Request for Proposals (RFP)
For
Medical Administrative Services

#12-RFP-GNRL-2022

Closing Date:
3:00 PM CST
Wednesday, March 23, 2022

IDEA Public Schools is accepting proposals from firms that are qualified and experienced in Medical Administrative Services only.

IDEA Public Schools reserves the right to revise and amend the specifications prior to the date set for the receipt of proposals. Respondents are requested to clarify any ambiguity, conflict, discrepancy, omission, or other error(s) in the RFP in writing. Revisions or amendments, if any, will be made by issuing an addendum. Every effort will be made to send addenda issued to the parties known to have been furnished a complete copy of the RFP. It is the responsibility of each Vendor, prior to submitting the Proposal, to contact IDEA to determine if addenda were issued and, if so, to obtain such addenda for attachment to the Proposal.

Inquiries and requests for information affecting the solicitation must be submitted in writing and shall be directed to Mia Harris, Assistant Director of Purchasing, at mia.harris@ideapublicschools.org. All inquiries via email should have the subject line read: Questions - #12-RFP-GNRL-2022 – Medical Administrative Services To provide IDEA Public Schools and affiliated entities (IDEA), sufficient time to adequately prepare responses to vendor inquiries, all questions must be submitted by **March 23, 2022** by 3:00 PM (CST). Contact with IDEA Public Schools personnel other than Mia Harris or designee regarding this solicitation may be a reason for elimination from the selection process. Any prospective respondent detecting conflict or ambiguity in the RFP should notify the Assistant Director of Purchasing, in writing, setting forth the grounds of the alleged conflict or ambiguity and requesting the issuance of a clarifying addendum.

Contact:
Mia Harris
Assistant Director of Purchasing
mia.harris@ideapublicschools.org
210-400-3933

TABLE OF CONTENTS

PART I – GENERAL INFORMATION AND INSTRUCTIONS

1. Introduction and Purpose

1.1. IDEA Public Schools prepares students from underserved communities for success in college and citizenship. We are a growing network of 137 high-performing charter schools serving approximately 78,000 students located throughout the Austin, El Paso, Houston, Permian Basin, Rio Grande Valley, San Antonio, Tarrant County in Texas, as well as locations in Louisiana and Florida. IDEA Public Schools is planning to expand to Jacksonville, FL in 2022, Cincinnati, OH in 2022, and Arkansas in 2023. Although IDEA's growth is rapid, it is also well planned and carefully planned. Schools begin with select grade levels and grow as students advance to eventually reach full scale as a Pre-K-12 campus.

1.2. The mission of IDEA Public Schools is College for All. IDEA serves primarily low-income students in underserved areas of both rural and urban communities. Over 80% of IDEA students are considered low-income and one of every three students is the first in their family to go to college. Since our first graduating class in 2007, 100% of our seniors have been accepted and matriculated to a college or university every year for fourteen consecutive years. Thanks to a rigorous path to college that begins in Pre-K, IDEA students attend selective universities throughout the country, win national awards and scholarships, and complete college at a rate six times the national average for low-income students.

2. Objectives

2.1 IDEA Public Schools (therein after referred to as IDEA) is accepting proposals from qualified vendors to provide Administrative Services Only (ASO) for Medical and Pharmacy Benefits and Fully Insured Medical. Proposers are asked to provide Fully Insured quotes to match the plan designs listed on pages 3 of Exhibit B **and/or** Administrative Service Only for Medical and Carve-In Pharmacy Benefits quotes. Proposals should include Vendor Owned Networks Only. With ASO proposals, please include a preliminary Stop Loss Quote with a specific deductible of $350,000, $400,000 and $450,000 and an Aggregating specific at 125%. The awarded contract(s) will become effective on September 1st, 2022 with implementation beginning early summer.

3. Proposal Submissions

3.1 Proposals should be prepared in such a way as to demonstrate a straightforward, concise delineation of capabilities that satisfy the requirements of the RFP.

3.2 To be considered, the Proposal must be prepared according to the following specifications and should include the following information and content:

- 3.2.1 Title Page
- 3.2.2 Section I – Preface
- 3.2.3 Section II – Summary of Experience
- 3.2.4 Section III – Proposal Response to Scope of Service and Performance Requirements
- 3.2.5 Cost Summary
- 3.2.6 References
- