMEQ			$38,618.65	4.92%			$8,572.35	$8,572.35	$0.00	10.99%	5	-61.54%	1	7.68	-61.43%	$4.94	$0.25	5.23%
ANTIVIRALS	PREZISTA			$23,932.71	-37.60%			$4,996.39	$4,996.39	$0.00	4.38%	5	-37.50%	2	7.68	-37.32%	$3.06	($1.83)	-37.41%
ANTIVIRALS	ISENTRESS			$22,810.19	-36.38%			$4,682.04	$4,682.04	$0.00	2.63%	5	-37.50%	2	7.68	-37.32%	$2.92	($1.65)	-36.19%
ANTIVIRALS	DOVATO			$22,604.19	82.40%			$2,412.23	$2,412.23	$0.00	17.40%	11	57.14%	1	16.89	57.61%	$2.89	$1.31	82.93%
ANTIVIRALS	ALL OTHER			$58,395.43	20.10%			$577.25	$2,869.15	$56.36	6.78%	108	-8.47%	42	165.79	-8.21%	$7.47	$1.27	20.45%
ANTIVIRALS	**ANTIVIRALS**	**2**	**3**	**$218,803.35**	**10.00%**	**98.62%**	**100.00%**	**$1,610.35**	**$4,009.50**	**$56.36**	**6.72%**	**145**	**-11.04%**	**44**	**222.59**	**-10.78%**	**$27.99**	**$2.62**	**10.32%**
DERMATOLOGICALS	STELARA			$154,023.61	189.91%			$17,569.09	$17,569.09	$0.00	2.66%	9	80.00%	2	13.82	80.53%	$19.70	$12.93	190.76%
DERMATOLOGICALS	DUPIXENT			$23,578.76	0.00%			$3,084.85	$3,084.85	$0.00	4.67%	8	0.00%	1	12.28	0.00%	$3.02	$3.02	0.00%
DERMATOLOGICALS	AZELAIC ACID			$1,706.29	348.85%			$223.27	$0.00	$223.27	4.69%	8	300.00%	3	12.28	301.18%	$0.22	$0.17	350.17%
DERMATOLOGICALS	DICLOFENAC SODIUM			$1,007.38	96.84%			$47.25	$0.00	$47.25	36.80%	29	70.59%	13	44.52	71.09%	$0.13	$0.06	97.42%
DERMATOLOGICALS	MYORISAN			$532.12	0.00%			$276.06	$0.00	$276.06	3.76%	2	0.00%	1	3.07	0.00%	$0.07	$0.07	0.00%
DERMATOLOGICALS	ALL OTHER			$4,264.67	4.64%			$47.91	$410.64	$43.10	72.71%	153	12.50%	102	234.87	12.83%	$0.55	$0.03	4.95%
DERMATOLOGICALS	**DERMATOLOGICALS**	**3**	**7**	**$185,112.83**	**218.64%**	**96.17%**	**100.00%**	**$927.46**	**$9,664.31**	**$53.77**	**4.74%**	**209**	**30.63%**	**113**	**320.84**	**31.01%**	**$23.68**	**$16.27**	**219.57%**
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	SPRYCEL			$124,784.86	-15.52%			$13,866.10	$13,866.10	$0.00	0.01%	9	-18.18%	1	13.82	-17.94%	$15.96	($2.88)	-15.27%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	METHOTREXATE			$778.18	66.86%			$40.42	$0.00	$40.42	41.22%	27	28.57%	6	41.45	28.95%	$0.10	$0.04	67.35%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ANASTROZOLE			$470.38	334.93%			$19.53	$0.00	$19.53	29.29%	31	-11.43%	8	47.59	-11.17%	$0.06	$0.05	336.21%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	METHOTREXATE SODIUM			$377.98	0.00%			$88.87	$0.00	$88.87	18.52%	5	0.00%	2	7.68	0.00%	$0.05	$0.05	0.00%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	TAMOXIFEN CITRATE			$110.22	-17.54%			$54.86	$0.00	$54.86	0.00%	2	0.00%	1	3.07	0.29%	$0.01	($0.00)	-17.29%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	ALL OTHER			$68.73	-99.89%			$10.74	$0.00	$10.74	171.13%	17	-48.48%	2	26.10	-48.33%	$0.01	($8.29)	-99.89%
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	**ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES**	**4**	**2**	**$126,590.35**	**-40.71%**	**100.00%**	**100.00%**	**$1,398.12**	**$13,866.10**	**$29.68**	**0.52%**	**91**	**-10.78%**	**19**	**139.70**	**-10.52%**	**$16.19**	**($11.04)**	**-40.54%**
RESPIRATORY AGENTS - MISC.	OFEV			$125,547.36	6.08%			$10,587.28	$10,587.28	$0.00	1.19%	12	0.00%	1	18.42	0.29%	$16.06	$0.96	6.39%
RESPIRATORY AGENTS - MISC.	**RESPIRATORY AGENTS - MISC.**	**5**	**4**	**$125,547.36**	**6.08%**	**0.00%**	**0.00%**	**$10,587.28**	**$10,587.28**	**$0.00**	**1.19%**	**12**	**0.00%**	**1**	**18.42**	**0.29%**	**$16.06**	**$0.96**	**6.39%**
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	REBIF REBIDOSE			$105,499.25	7.44%			$8,198.40	$8,198.40	$0.00	1.02%	13	0.00%	1	19.96	0.29%	$13.50	$0.97	7.75%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	NICOTINE TRANSDERMAL SYSTEM			$42.49	-50.58%			$41.99	$0.00	$41.99	0.00%	1	-50.00%	1	1.54	-49.85%	$0.01	($0.01)	-50.44%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	MEMANTINE HYDROCHLORIDE			$3.59	0.00%			$13.59	$0.00	$13.59	278.55%	1	0.00%	2	1.54	0.00%	$0.00	$0.00	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	DONEPEZIL HYDROCHLORIDE			$0.00	0.00%			$1.36	$0.00	$1.36	0.00%	1	0.00%	1	1.54	0.00%	$0.00	$0.00	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ALL OTHER			$0.00	-100.00%			$0.00	$0.00	$0.00	0.00%	0	-100.00%	0	0.00	-100.00%	$0.00	($0.37)	-100.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	**PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.**	**6**	**5**	**$105,545.33**	**4.32%**	**100.00%**	**100.00%**	**$6,664.76**	**$8,198.40**	**$18.98**	**1.03%**	**16**	**-44.83%**	**4**	**24.56**	**-44.67%**	**$13.50**	**$0.60**	**4.63%**
ANTIDIABETICS	TRULICITY			$17,112.15	7.66%			$1,129.83	$1,129.83	$0.00	12.27%	17	6.25%	2	26.10	6.56%	$2.19	$0.16	7.98%
ANTIDIABETICS	INVOKANA			$8,228.82	27.66%			$1,044.13	$1,044.13	$0.00	39.58%	11	-26.67%	2	16.89	-26.45%	$1.05	$0.23	28.04%
ANTIDIABETICS	TOUJEO SOLOSTAR			$8,036.11	-16.76%			$726.22	$726.22	$0.00	17.50%	13	-7.14%	2	19.96	-6.87%	$1.03	($0.20)	-16.51%
ANTIDIABETICS	TRESIBA FLEXTOUCH			$7,548.93	-8.78%			$1,338.52	$1,338.52	$0.00	41.85%	8	33.33%	1	12.28	33.73%	$0.97	($0.09)	-8.51%

ANTIDIABETICS	OZEMPIC			$7,084.86	-13.16%			$1,993.72	$1,993.72	$0.00	12.56%	4	-60.00%	4	6.14	-59.88%	$0.91	($0.13)	-12.91%
ANTIDIABETICS	ALL OTHER			$32,246.11	-20.59%			$127.93	$725.87	$10.98	50.51%	379	-6.65%	67	581.81	-6.38%	$4.13	($1.05)	-20.35%
ANTIDIABETICS	**ANTIDIABETICS**	**7**	**6**	**$80,256.98**	**-9.86%**	**99.07%**	**100.00%**	**$248.38**	**$902.79**	**$10.98**	**33.77%**	**432**	**-7.49%**	**67**	**663.17**	**-7.22%**	**$10.27**	**($1.09)**	**-9.59%**
ANTICONVULSANTS	LAMICTAL XR			$15,218.08	-57.42%			$2,636.25	$2,636.25	$0.00	3.94%	6	-50.00%	1	9.21	-49.85%	$1.95	($2.61)	-57.30%
ANTICONVULSANTS	TOPIRAMATE ER			$4,957.61	0.00%			$2,498.61	$0.00	$2,498.61	0.81%	2	0.00%	1	3.07	0.00%	$0.63	$0.63	0.00%
ANTICONVULSANTS	GABAPENTIN			$415.67	43.27%			$13.87	$0.00	$13.87	238.59%	100	16.28%	32	153.51	16.62%	$0.05	$0.02	43.69%
ANTICONVULSANTS	PHENYTOIN SODIUM EXTENDED			$176.37	-37.17%			$71.90	$0.00	$71.90	63.14%	4	0.00%	1	6.14	0.29%	$0.02	($0.01)	-36.98%
ANTICONVULSANTS	PREGABALIN			$43.61	0.58%			$34.19	$0.00	$34.19	213.83%	4	33.33%	2	6.14	33.73%	$0.01	$0.00	0.87%
ANTICONVULSANTS	ALL OTHER			$105.32	-83.05%			$17.43	$894.70	$10.30	1974.24%	124	-13.89%	20	190.35	-13.64%	$0.01	($0.07)	-83.00%
ANTICONVULSANTS	**ANTICONVULSANTS**	**8**	**8**	**$20,916.66**	**-43.43%**	**97.50%**	**100.00%**	**$103.28**	**$2,387.45**	**$34.66**	**18.72%**	**240**	**-3.61%**	**53**	**368.43**	**-3.33%**	**$2.68**	**($2.04)**	**-43.27%**
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ADVAIR DISKUS			$7,608.53	-5.96%			$441.26	$441.26	$0.00	4.48%	18	-5.26%	3	27.63	-4.98%	$0.97	($0.06)	-5.69%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	SYMBICORT			$3,621.63	9.03%			$352.30	$352.30	$0.00	26.51%	13	0.00%	5	19.96	0.29%	$0.46	$0.04	9.35%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	BUDESONIDE			$1,365.95	998.91%			$1,395.95	$0.00	$1,395.95	2.20%	1	0.00%	1	1.54	0.29%	$0.17	$0.16	1002.15%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	VENTOLIN HFA			$1,117.24	381.34%			$70.30	$70.30	$0.00	32.35%	21	10.53%	11	32.24	10.85%	$0.14	$0.11	382.76%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	IPRATROPIUM BROMIDE/ALBUTEROL SULFATE			$559.15	148.10%			$31.15	$0.00	$31.15	33.98%	24	0.00%	3	36.84	0.29%	$0.07	$0.04	148.83%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ALL OTHER			$1,516.71	96.12%			$39.21	$261.00	$17.70	368.11%	181	-15.81%	81	277.86	-15.57%	$0.19	$0.10	96.70%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	**ANTIASTHMATIC AND BRONCHODILATOR AGENTS**	**9**	**10**	**$15,789.21**	**23.66%**	**96.90%**	**84.82%**	**$90.07**	**$267.28**	**$26.65**	**47.28%**	**258**	**-11.34%**	**92**	**396.06**	**-11.08%**	**$2.02**	**$0.39**	**24.03%**
CONTRACEPTIVES	NUVARING			$4,999.60	21.47%			$293.99	$293.99	$0.00	0.00%	17	-15.00%	5	26.10	-14.75%	$0.64	$0.11	21.83%
CONTRACEPTIVES	XULANE			$791.97	0.00%			$263.99	$263.99	$0.00	0.00%	3	0.00%	1	4.61	0.00%	$0.10	$0.10	0.00%
CONTRACEPTIVES	DROSPIRENONE/ETHINYL ESTRADIOL			$775.84	13.51%			$96.93	$0.00	$96.93	0.00%	8	60.00%	3	12.28	60.47%	$0.10	$0.01	13.84%
CONTRACEPTIVES	HAILEY 1.5/30			$645.92	1448.23%			$40.18	$0.00	$40.18	0.00%	16	700.00%	3	24.56	702.35%	$0.08	$0.08	1452.78%
CONTRACEPTIVES	JUNEL FE 1/20			$645.29	-35.93%			$33.77	$0.00	$33.77	0.00%	19	-61.22%	7	29.17	-61.11%	$0.08	($0.05)	-35.74%
CONTRACEPTIVES	ALL OTHER			$7,288.52	-21.25%			$33.33	$0.00	$33.33	0.00%	218	1.40%	52	334.66	1.69%	$0.93	($0.25)	-21.02%
CONTRACEPTIVES	**CONTRACEPTIVES**	**10**	**9**	**$15,147.14**	**0.29%**	**98.93%**	**100.00%**	**$53.80**	**$289.49**	**$35.74**	**0.00%**	**281**	**-3.44%**	**60**	**431.37**	**-3.15%**	**$1.94**	**$0.01**	**0.58%**
ALL OTHER	ALL OTHER			$107,110.16	4.25%			$29.46	$143.44	$20.85	79.24%	6,292	-7.02%	537	9,658.95	-6.75%	$13.70	$0.60	4.55%
Total	**Total**			**$1,267,185.00**	**5.55%**	**98.08%**	**99.50%**	**$172.84**	**$1,563.39**	**$22.70**	**12.80%**	**8,230**	**-6.68%**	**571**	**12,634.00**	**-6.40%**	**$162.11**	**$8.98**	**5.86%**

Top Drugs by Paid/Prescription

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2020 to 04/2021
Prior Service Period: From 05/2019 to 04/2020
Current Paid Period: From 05/2020 to 07/2021
Prior Paid Period: From 05/2019 to 07/2020
Rank: 10
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
STELARA	1	7	$154,023.61	$53,127.91	189.91%	$4,100.00	$550.00	645.45%	$158,123.61	$53,677.91	194.58%	$300.00	$250.00	$3,800.00	$300.00	$0.00	$0.00	$158,121.81	$53,677.91	$1.80	$0.00
HUMIRA PEN	2	2	$149,305.07	$125,046.38	19.40%	$660.00	$4,150.00	-84.10%	$149,965.07	$129,196.38	16.07%	$360.00	$650.00	$300.00	$3,500.00	$0.00	$0.00	$149,965.07	$129,196.38	$0.00	$0.00
OFEV	3	3	$125,547.36	$118,356.04	6.08%	$1,500.00	$1,500.00	0.00%	$127,047.36	$119,856.04	6.00%	$1,200.00	$1,200.00	$300.00	$300.00	$0.00	$0.00	$127,047.36	$119,856.04	$0.00	$0.00
SPRYCEL	4	1	$124,784.86	$147,709.81	-15.52%	$10.00	$110.00	-90.91%	$124,794.86	$147,819.81	-15.58%	$10.00	$110.00	$0.00	$0.00	$0.00	$0.00	$124,794.86	$147,819.81	$0.00	$0.00
REBIF REBIDOSE	5	4	$105,499.25	$98,195.17	7.44%	$1,080.00	$1,080.00	0.00%	$106,579.25	$99,275.17	7.36%	$780.00	$780.00	$300.00	$300.00	$0.00	$0.00	$106,579.25	$99,275.17	$0.00	$0.00
BIKTARVY	6	13	$52,442.18	$26,893.10	95.00%	$930.00	$771.85	20.49%	$53,372.18	$27,664.95	92.93%	$930.00	$540.00	$0.00	$231.85	$0.00	$0.00	$53,370.23	$27,656.85	$1.95	$8.10
XELJANZ XR	7	0	$45,164.30	$0.00	0.00%	$1,526.32	$0.00	0.00%	$46,690.62	$0.00	0.00%	$240.00	$0.00	$300.00	$0.00	$986.32	$0.00	$46,690.17	$0.00	$0.45	$0.00
ENBREL SURECLICK	8	5	$41,879.01	$96,552.95	-56.63%	$4,231.00	$6,921.60	-38.87%	$46,110.01	$103,474.55	-55.44%	$450.00	$200.00	$3,781.00	$3,721.60	$0.00	$3,000.00	$46,109.11	$103,461.95	$0.90	$12.60
TRIUMEQ	9	9	$38,618.65	$36,807.32	4.92%	$4,243.09	$3,881.56	9.30%	$42,861.74	$40,688.88	5.34%	$750.00	$550.00	$3,493.09	$3,331.56	$0.00	$0.00	$42,861.74	$40,678.08	$0.00	$10.80
ENBREL	10	12	$29,061.97	$31,432.89	-7.54%	$3,530.55	$3,850.00	-8.29%	$32,592.52	$35,282.89	-7.62%	$300.00	$350.00	$3,230.55	$3,500.00	$0.00	$0.00	$32,592.52	$35,282.89	$0.00	$0.00
ALL OTHER			$400,858.74	$466,426.04	-14.06%	$140,350.32	$160,746.60	-12.69%	$541,209.06	$627,172.64	-13.71%	$57,828.60	$64,274.82	$82,073.52	$95,427.18	$448.20	$1,044.60	$534,325.46	$620,250.21	$1,326.42	$5,677.64
Total			**$1,267,185.00**	**$1,200,547.61**	**5.55%**	**$162,161.28**	**$183,561.61**	**-11.66%**	**$1,429,346.28**	**$1,384,109.22**	**3.27%**	**$63,148.60**	**$68,904.82**	**$97,578.16**	**$110,612.19**	**$1,434.52**	**$4,044.60**	**$1,422,457.58**	**$1,377,155.29**	**$1,331.52**	**$5,709.14**

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
STELARA	1	7	$17,113.73	$10,625.58	61.06%	$455.55	$110.00	313.64%	$17,569.29	$10,735.58	63.65%	$33.33	$50.00	$422.22	$60.00	$0.00	$0.00	$17,569.09	$10,735.58	$0.20	$0.00
HUMIRA PEN	2	2	$10,664.64	$9,618.95	10.87%	$47.14	$319.23	-85.27%	$10,711.79	$9,938.18	7.78%	$25.71	$50.00	$21.42	$269.23	$0.00	$0.00	$10,711.79	$9,938.18	$0.00	$0.00
OFEV	3	3	$10,462.28	$9,863.00	6.07%	$125.00	$125.00	0.00%	$10,587.28	$9,988.00	6.00%	$100.00	$100.00	$25.00	$25.00	$0.00	$0.00	$10,587.28	$9,988.00	$0.00	$0.00
SPRYCEL	4	1	$13,864.98	$13,428.16	3.25%	$1.11	$10.00	-80.00%	$13,866.09	$13,438.16	3.18%	$1.11	$10.00	$0.00	$0.00	$0.00	$0.00	$13,866.09	$13,438.16	$0.00	$0.00
REBIF REBIDOSE	5	4	$8,115.32	$7,553.47	7.43%	$83.07	$83.07	0.00%	$8,198.40	$7,636.55	7.35%	$60.00	$60.00	$23.07	$23.07	$0.00	$0.00	$8,198.40	$7,636.55	$0.00	$0.00
BIKTARVY	6	13	$4,767.47	$2,988.12	59.54%	$84.54	$85.76	-1.18%	$4,852.01	$3,073.88	57.86%	$84.54	$60.00	$0.00	$25.76	$0.00	$0.00	$4,851.83	$3,072.98	$0.17	$0.90
XELJANZ XR	7	0	$4,516.43	$0.00	0.00%	$152.63	$0.00	0.00%	$4,669.06	$0.00	0.00%	$24.00	$0.00	$30.00	$0.00	$98.63	$0.00	$4,669.01	$0.00	$0.04	$0.00
ENBREL SURECLICK	8	5	$4,187.90	$4,388.77	-4.56%	$423.10	$314.61	34.39%	$4,611.00	$4,703.38	-1.96%	$45.00	$9.09	$378.10	$169.16	$0.00	$136.36	$4,610.91	$4,702.81	$0.09	$0.57
TRIUMEQ	9	9	$7,723.73	$2,831.33	172.80%	$848.61	$298.58	184.56%	$8,572.34	$3,129.91	173.92%	$150.00	$42.30	$698.61	$256.27	$0.00	$0.00	$8,572.34	$3,129.08	$0.00	$0.83
ENBREL	10	12	$4,843.66	$4,490.41	7.86%	$588.42	$550.00	6.91%	$5,432.08	$5,040.41	7.76%	$50.00	$50.00	$538.42	$500.00	$0.00	$0.00	$5,432.08	$5,040.41	$0.00	$0.00
ALL OTHER			$49.30	$53.52	-7.55%	$17.26	$18.44	-5.56%	$66.56	$71.97	-7.04%	$7.11	$7.37	$10.09	$10.95	$0.05	$0.11	$65.71	$71.17	$0.16	$0.65
Total			**$153.97**	**$136.13**	**12.50%**	**$19.70**	**$20.81**	**-5.00%**	**$173.67**	**$156.94**	**10.26%**	**$7.67**	**$7.81**	**$11.85**	**$12.54**	**$0.17**	**$0.45**	**$172.83**	**$156.15**	**$0.16**	**$0.64**

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 %
STELARA	1	7	9	5	80.00%	2	1	100.00%	4.50	5.00	0.77	0.50	29.00	30.00	$19.70	$6.77	190.99%	13.82	7.65	80.53%
HUMIRA PEN	2	2	14	13	7.69%	1	1	0.00%	14.00	13.00	4.00	4.00	28.00	28.00	$19.10	$15.94	19.82%	21.49	19.90	8.01%
OFEV	3	3	12	12	0.00%	1	1	0.00%	12.00	12.00	60.00	60.00	30.00	30.00	$16.06	$15.09	6.43%	18.42	18.37	0.29%
SPRYCEL	4	1	9	11	-18.18%	1	1	0.00%	9.00	11.00	30.00	30.00	30.00	30.00	$15.96	$18.84	-15.29%	13.82	16.84	-17.94%
REBIF REBIDOSE	5	4	13	13	0.00%	1	1	0.00%	13.00	13.00	6.00	6.00	28.00	28.00	$13.49	$12.52	7.75%	19.96	19.90	0.29%
BIKTARVY	6	13	11	9	22.22%	2	1	100.00%	5.50	9.00	46.36	30.00	46.00	30.00	$6.70	$3.43	95.34%	16.89	13.78	22.58%
XELJANZ XR	7	0	10	0	0.00%	1	0	0.00%	10.00	0.00	30.00	0.00	30.00	0.00	$5.77	$0.00	0.00%	15.35	0.00	0.00%
ENBREL SURECLICK	8	5	10	22	-54.55%	3	2	50.00%	3.33	11.00	4.00	3.97	28.00	28.00	$5.35	$12.31	-56.54%	15.35	33.67	-54.41%
TRIUMEQ	9	9	5	13	-61.54%	1	2	-50.00%	5.00	6.50	90.00	34.61	90.00	34.00	$4.94	$4.69	5.33%	7.68	19.90	-61.43%
ENBREL	10	12	6	7	-14.29%	1	1	0.00%	6.00	7.00	4.00	3.95	28.00	28.00	$3.71	$4.00	-7.25%	9.21	10.71	-14.03%
ALL OTHER			8,131	8,714	-6.69%	571	581	-1.72%	14.24	15.00	60.64	59.31	44.00	42.00	$51.28	$59.49	-13.80%	12,482.03	13,337.76	-6.42%
Total			**8,230**	**8,819**	**-6.68%**	**571**	**581**	**-1.72%**	**14.41**	**15.18**	**60.21**	**58.83**	**44.00**	**42.00**	**$162.10**	**$153.13**	**5.86%**	**12,634.00**	**13,498.47**	**-6.40%**

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.

Monitoring by Utilization and Enrollment

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2021 to 04/2022
Current Paid Period: From 05/2021 to 05/2022

	Enrollment		Premium			Capitation				Fee for Service Claims						
Paid Year Month	Contracts	Members	ASO/MPP Fee	Stoploss Premium	Total Premium	PCP	Specialty	Total Capitation	Value Based Programs	Inpatient	Outpatient	Physician	Other	Total Medical	Pharmacy	Grand Total
202105	521	633	$67,878.39	$0.00	$67,878.39	$0.00	$904.80	$904.80	$0.00	$23,999.63	$8,042.11	$8,945.17	$5,354.68	$46,341.59	$30,985.38	$78,231.77
202106	511	619	$67,747.12	$0.00	$67,747.12	$0.00	$886.05	$886.05	$0.00	$107,740.64	$179,319.46	$99,182.51	$15,367.90	$401,610.51	$141,057.04	$543,553.60
202107	504	608	$66,090.69	$0.00	$66,090.69	$0.00	$869.16	$869.16	$0.00	$189,876.74	$73,116.23	$31,024.10	$20,510.60	$314,527.67	$69,973.89	$385,370.72
202108	492	592	$31,122.00	$0.00	$31,122.00	$0.00	$875.39	$875.39	$0.00	$47,844.56	$115,306.16	$48,675.74	$44,319.54	$256,146.00	$81,872.14	$338,893.53
202109	495	596	$30,555.00	$0.00	$30,555.00	$0.00	$870.62	$870.62	$1,020.84	$260,247.07	$124,159.56	$41,947.60	$11,576.08	$437,930.31	$132,384.93	$572,206.70
202110	526	635	$32,382.00	$0.00	$32,382.00	$0.00	$918.55	$918.55	$977.40	$20,278.66	$87,767.29	$35,501.50	$20,247.22	$163,794.67	$78,642.65	$244,333.27
202111	523	633	$34,022.10	$0.00	$34,022.10	$0.00	$912.96	$912.96	$973.78	$6,814.24	$92,218.64	$66,838.03	$10,890.56	$176,761.47	$86,291.69	$264,939.90
202112	522	631	$32,883.90	$0.00	$32,883.90	$0.00	$911.55	$911.55	$956.30	$44,183.33	$77,986.81	$44,582.98	$25,075.97	$191,829.09	$119,453.73	$313,150.67
202201	521	632	$32,697.00	$0.00	$32,697.00	$0.00	$915.11	$915.11	$957.29	$90,188.09	$77,100.21	$29,880.69	$17,386.36	$214,555.35	$64,520.55	$280,948.30
202202	520	632	$32,949.00	$0.00	$32,949.00	$0.00	$887.24	$887.24	$1,033.94	$37,385.55	$94,286.45	$24,391.61	$14,518.58	$170,582.19	$48,142.94	$220,646.31
202203	521	633	$32,760.00	$0.00	$32,760.00	$0.00	$909.48	$909.48	$3,123.82	$89,451.13	$103,124.21	$43,724.68	$23,403.17	$259,703.19	$106,119.20	$369,855.69
202204	518	628	$32,760.00	$0.00	$32,760.00	$0.00	$923.66	$923.66	$3,123.82	$48,349.34	$63,761.29	$47,537.74	$11,998.82	$171,647.19	$88,284.40	$263,979.07
202205	0	0	$0.00	$0.00	$0.00	$0.00	($6.38)	($6.38)	$3,113.49	$3,976.72	$19,416.40	$49,877.83	$7,952.03	$81,222.98	$5,756.27	$90,086.36
Total	**6,174**	**7,472**	**$493,847.20**	**$0.00**	**$493,847.20**	**$0.00**	**$10,778.19**	**$10,778.19**	**$15,280.68**	**$970,335.70**	**$1,115,604.82**	**$572,110.18**	**$228,601.51**	**$2,886,652.21**	**$1,053,484.81**	**$3,966,195.89**
Grouping Avg	**475**	**575**	**$37,988.25**	**$0.00**	**$37,988.25**	**$0.00**	**$829.09**	**$829.09**	**$1,175.44**	**$74,641.21**	**$85,815.76**	**$44,008.48**	**$17,584.73**	**$222,050.17**	**$81,037.29**	**$305,091.99**
Monthly Avg	**475**	**575**	**$37,988.25**	**$0.00**	**$37,988.25**	**$0.00**	**$829.09**	**$829.09**	**$1,175.44**	**$74,641.21**	**$85,815.76**	**$44,008.48**	**$17,584.73**	**$222,050.17**	**$81,037.29**	**$305,091.99**

Notes:
- **Grand Total includes Medical FFS, Pharmacy FFS, Incentives and Capitation.**
- **Grouping Avg – Average of the distinct groupings chosen by the user.**
- **Monthly Avg – Average of a measure over Service/Paid time period.**
- **Enrollment is recast to reflect retroactive adjustments.**
- **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
202105	466	12	36	7	0	0	0	521	633
202106	457	12	36	6	0	0	0	511	619
202107	452	11	36	5	0	0	0	504	608
202108	441	11	35	5	0	0	0	492	592
202109	444	11	35	5	0	0	0	495	596
202110	471	12	37	6	0	0	0	526	635
202111	468	12	37	6	0	0	0	523	633
202112	468	11	37	6	0	0	0	522	631
202201	467	10	38	6	0	0	0	521	632
202202	466	9	38	7	0	0	0	520	632
202203	467	9	38	7	0	0	0	521	633
202204	464	9	39	6	0	0	0	518	628
Total	**5,531**	**129**	**442**	**72**	**0**	**0**	**0**	**6,174**	**7,472**
Grouping Avg	**461**	**11**	**37**	**6**	**0**	**0**	**0**	**515**	**623**
Monthly Avg	**461**	**11**	**37**	**6**	**0**	**0**	**0**	**515**	**623**

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.

Key Indicators

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2021 to 04/2022
Prior Service Period: From 05/2020 to 04/2021
Current Paid Period: From 05/2021 to 05/2022
Prior Paid Period: From 05/2020 to 05/2021

	Current	Prior	Change	Change %
Payments Per Employee Per Year	$7,708.80	$7,372.08	$336.72	4.57%
Payments Per Member Per Year	$6,369.60	$6,096.12	$273.48	4.49%
Enrollment:				
Employees	515	539	(24)	-4.49%
Members	623	651	(29)	-4.41%
Payments:				
Inpatient Facility	$970,335.70	$798,685.70	$171,650.00	21.49%
Outpatient Facility	$1,115,604.82	$913,483.13	$202,121.69	22.13%
Total Facility	**$2,085,940.52**	**$1,712,168.83**	**$373,771.69**	**21.83%**
Professional	$800,711.69	$940,722.18	($140,010.49)	-14.88%
PCP	$101,318.46	$98,678.96	$2,639.50	2.67%
Specialist	$699,393.23	$842,043.22	($142,649.99)	-16.94%
Capitation	$10,778.19	$48,691.70	($37,913.51)	-77.86%
Value Based Programs	$15,280.68	$2,320.70	$12,959.98	558.45%
Pharmacy	$1,053,484.81	$1,267,235.00	($213,750.19)	-16.87%
Grand Total	**$3,966,195.89**	**$3,971,138.41**	**($4,942.52)**	**-0.12%**

	Current	Prior	Change	Change %
Payments Per Member Per Month:				
Inpatient Facility	$129.86	$102.17	$27.69	27.10%
Outpatient Facility	$149.30	$116.85	$32.45	27.77%
Total Facility	**$279.16**	**$219.03**	**$60.13**	**27.45%**
Professional	$107.16	$120.34	($13.18)	-10.95%
PCP	$13.55	$12.62	$0.93	7.37%
Specialist	$93.60	$107.71	($14.11)	-13.10%
Capitation	$1.44	$6.22	($4.78)	-76.85%
Value Based Programs	$2.04	$0.28	$1.76	$6.29
Pharmacy	$140.99	$162.11	($21.12)	-13.03%
Grand Total	**$530.80**	**$508.01**	**$22.79**	**4.49%**
Other Key Payment Indicators:				
Inpatient Payments/Day	$8,086.13	$4,754.08	$3,332.05	70.09%
Inpatient Payments/Admissions	$22,053.08	$19,016.32	$3,036.76	15.97%
Outpatient Payments/Visit	$1,776.44	$1,580.42	$196.02	12.40%
Professional Payments/Service	$87.83	$91.39	($3.56)	-3.90%
PCP Payments/Service	$41.43	$41.44	($0.01)	-0.02%
Specialist Payments/Service	$104.84	$106.42	($1.58)	-1.48%
Pharmacy Payments/Script	$137.40	$153.95	($16.55)	-10.75%

	Current	Prior	Change	Change %
Key Utilization Indicators:				
Inpatient Facility				
Inpatient Days/1000 Members	193	258	(65)	-25.27%
Inpatient Admissions/1000 Members	71	64	6	9.60%

Average Length of Inpatient Stay	2.73	4.00	(1.27)	-31.82%
% Facility Admissions > 10	0.00%	14.29%		
Outpatient Facility				
Outpatient Visits/1000 Members	1,009	887	121	13.67%
Emer Rm Visits/1000 Members	173	187	(14)	-7.39%
Other Visits/1000 Members	835	700	135	19.30%
Professional				
Professional Services/1000 Members	14,640	15,801	(1,161)	-7.35%
PCP Services/1000 Members	3,927	3,655	272	7.43%
Specialist Services/1000 Members	10,714	12,146	(1,432)	-11.79%
Pharmacy:				
Pharmacy Scripts/1000 Members	12,313	12,636	(322)	-2.55%

Value Based Programs line includes earned incentives for managing quality with cost efficiencies. Supplemental detail included on MBI EBP report.

Included in the Valued Based Program line are CBF Care Coordination Fees and Shared Savings that members have incurred outside of Florida

Brand Vs Generic

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2021 to 04/2022
Current Paid Period: From 05/2021 to 05/2022

Utilization	Retail	Retail 90 Day	Mail Order	Total
Total Rx Users	549	327	4	562
Total Rx	4,846	2,783	38	7,667
Generic	4,026	2,696	38	6,760
Multi-Source Brand Generic Available	65	25	0	90
Multi-Source Brand w/o Generic Available	29	1	0	30
Single Source Brand	726	61	0	787
Acute Rx %	57.06%	7.19%	23.68%	38.79%
Maintenance Rx %	42.94%	92.81%	76.32%	61.21%
Member Utilization				
Rx/1000	7,783	4,469	61	12,313
Member PMPM	$16.24	$8.30	$0.06	$24.62
Member PMPY	$194.88	$99.60	$0.72	$295.44
Generic %	83.08%	96.87%	100.00%	88.17%
Multi-Source Brand %	0.60%	0.04%	0.00%	0.39%
Multi-Source Brand Generic Available %	1.34%	0.90%	0.00%	1.17%
Single Source Brand %	14.98%	2.19%	0.00%	10.26%
Generic Substitution %	98.41%	99.08%	0.00%	98.69%
Formulary %	94.94%	99.43%	100.00%	96.60%
Days Supply				
Total Days Supply	91,073	250,477	3,060	344,610
Average Days Supply	18.79	90.00	80.53	44.95
Cost				
Plan Paid PMPM	$108.47	$31.74	$0.76	$140.99
Member Paid PMPM	$16.24	$8.30	$0.06	$24.62
Total PMPM	$124.72	$40.05	$0.83	$165.61
Generic PMPM	$7.64	$13.88	$0.83	$22.36
Brand PMPM	$117.08	$26.16	$0.00	$143.24
Total PMPY	$1,496.69	$480.67	$10.06	$1,987.42

Notes:
- Retail 90 Days = Prescription filled for a days supply greater than 31 up to a maximum of 93.
- Member Submitted = Manually submitted paper claim. Member Submitted amounts are included in Retail, Retail 90 Days and Mail Order.
- Total for Total Rx Users does not represent a summation of Retail, Retail 90 Days and Mail Order. A member's Rx may be filled in more than one category.
- Utilization counts are determined by scripts written. Retail, Mail Order and Retail 90 Days count as 1 unit.

TOTAL COST	Retail	Retail 90 Day	Mail Order	Total
Total Cost	$931,941.20	$299,295.77	$6,265.91	$1,237,502.88
Total Ingredient Cost	$916,999.11	$299,126.04	$6,265.91	$1,222,391.06
Total Ingredient Cost - Generic	$56,225.55	$103,605.25	$6,265.91	$166,096.71
Total Ingredient Cost - Multi-Source Brand	$5,102.24	$1,020.34	$0.00	$6,122.58
Total Ingredient Cost - Single Source Brand	$840,935.43	$180,143.50	$0.00	$1,021,078.93
Total Ingredient Cost - Brand Generic Available	$14,735.89	$14,356.95	$0.00	$29,092.84
Total Cost - Formulary	$783,958.57	$287,850.14	$6,265.91	$1,078,074.62
Total Cost - Non-Formulary	$147,982.63	$11,445.63	$0.00	$159,428.26
Avg Total Cost / Claim	$192.31	$107.54	$164.89	$161.40
Avg Total Cost / Day	$10.23	$1.19	$2.04	$3.59
Total Cost PMPY	$1,496.69	$480.67	$10.06	$1,987.42
Total Cost PMPM	$124.72	$40.05	$0.83	$165.61
Avg Total Cost - Generic	$14.18	$38.49	$164.89	$24.72
Avg Total Cost - Multi-Source Brand	$176.08	$1,020.44	$0.00	$204.22
Avg Total Cost - Single Source Brand	$1,177.65	$2,953.18	$0.00	$1,315.27
Avg Total Cost - Brand Generic Available	$226.96	$574.33	$0.00	$323.45
Avg Total Cost - Formulary	$170.38	$104.02	$164.89	$145.56
Avg Total Cost - Non-Formulary	$604.01	$715.35	$0.00	$610.83
PLAN PAID				
Total Plan Paid Amount	$810,522.71	$237,217.92	$5,744.18	$1,053,484.81
Plan Paid - Generic	$26,783.91	$56,993.58	$5,744.18	$89,521.67
Plan Paid - Multi-Source Brand	$3,491.13	$870.44	$0.00	$4,361.57
Plan Paid - Single Source Brand	$767,523.30	$167,104.28	$0.00	$934,627.58
Plan Paid - Brand Generic Available	$12,724.37	$12,249.62	$0.00	$24,973.99
Plan Paid - Formulary	$682,953.38	$227,841.78	$5,744.18	$916,539.34
Plan Paid - Non-Formulary	$127,569.33	$9,376.14	$0.00	$136,945.47
Avg Total Plan Paid / Claim	$167.25	$85.23	$151.16	$137.40
Avg Total Plan Paid / Day	$8.89	$0.94	$1.87	$3.05
Plan Paid PMPY	$1,301.70	$380.97	$9.23	$1,691.89
Plan Paid PMPM	$108.47	$31.74	$0.76	$140.99
Plan Cost Share Contribution %	86.00%	79.00%	91.00%	85.00%
Avg Plan Paid - Generic	$6.65	$21.14	$151.16	$13.24
Avg Plan Paid - Multi-Source Brand	$120.38	$870.44	$0.00	$145.38
Avg Plan Paid - Single Source Brand	$1,057.19	$2,739.41	$0.00	$1,187.58
Avg Plan Paid - Brand Generic Available	$195.75	$489.98	$0.00	$277.48
Avg Plan Paid - Formulary	$148.43	$82.34	$151.16	$123.75
Avg Plan Paid - Non-Formulary	$520.69	$586.00	$0.00	$524.69
MEMBER PAID				
Total Member Paid Amount	$121,418.49	$62,077.85	$521.73	$184,018.07
Member Paid - Generic	$30,317.90	$46,779.13	$521.73	$77,618.76
Member Paid - Multi-Source Brand	$1,615.22	$150.00	$0.00	$1,765.22
Member Paid - Single Source Brand	$87,457.32	$13,039.85	$0.00	$100,497.17
Member Paid - Brand Generic Available	$2,028.05	$2,108.87	$0.00	$4,136.92
Member Paid - Formulary	$101,005.19	$60,008.36	$521.73	$161,535.28
Member Paid - Non-Formulary	$20,413.30	$2,069.49	$0.00	$22,482.79
Avg Total Member Paid / Claim	$25.05	$22.30	$13.72	$24.00
Avg Total Member Paid / Day	$1.33	$0.24	$0.17	$0.53
Member Paid PMPY	$195.00	$99.70	$0.84	$295.53
Member Paid PMPM	$16.24	$8.30	$0.06	$24.62
Member Cost Share Contribution %	13.00%	20.00%	8.00%	14.00%
Avg Member Paid - Generic	$7.53	$17.35	$13.72	$11.48
Avg Member Paid - Multi-Source Brand	$55.69	$150.00	$0.00	$58.84

Avg Member Paid - Single Source Brand	$120.46	$213.76	$0.00	$127.69
Avg Member Paid - Brand Generic Available	$31.20	$84.35	$0.00	$45.96
Avg Member Paid - Formulary	$21.95	$21.68	$13.72	$21.81
Avg Member Paid - Non-Formulary	$83.31	$129.34	$0.00	$86.14
PRICING / NETWORK PERFORMANCE				
Avg Ingredient Cost / Rx	$189.22	$107.48	$164.89	$159.43
Avg Ingredient Cost / Generic Rx	$13.96	$38.42	$164.89	$24.57
Avg Ingredient Cost / Multi-Source Brand Rx	$175.93	$1,020.34	$0.00	$204.08
Avg Ingredient Cost / Single Source Brand Rx	$1,158.31	$2,953.17	$0.00	$1,297.43
Avg Ingredient Cost / Brand Generic Available Rx	$226.70	$574.27	$0.00	$323.25
Avg Ingredient Cost / Formulary	$168.61	$103.96	$164.89	$144.44
Avg Ingredient Cost / Non-Formulary	$576.34	$715.27	$0.00	$584.86
Avg Dispense Fee / Rx	$0.19	$0.06	$0.00	$0.14
Avg Dispense Fee / Generic Rx	$0.21	$0.06	$0.00	$0.15
Avg Dispense Fee / Multi-Source Brand Rx	$0.14	$0.10	$0.00	$0.14
Avg Dispense Fee / Single Source Brand Rx	$0.08	$0.01	$0.00	$0.07
Avg Dispense Fee / Brand Generic Available Rx	$0.25	$0.06	$0.00	$0.20
Avg Dispense Fee / Formulary	$0.20	$0.06	$0.00	$0.14
Avg Dispense Fee / Non-Formulary	$0.05	$0.07	$0.00	$0.05

Notes:

- Retail 90 Days = Prescription filled for a days supply greater than 31 up to a maximum of 93.

- Member Submitted = Manually submitted paper claim. Member Submitted amounts are included in Retail, Retail 90 Days and Mail Order.

- Total for Total Rx Users does not represent a summation of Retail, Retail 90 Days and Mail Order. A member's Rx may be filled in more than one category.

- Utilization counts are determined by scripts written. Retail, Mail Order and Retail 90 Days count as 1 unit.

Top Drug Classes by Paid/Prescription

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2021 to 04/2022
Prior Service Period: From 05/2020 to 04/2021
Current Paid Period: From 05/2021 to 05/2022
Prior Paid Period: From 05/2020 to 05/2021
Rank: 10
Rx Sort By: PAID

Drug Class	Drug	Current Rank	Prior Rank	Current Plan Paid Amt	Plan Paid Chg Pct	Formulary Pct	Substitution Pct	Avg Ingredient/ Rx	Avg Ingredient/ Brand	Avg Ingredient/ Generic	Cost Share Pct	# of Rx's	Rx Chg Pct	Total Rx Users	Current Util/1000	Current Util Chg Pct	Current Plan Paid PMPM	Plan Paid Chg	Paid PMPM Chg Pct
ANALGESICS - ANTI-INFLAMMATORY	HUMIRA PEN			$136,447.26	-8.61%			$11,415.61	$11,415.61	$0.00	0.40%	12	-14.29%	1	19.27	-10.33%	$18.26	($0.84)	-4.39%
ANALGESICS - ANTI-INFLAMMATORY	ENBREL SURECLICK			$73,624.09	75.80%			$5,726.50	$5,726.50	$0.00	8.89%	14	40.00%	2	22.48	46.46%	$9.85	$4.50	83.92%
ANALGESICS - ANTI-INFLAMMATORY	ENBREL			$50,407.12	73.45%			$5,779.64	$5,779.64	$0.00	14.66%	10	66.67%	1	16.06	74.36%	$6.75	$3.03	81.46%
ANALGESICS - ANTI-INFLAMMATORY	XELJANZ XR			$32,298.77	-28.49%			$4,674.11	$4,674.11	$0.00	1.30%	7	-30.00%	1	11.24	-26.77%	$4.32	($1.46)	-25.18%
ANALGESICS - ANTI-INFLAMMATORY	CELECOXIB			$420.64	79.18%			$25.36	$0.00	$25.36	130.79%	38	46.15%	12	61.03	52.90%	$0.06	$0.03	87.45%
ANALGESICS - ANTI-INFLAMMATORY	ALL OTHER			$736.81	2.26%			$12.83	$0.00	$12.83	187.26%	163	-13.30%	97	261.78	-9.29%	$0.10	$0.01	6.98%
ANALGESICS - ANTI-INFLAMMATORY	**ANALGESICS - ANTI-INFLAMMATORY**	**1**	**1**	**$293,934.69**	**10.35%**	**100.00%**	**100.00%**	**$1,273.48**	**$7,155.20**	**$15.20**	**5.72%**	**244**	**-3.94%**	**110**	**391.86**	**0.50%**	**$39.34**	**$5.26**	**15.45%**
ANTIVIRALS	DOVATO			$42,891.73	89.75%			$2,491.86	$2,491.86	$0.00	16.20%	20	81.82%	2	32.12	90.21%	$5.74	$2.85	98.51%
ANTIVIRALS	BIKTARVY			$34,739.01	-33.76%			$7,117.60	$7,117.60	$0.00	2.45%	5	-54.55%	1	8.03	-52.45%	$4.65	($2.06)	-30.70%
ANTIVIRALS	PREZCOBIX			$23,389.36	41.89%			$5,997.34	$5,997.34	$0.00	2.57%	4	33.33%	1	6.42	39.49%	$3.13	$1.02	48.44%
ANTIVIRALS	PREZISTA			$20,388.40	-14.81%			$5,247.10	$5,247.10	$0.00	2.94%	4	-20.00%	1	6.42	-16.31%	$2.73	($0.33)	-10.88%
ANTIVIRALS	ISENTRESS			$18,807.07	-17.55%			$4,926.77	$4,926.77	$0.00	4.79%	4	-20.00%	1	6.42	-16.31%	$2.52	($0.40)	-13.74%
ANTIVIRALS	ALL OTHER			$36,758.06	-54.35%			$594.48	$5,931.53	$149.72	5.14%	65	-40.91%	33	104.39	-38.18%	$4.92	($5.38)	-52.25%
ANTIVIRALS	**ANTIVIRALS**	**2**	**2**	**$176,973.63**	**-19.12%**	**99.02%**	**100.00%**	**$1,850.50**	**$4,280.18**	**$149.72**	**6.66%**	**102**	**-29.66%**	**34**	**163.81**	**-26.41%**	**$23.68**	**($4.31)**	**-15.38%**
DERMATOLOGICALS	STELARA			$113,577.86	-26.26%			$16,653.01	$16,653.01	$0.00	2.64%	7	-22.22%	2	11.24	-18.63%	$15.20	($4.50)	-22.85%
DERMATOLOGICALS	DUPIXENT			$11,618.49	-50.72%			$3,080.68	$3,080.68	$0.00	297.73%	15	87.50%	2	24.09	96.16%	$1.55	($1.46)	-48.45%
DERMATOLOGICALS	SOOLANTRA			$960.05	0.00%			$611.86	$611.86	$0.00	91.29%	3	200.00%	2	4.82	213.85%	$0.13	$0.13	0.00%
DERMATOLOGICALS	AZELAIC ACID			$491.50	-71.19%			$132.71	$0.00	$132.71	8.14%	4	-50.00%	3	6.42	-47.69%	$0.07	($0.15)	-69.86%
DERMATOLOGICALS	AMNESTEEM			$343.16	-11.80%			$181.58	$0.00	$181.58	5.83%	2	100.00%	1	3.21	109.23%	$0.05	($0.00)	-7.73%
DERMATOLOGICALS	ALL OTHER			$1,445.55	-73.31%			$24.40	$91.12	$23.92	137.11%	139	-23.63%	98	223.23	-20.10%	$0.19	($0.50)	-72.07%
DERMATOLOGICALS	**DERMATOLOGICALS**	**3**	**3**	**$128,436.61**	**-30.62%**	**97.06%**	**100.00%**	**$993.54**	**$6,334.92**	**$29.13**	**31.54%**	**170**	**-18.66%**	**104**	**273.02**	**-14.90%**	**$17.19**	**($6.49)**	**-27.41%**
RESPIRATORY AGENTS - MISC.	OFEV			$109,978.46	-12.40%			$11,117.85	$11,117.85	$0.00	1.09%	10	-16.67%	1	16.06	-12.82%	$14.72	($1.34)	-8.36%
RESPIRATORY AGENTS - MISC.	**RESPIRATORY AGENTS - MISC.**	**4**	**5**	**$109,978.46**	**-12.40%**	**0.00%**	**0.00%**	**$11,117.85**	**$11,117.85**	**$0.00**	**1.09%**	**10**	**-16.67%**	**1**	**16.06**	**-12.82%**	**$14.72**	**($1.34)**	**-8.36%**
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	REBIF REBIDOSE			$108,590.89	2.93%			$8,436.22	$8,436.22	$0.00	0.99%	13	0.00%	1	20.88	4.62%	$14.53	$1.04	7.68%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	DISULFIRAM			$508.49	0.00%			$192.70	$0.00	$192.70	13.77%	3	0.00%	1	4.82	0.00%	$0.07	$0.07	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ACAMPROSATE CALCIUM DR			$180.36	0.00%			$190.06	$0.00	$190.06	5.54%	1	0.00%	1	1.61	0.00%	$0.02	$0.02	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	NICOTINE TRANSDERMAL SYSTEM			$115.35	171.48%			$38.22	$0.00	$38.22	0.00%	3	200.00%	2	4.82	213.85%	$0.02	$0.01	184.01%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	MEMANTINE HYDROCHLORIDE			$0.00	-100.00%			$9.32	$0.00	$9.32	0.00%	2	100.00%	1	3.21	109.23%	$0.00	($0.00)	-100.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	ALL OTHER			$0.00	0.00%			$0.00	$0.00	$0.00	0.00%	0	-100.00%	0	0.00	-100.00%	$0.00	$0.00	0.00%
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	**PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.**	**5**	**6**	**$109,395.09**	**3.65%**	**100.00%**	**100.00%**	**$5,026.01**	**$8,436.22**	**$100.16**	**1.08%**	**22**	**37.50%**	**5**	**35.33**	**43.85%**	**$14.64**	**$1.14**	**8.43%**
ANTIDIABETICS	OZEMPIC			$25,084.93	254.06%			$1,280.55	$1,280.55	$0.00	32.75%	26	550.00%	8	41.76	580.01%	$3.36	$2.45	270.41%
ANTIDIABETICS	RYBELSUS			$12,861.52	218.80%			$1,381.69	$1,381.69	$0.00	18.19%	11	37.50%	2	17.67	43.85%	$1.72	$1.21	233.52%
ANTIDIABETICS	INVOKANA			$8,446.00	2.64%			$960.17	$960.17	$0.00	36.42%	12	9.09%	2	19.27	14.13%	$1.13	$0.08	7.38%
ANTIDIABETICS	TRESIBA FLEXTOUCH			$7,573.20	0.32%			$1,265.03	$1,265.03	$0.00	16.93%	7	-12.50%	1	11.24	-8.46%	$1.01	$0.05	4.95%
ANTIDIABETICS	JANUMET			$5,110.88	42.03%			$1,427.72	$1,427.72	$0.00	11.74%	4	33.33%	1	6.42	39.49%	$0.68	$0.22	48.59%
ANTIDIABETICS	ALL OTHER			$20,753.71	-58.34%			$89.99	$449.49	$11.72	43.26%	330	-17.09%	62	529.98	-13.26%	$2.78	($3.59)	-56.41%
ANTIDIABETICS	**ANTIDIABETICS**	**6**	**7**	**$79,830.24**	**-0.59%**	**97.44%**	**100.00%**	**$267.38**	**$849.59**	**$11.72**	**30.68%**	**390**	**-9.72%**	**64**	**626.34**	**-5.55%**	**$10.68**	**$0.41**	**4.00%**
ANTICONVULSANTS	TOPIRAMATE ER			$23,019.36	364.32%			$2,580.89	$0.00	$2,580.89	0.91%	9	350.00%	1	14.45	370.78%	$3.08	$2.45	385.76%
ANTICONVULSANTS	GABAPENTIN			$410.24	-1.31%			$15.77	$0.00	$15.77	206.41%	79	-21.00%	28	126.87	-17.35%	$0.05	$0.00	3.25%
ANTICONVULSANTS	PHENYTOIN SODIUM EXTENDED			$340.19	92.88%			$115.01	$0.00	$115.01	35.27%	4	0.00%	1	6.42	4.62%	$0.05	$0.02	101.79%
ANTICONVULSANTS	DIVALPROEX SODIUM DR			$46.72	12.71%			$14.07	$0.00	$14.07	266.25%	12	0.00%	2	19.27	4.62%	$0.01	$0.00	17.92%
ANTICONVULSANTS	DIVALPROEX SODIUM ER			$29.33	0.00%			$38.83	$0.00	$38.83	34.09%	1	0.00%	1	1.61	0.00%	$0.00	$0.00	0.00%
ANTICONVULSANTS	ALL OTHER			$19.48	-99.87%			$15.46	$0.00	$15.46	5830.95%	74	-39.34%	23	118.84	-36.54%	$0.00	($1.96)	-99.87%
ANTICONVULSANTS	**ANTICONVULSANTS**	**7**	**8**	**$23,865.32**	**14.10%**	**100.00%**	**100.00%**	**$146.85**	**$0.00**	**$146.85**	**10.25%**	**179**	**-25.42%**	**51**	**287.47**	**-21.97%**	**$3.19**	**$0.52**	**19.37%**
VACCINES	MODERNA COVID-19 VACCINE			$8,960.00	239.64%			$0.00	$0.00	$0.00	0.00%	224	157.47%	153	359.74	169.36%	$1.20	$0.86	255.32%

VACCINES	SHINGRIX			$6,187.84	14.67%			$162.55	$162.55	$0.00	0.00%	35	6.06%	23	56.21	10.96%	$0.83	$0.14	19.97%
VACCINES	PFIZER-BIONTECH COVID-19VACCINE			$2,920.00	170.73%			$0.00	$0.00	$0.00	0.00%	73	135.48%	47	117.24	146.36%	$0.39	$0.25	183.23%
VACCINES	FLUCELVAX QUADRIVALENT 2021-2022			$1,471.73	0.00%			$27.44	$27.44	$0.00	0.00%	36	0.00%	36	57.82	0.00%	$0.20	$0.20	0.00%
VACCINES	FLUZONE QUADRIVALENT 2021-2022			$524.42	0.00%			$21.28	$21.28	$0.00	0.00%	15	0.00%	15	24.09	0.00%	$0.07	$0.07	0.00%
VACCINES	ALL OTHER			$2,124.94	-52.83%			$36.25	$36.25	$0.00	0.00%	34	-62.64%	32	54.60	-60.91%	$0.28	($0.29)	-50.65%
VACCINES	**VACCINES**	**8**	**11**	**$22,188.93**	**62.94%**	**59.71%**	**0.00%**	**$19.73**	**$19.73**	**$0.00**	**0.00%**	**417**	**72.31%**	**238**	**669.70**	**80.27%**	**$2.97**	**$1.23**	**70.47%**
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ADVAIR DISKUS			$10,834.15	42.39%			$555.33	$555.33	$0.00	2.58%	20	11.11%	4	32.12	16.24%	$1.45	$0.48	48.97%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	SYMBICORT			$3,974.99	9.76%			$356.27	$356.27	$0.00	34.47%	15	15.38%	6	24.09	20.71%	$0.53	$0.07	14.82%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	TRELEGY ELLIPTA			$3,375.63	0.00%			$1,113.83	$1,113.83	$0.00	31.99%	4	0.00%	2	6.42	0.00%	$0.45	$0.45	0.00%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ALBUTEROL SULFATE HFA			$1,025.12	188.17%			$29.26	$0.00	$29.26	219.13%	111	126.53%	60	178.27	136.99%	$0.14	$0.09	201.48%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	MONTELUKAST SODIUM			$424.02	158.56%			$19.66	$0.00	$19.66	365.41%	100	-5.66%	46	160.60	-1.30%	$0.06	$0.04	170.50%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	ALL OTHER			$971.33	-75.95%			$39.12	$70.10	$26.30	65.63%	41	-43.06%	22	65.85	-40.43%	$0.13	($0.39)	-74.84%
ANTIASTHMATIC AND BRONCHODILATOR AGENTS	**ANTIASTHMATIC AND BRONCHODILATOR AGENTS**	**9**	**9**	**$20,605.24**	**30.50%**	**97.94%**	**90.23%**	**$95.27**	**$426.42**	**$24.90**	**34.76%**	**291**	**12.79%**	**104**	**467.34**	**18.00%**	**$2.76**	**$0.74**	**36.53%**
CONTRACEPTIVES	NUVARING			$5,450.19	9.01%			$419.15	$419.15	$0.00	0.00%	13	-23.53%	4	20.88	-20.00%	$0.73	$0.09	14.05%
CONTRACEPTIVES	SIMPESSE			$647.12	0.00%			$161.78	$0.00	$161.78	0.00%	4	0.00%	1	6.42	0.00%	$0.09	$0.09	0.00%
CONTRACEPTIVES	ERRIN			$508.02	30.45%			$63.40	$0.00	$63.40	0.00%	8	-42.86%	2	12.85	-40.22%	$0.07	$0.02	36.47%
CONTRACEPTIVES	DROSPIRENONE/ETHINYL ESTRADIOL			$410.60	-47.08%			$40.90	$0.00	$40.90	0.00%	10	25.00%	3	16.06	30.77%	$0.05	($0.04)	-44.63%
CONTRACEPTIVES	ESTARYLLA			$397.31	93.82%			$56.67	$0.00	$56.67	0.00%	7	40.00%	2	11.24	46.46%	$0.05	$0.03	102.77%
CONTRACEPTIVES	ALL OTHER			$4,956.63	-43.53%			$37.37	$145.20	$30.59	27.74%	169	-28.69%	44	271.41	-25.40%	$0.66	($0.46)	-40.92%
CONTRACEPTIVES	**CONTRACEPTIVES**	**10**	**10**	**$12,369.87**	**-18.34%**	**95.73%**	**99.47%**	**$65.04**	**$300.04**	**$36.30**	**11.12%**	**211**	**-24.91%**	**53**	**338.87**	**-21.44%**	**$1.66**	**($0.28)**	**-14.56%**
ALL OTHER	ALL OTHER			$75,906.73	-65.51%			$27.00	$278.02	$19.51	101.50%	5,631	-8.32%	502	9,043.36	-4.09%	$10.16	($18.00)	-63.92%
Total	**Total**			**$1,053,484.81**	**-16.87%**	**96.60%**	**99.56%**	**$159.44**	**$1,164.60**	**$24.57**	**17.47%**	**7,667**	**-6.85%**	**562**	**12,313.17**	**-2.55%**	**$140.99**	**($21.12)**	**-13.03%**

Top Drugs by Paid/Prescription

Company: SUWANNEE CNTY BOARD OF PUBLIC
Group: 78170
Current Service Period: From 05/2021 to 04/2022
Prior Service Period: From 05/2020 to 04/2021
Current Paid Period: From 05/2021 to 05/2022
Prior Paid Period: From 05/2020 to 05/2021
Rank: 10
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
HUMIRA PEN	1	2	$136,447.26	$149,305.07	-8.61%	$540.00	$660.00	-18.18%	$136,987.26	$149,965.07	-8.65%	$240.00	$360.00	$300.00	$300.00	$0.00	$0.00	$136,987.26	$149,965.07	$0.00	$0.00
STELARA	2	1	$113,577.86	$154,023.61	-26.26%	$2,993.23	$4,100.00	-26.98%	$116,571.09	$158,123.61	-26.28%	$350.00	$300.00	$2,643.23	$3,800.00	$0.00	$0.00	$116,571.09	$158,121.81	$0.00	$1.80
OFEV	3	3	$109,978.46	$125,547.36	-12.40%	$1,200.00	$1,500.00	-20.00%	$111,178.46	$127,047.36	-12.49%	$900.00	$1,200.00	$300.00	$300.00	$0.00	$0.00	$111,178.46	$127,047.36	$0.00	$0.00
REBIF REBIDOSE	4	5	$108,590.89	$105,499.25	2.93%	$1,080.00	$1,080.00	0.00%	$109,670.89	$106,579.25	2.90%	$780.00	$780.00	$300.00	$300.00	$0.00	$0.00	$109,670.89	$106,579.25	$0.00	$0.00
ENBREL SURECLICK	5	8	$73,624.09	$41,879.01	75.80%	$6,546.94	$4,231.00	54.72%	$80,171.03	$46,110.01	73.87%	$700.00	$450.00	$5,846.94	$3,781.00	$0.00	$0.00	$80,171.03	$46,109.11	$0.00	$0.90
ENBREL	6	10	$50,407.12	$29,061.97	73.45%	$7,389.24	$3,530.55	109.29%	$57,796.36	$32,592.52	77.33%	$400.00	$300.00	$6,989.24	$3,230.55	$0.00	$0.00	$57,796.36	$32,592.52	$0.00	$0.00
DOVATO	7	14	$42,891.73	$22,604.19	89.75%	$6,947.56	$3,932.29	76.68%	$49,839.29	$26,536.48	87.81%	$900.00	$500.00	$6,047.56	$3,432.29	$0.00	$0.00	$49,837.29	$26,534.58	$2.00	$1.90
BIKTARVY	8	6	$34,739.01	$52,442.18	-33.76%	$850.00	$930.00	-8.60%	$35,589.01	$53,372.18	-33.32%	$550.00	$930.00	$300.00	$0.00	$0.00	$0.00	$35,588.01	$53,370.23	$1.00	$1.95
XELJANZ XR	9	7	$32,298.77	$45,164.30	-28.49%	$420.00	$1,526.32	-72.48%	$32,718.77	$46,690.62	-29.92%	$420.00	$240.00	$0.00	$300.00	$0.00	$986.32	$32,718.77	$46,690.17	$0.00	$0.45
OZEMPIC	10	26	$25,084.93	$7,084.86	254.09%	$8,215.79	$890.00	823.03%	$33,300.72	$7,974.86	317.59%	$2,810.00	$590.00	$5,405.79	$300.00	$0.00	$0.00	$33,294.38	$7,974.86	$6.34	$0.00
ALL OTHER			$325,844.69	$534,623.20	-39.05%	$147,835.31	$140,998.71	4.85%	$473,680.00	$675,621.91	-29.89%	$49,171.53	$57,448.60	$98,663.78	$83,101.91	$0.00	$448.20	$458,577.52	$668,740.16	$1,115.53	$1,324.57
Total			**$1,053,484.81**	**$1,267,235.00**	**-16.87%**	**$184,018.07**	**$163,378.87**	**12.63%**	**$1,237,502.88**	**$1,430,613.87**	**-13.50%**	**$57,221.53**	**$63,098.60**	**$126,796.54**	**$98,845.75**	**$0.00**	**$1,434.52**	**$1,222,391.06**	**$1,423,725.12**	**$1,124.87**	**$1,331.57**

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
HUMIRA PEN	1	2	$11,370.60	$10,664.64	6.61%	$45.00	$47.14	-4.26%	$11,415.60	$10,711.79	6.56%	$20.00	$25.71	$25.00	$21.42	$0.00	$0.00	$11,415.60	$10,711.79	$0.00	$0.00
STELARA	2	1	$16,225.40	$17,113.73	-5.19%	$427.60	$455.55	-5.93%	$16,653.01	$17,569.29	-5.21%	$50.00	$33.33	$377.60	$422.22	$0.00	$0.00	$16,653.01	$17,569.09	$0.00	$0.20
OFEV	3	3	$10,997.84	$10,462.28	5.11%	$120.00	$125.00	-4.00%	$11,117.84	$10,587.28	5.01%	$90.00	$100.00	$30.00	$25.00	$0.00	$0.00	$11,117.84	$10,587.28	$0.00	$0.00
REBIF REBIDOSE	4	5	$8,353.14	$8,115.32	2.92%	$83.07	$83.07	0.00%	$8,436.22	$8,198.40	2.89%	$60.00	$60.00	$23.07	$23.07	$0.00	$0.00	$8,436.22	$8,198.40	$0.00	$0.00
ENBREL SURECLICK	5	8	$5,258.86	$4,187.90	25.56%	$467.63	$423.10	10.40%	$5,726.50	$4,611.00	24.18%	$50.00	$45.00	$417.63	$378.10	$0.00	$0.00	$5,726.50	$4,610.91	$0.00	$0.09
ENBREL	6	10	$5,040.71	$4,843.66	4.07%	$738.92	$588.42	25.51%	$5,779.63	$5,432.08	6.39%	$40.00	$50.00	$698.92	$538.42	$0.00	$0.00	$5,779.63	$5,432.08	$0.00	$0.00
DOVATO	7	14	$2,144.58	$2,054.92	4.33%	$347.37	$357.48	-2.80%	$2,491.96	$2,412.40	3.28%	$45.00	$45.45	$302.37	$312.02	$0.00	$0.00	$2,491.86	$2,412.23	$0.10	$0.17
BIKTARVY	8	6	$6,947.80	$4,767.47	45.73%	$170.00	$84.54	101.19%	$7,117.80	$4,852.01	46.68%	$110.00	$84.54	$60.00	$0.00	$0.00	$0.00	$7,117.60	$4,851.83	$0.20	$0.17
XELJANZ XR	9	7	$4,614.11	$4,516.43	2.15%	$60.00	$152.63	-60.53%	$4,674.11	$4,669.06	0.11%	$60.00	$24.00	$0.00	$30.00	$0.00	$98.63	$4,674.11	$4,669.01	$0.00	$0.04
OZEMPIC	10	26	$964.80	$1,771.21	-45.51%	$315.99	$222.50	41.89%	$1,280.79	$1,993.71	-35.73%	$108.07	$147.50	$207.91	$75.00	$0.00	$0.00	$1,280.55	$1,993.71	$0.24	$0.00
ALL OTHER			$43.19	$65.75	-33.85%	$19.59	$17.34	11.76%	$62.79	$83.09	-24.10%	$6.51	$7.06	$13.08	$10.22	$0.00	$0.05	$60.79	$82.24	$0.14	$0.16
Total			**$137.40**	**$153.95**	**-10.46%**	**$24.00**	**$19.84**	**21.05%**	**$161.40**	**$173.80**	**-6.94%**	**$7.46**	**$7.66**	**$16.53**	**$12.00**	**$0.00**	**$0.17**	**$159.43**	**$172.97**	**$0.14**	**$0.16**

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 %
HUMIRA PEN	1	2	12	14	-14.29%	1	1	0.00%	12.00	14.00	4.00	4.00	28.00	28.00	$18.26	$19.10	-4.40%	19.27	21.49	-10.33%
STELARA	2	1	7	9	-22.22%	2	2	0.00%	3.50	4.50	0.71	0.77	30.00	29.00	$15.20	$19.70	-22.84%	11.24	13.82	-18.63%
OFEV	3	3	10	12	-16.67%	1	1	0.00%	10.00	12.00	60.00	60.00	30.00	30.00	$14.71	$16.06	-8.41%	16.06	18.42	-12.82%
REBIF REBIDOSE	4	5	13	13	0.00%	1	1	0.00%	13.00	13.00	6.00	6.00	28.00	28.00	$14.53	$13.49	7.71%	20.88	19.96	4.62%
ENBREL SURECLICK	5	8	14	10	40.00%	2	3	-33.33%	7.00	3.33	4.00	4.00	28.00	28.00	$9.85	$5.35	84.11%	22.48	15.35	46.46%
ENBREL	6	10	10	6	66.67%	1	1	0.00%	10.00	6.00	4.00	4.00	28.00	28.00	$6.74	$3.71	81.67%	16.06	9.21	74.36%
DOVATO	7	14	20	11	81.82%	2	1	100.00%	10.00	11.00	30.00	30.00	30.00	30.00	$5.74	$2.89	98.62%	32.12	16.89	90.21%
BIKTARVY	8	6	5	11	-54.55%	1	2	-50.00%	5.00	5.50	66.00	46.36	66.00	46.00	$4.64	$6.70	-30.75%	8.03	16.89	-52.45%
XELJANZ XR	9	7	7	10	-30.00%	1	1	0.00%	7.00	10.00	30.00	30.00	30.00	30.00	$4.32	$5.77	-25.13%	11.24	15.35	-26.77%
OZEMPIC	10	26	26	4	550.00%	8	4	100.00%	3.25	1.00	2.76	4.12	61.00	74.00	$3.35	$0.90	272.22%	41.76	6.14	580.02%
ALL OTHER			7,543	8,131	-7.23%	562	571	-1.58%	13.42	14.24	60.34	60.69	45.00	44.00	$43.60	$68.39	-36.25%	12,114.03	12,482.03	-2.95%
Total			**7,667**	**8,231**	**-6.85%**	**562**	**571**	**-1.58%**	**13.64**	**14.42**	**59.63**	**60.21**	**44.00**	**44.00**	**$140.99**	**$162.11**	**-13.03%**	**12,313.17**	**12,635.54**	**-2.55%**

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.

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$300** Pharmacy Deductible; . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,350** Per Person/**$12,700** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: $50 Copay per Visit/ Primary Care Visits: $50 Copay per Visit/ Virtual Visits: $50 Copay per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $65 Copay per Visit/ Specialist: $65 Copay per Visit/ Virtual Visits: $65 Copay per Visit	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $65 Copay per Visit/ Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $65 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	$500 Copay per Visit	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$300 Pharmacy Deductible + $50 Copay per Prescription at retail, $300 Pharmacy Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$300 Pharmacy Deductible + $80 Copay per Prescription at retail, $300 Pharmacy Deductible + $200 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	$350 Copay per Visit	$350 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: No Charge - Visits 1-2	Not Covered	Out-of-Network only covered out-of-state.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		$85 Copay for remaining Visits/ Urgent Care Visits: $85 Copay per Visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Not Covered	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge/ Specialist Virtual Visits: No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$65 Copay on initial Visit	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	$65 Copay per Visit	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	Motorized Wheelchairs: $500 Copay per Visit/ All Other: No Charge	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 30% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

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

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

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323

x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? [Yes / No]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$5,000
Specialist Copayment	$65
Hospital (facility) Coinsurance	30%
Other No Charge	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,460**

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

The plan's overall deductible	$5,000
Specialist Copayment	$65
Hospital (facility) Coinsurance	30%
Other No Charge	$0

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,030**

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

The plan's overall deductible	$5,000
Specialist Copayment	$65
Hospital (facility) Coinsurance	30%
Other Copayment	$350

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,300**

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

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

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

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

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

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

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

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

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

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.[insert].com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,550** Per Person. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible + 10% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: Deductible/ Urgent Care Visits: Deductible + 10% Coinsurance	Not Covered	Out-of-Network only covered out-of-state.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 10% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

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

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

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

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

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

About these Coverage Examples:

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

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,870**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$5,130**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

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

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

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

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

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

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

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

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

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.[insert].com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$5,000** Per Person/**$10,000** Family. Out-of-Network: Not Applicable.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,850** Per Person/**$13,100** Family. Out-Of-Network: Not Applicable.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 10% Coinsurance/ Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	Not Covered	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible + 10% Coinsurance/ Independent Diagnostic Testing Center: Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Imaging (CT/PET scans, MRIs)	Deductible + 10% Coinsurance	Not Covered	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	Not Covered	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Not Covered	Not Covered	Not Covered
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Not Covered	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————
If you need immediate medical attention	Emergency room care	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	————none————
	Emergency medical transportation	Deductible + 10% Coinsurance	In-Network Deductible + 10% Coinsurance	Out-of-Network only covered for emergencies.
	Urgent care	Value Choice Provider: Deductible/ Urgent Care Visits: Deductible + 10% Coinsurance	Not Covered	Out-of-Network only covered out-of-state.
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 10% Coinsurance	Not Covered	Inpatient Rehab Services limited to 30 days. Prior Authorization may be required. Your benefits/services may be denied.
	Physician/surgeon fees	Deductible + 10% Coinsurance	Not Covered	————none————

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 10% Coinsurance/ Specialist Virtual Visits: Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied. Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 10% Coinsurance	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 10% Coinsurance	Not Covered	————none————
	Childbirth/delivery facility services	Deductible + 10% Coinsurance	Not Covered	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 30 visits, including 30 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 10% Coinsurance	Not Covered	Coverage limited to 45 days. Prior Authorization may be required. Your benefits/services may be denied.
	Durable medical equipment	Deductible + 10% Coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age. Prior Authorization may be required. Your benefits/services may be denied.
	Hospice services	Deductible + 10% Coinsurance	Not Covered	Prior Authorization may be required. Your benefits/services may be denied.
	Children's eye exam	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-preferred brand drugs
- Pediatric dental check-up
- Pediatric eye exam
- Pediatric glasses
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care unless for treatment of diabetes
- Weight loss programs

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

- Chiropractic care - Limited to 30 visits
- Most coverage provided outside the United States. See www.floridablue.com.

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

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

Does this plan provide Minimum Essential Coverage? Yes

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **[Yes / No]**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$10
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,870**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$5,130**

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

The plan's overall deductible	**$5,000**
Specialist Coinsurance	**10%**
Hospital (facility) Coinsurance	**10%**
Other Coinsurance	**10%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

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

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

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

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

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

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

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

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

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.[insert].com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,500** Per Person. Out-of-Network: **$5,000** Per Person.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,500** Per Person. Out-Of-Network: **$11,600** Per Person.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Value Choice Provider: Deductible/ Urgent Care	Value Choice Provider: Not Covered/ Urgent Care	————none————

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Visits: Deductible + 30% Coinsurance	Visits: Deductible + 20% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 30% Coinsurance/ Specialist Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance/ Hospital: Per Admission Deductible + Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323

x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? [Yes / No]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$3,500**
Specialist Coinsurance	**30%**
Hospital (facility) Coinsurance	**30%**
Other No Charge	**$0**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,070**

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

The plan's overall deductible	**$3,500**
Specialist Coinsurance	**30%**
Hospital (facility) Coinsurance	**30%**
Other Coinsurance	**30%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$500
Coinsurance	$40
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,070**

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

The plan's overall deductible	**$3,500**
Specialist Coinsurance	**30%**
Hospital (facility) Coinsurance	**30%**
Other Coinsurance	**30%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

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

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

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

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

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

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

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

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

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

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.[insert].com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-352-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$3,500** Per Person/**$7,000** Family. Out-of-Network: **$10,000** Per Person/**$10,000** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$6,500** Per Person/**$13,000** Family. Out-Of-Network: **$23,200** Per Person/**$23,200** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: Deductible/ Primary Care Visits: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: Deductible/ Specialist: Deductible + 30% Coinsurance/ Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	40% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: Deductible/ Independent Clinical Lab: Deductible/ Independent Diagnostic Testing Center: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	Deductible + $10 Copay per Prescription at retail, Deductible + $25 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	Deductible + $50 Copay per Prescription at retail, Deductible + $125 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	Deductible + $80 Copay per Prescription at retail, Deductible + $200 Copay per Prescription by mail	In-Network Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 40% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	Deductible + 30% Coinsurance	Deductible + 30% Coinsurance	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Value Choice Provider: Deductible/ Urgent Care	Value Choice Provider: Not Covered/ Urgent Care	————none————

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Visits: Deductible + 30% Coinsurance	Visits: Deductible + 30% Coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Inpatient Rehab Services limited to 30 days. Option 2 hospitals may have a higher cost share.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible + 30% Coinsurance/ Specialist Virtual Visits: Deductible + 30% Coinsurance	Deductible + 40% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance/ Hospital: Per Admission Deductible + Deductible + 40% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Hospital Option 1: Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 40% Coinsurance	Option 2 hospitals may have a higher cost share.
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 40% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

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

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

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

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

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance,

contact the insurer at 1-800-352-2583. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For group health coverage subject to ERISA contact your employee services department. For non-federal governmental group health plans and church plans that are group health plans contact your employee services department. You may also contact the state insurance department at 1-877-693-5236. Additionally, a consumer assistance program can help you file your appeal. Contact U.S. Department of Labor Employee Benefits Security Administration at 1-866-4-USA-DOL (866-487-2365) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$3,500**
Specialist Coinsurance	**30%**
Hospital (facility) Coinsurance	**30%**
Other No Charge	**$0**

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,070**

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

The plan's overall deductible	**$3,500**
Specialist Coinsurance	**30%**
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Other Coinsurance	**30%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$500
Coinsurance	$40
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$4,070**

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

The plan's overall deductible	**$3,500**
Specialist Coinsurance	**30%**
Hospital (facility) Coinsurance	**30%**
Other Coinsurance	**30%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

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

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

If you need these services, contact:

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

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

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

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

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

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

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

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

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

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

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

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

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

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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: **$1,500** Per Person/**$4,500** Family. Out-of-Network: **$4,500** Per Person/**$13,500** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$300** Pharmacy Deductible; **$500** Out-of-Network Per Admission Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Yes. In-Network: **$5,500** Per Person/**$11,000** Family. Out-Of-Network: **$11,000** Per Person/**$22,000** Family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://providersearch.floridablue.com/providersearch/pub/index.htm or call 1-800-352-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Value Choice Provider: $30 Copay per Visit / Primary Care Visits: $30 Copay per Visit/ Virtual Visits: $30 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Specialist visit	Value Choice Specialist: $55 Copay per Visit/ Specialist: $55 Copay per Visit/ Virtual Visits: $55 Copay per Visit	Deductible + 50% Coinsurance/ Virtual Visits: Not Covered	Physician administered drugs may have higher cost share. Virtual Visit services are only covered for In-Network providers.
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	Physician administered drugs may have higher cost share. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Value Choice Specialist: $55 Copay per Visit/ Independent Clinical Lab: No Charge/ Independent Diagnostic Testing Center: $50 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share.
	Imaging (CT/PET scans, MRIs)	$250 Copay per Visit	Deductible + 50% Coinsurance	Tests performed in hospitals may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.floridablue.com/tools-resources/pharmacy/medication-guide	Generic drugs	$10 Copay per Prescription at retail, $25 Copay per Prescription by mail	50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order. Responsible Rx programs such as Prior Authorization may apply. See Medication guide for more information.
	Preferred brand drugs	$300 Pharmacy Deductible + $60 Copay per Prescription at retail, $300 Pharmacy Deductible + $150 Copay per Prescription by mail	$300 Pharmacy Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Non-preferred brand drugs	$300 Pharmacy Deductible + $100 Copay per Prescription at retail, $300 Pharmacy Deductible + $250 Copay per Prescription by mail	$300 Pharmacy Deductible + 50% Coinsurance	Up to 30 day supply for retail, 90 day supply for mail order.
	Specialty drugs	Specialty drugs are subject to the cost share based on applicable drug tier.	Specialty drugs are subject to the cost share based on the applicable drug tier.	Not covered through Mail Order. Up to 30 day supply for retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center: $200 Copay per Visit/ Hospital: Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
	Physician/surgeon fees	Ambulatory Surgical Center: $55 Copay per Visit/ Hospital: Deductible + 30% Coinsurance	Ambulatory Surgical Center: Deductible + 50% Coinsurance/ Hospital: In-Network Deductible + 30% Coinsurance	————none————

For more information about limitations and exceptions, see the plan or policy document at www.[insert].com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$250 Copay per Visit	$250 Copay per Visit	————none————
	Emergency medical transportation	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Urgent care	Value Choice Provider: $60 Copay- Visits 1-2 $60 Copay for remaining Visits/ Urgent Care Visits: $60 Copay per Visit	Value Choice Provider: Not Covered/ Urgent Care Visits: Deductible + $60 Copay per Visit	————none————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	Inpatient Rehab Services limited to 30 days.
	Physician/surgeon fees	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge/ Specialist Virtual Visits: No Charge	50% Coinsurance/ Specialist Virtual Visits: Not Covered	Virtual Visit services are only covered for In-Network providers.
	Inpatient services	No Charge	Physician Services: No Charge/ Hospital: 50% Coinsurance	Prior Authorization may be required. Your benefits/services may be denied.
If you are pregnant	Office visits	$55 Copay on initial Visit	Deductible + 50% Coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Deductible + 30% Coinsurance	In-Network Deductible + 30% Coinsurance	————none————
	Childbirth/delivery facility services	Deductible + 30% Coinsurance	Per Admission Deductible + Deductible + 50% Coinsurance	————none————
If you need help recovering or have other special health needs	Home health care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 visits.
	Rehabilitation services	$55 Copay per Visit	Deductible + 50% Coinsurance	Coverage limited to 35 visits, including 26 manipulations. Services performed in hospital

For more information about limitations and exceptions, see the plan or policy document at **www.[insert].com**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				may have higher cost share. Prior Authorization may be required. Your benefits/services may be denied.
	Habilitation services	Not Covered	Not Covered	Not Covered
	Skilled nursing care	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Coverage limited to 60 days.
	Durable medical equipment	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	Excludes vehicle modifications, home modifications, exercise, bathroom equipment and replacement of DME due to use/age.
	Hospice services	Deductible + 30% Coinsurance	Deductible + 50% Coinsurance	————none————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323

x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? [Yes / No]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

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

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

The plan's overall deductible	$1,500
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other No Charge	$0

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,570**

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

The plan's overall deductible	$1,500
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Coinsurance	30%

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$300
Copayments	$1,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$2,030**

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

The plan's overall deductible	$1,500
Specialist Copayment	$55
Hospital (facility) Coinsurance	30%
Other Copayment	$250

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$600
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,160**

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

Section 1557 Notification: Discrimination is Against the Law

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

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

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

If you need these services, contact:

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

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

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

Florida Combined Life:
Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
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civilrightscoordinator@fclife.com

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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

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

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

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-253-008-1 (رقم هاتف الصم والبكم: 1-800-559-0778. اتصل برقم 1-800-333-7222.

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

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

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

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

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવા તમારા માટે ઉપલબ્ધ છે.

ફોન કરો 1-800-352-2583 (TTY: 1-800-955-8770). FEP: **ફોન કરો** 1-800-333-2227

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

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

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

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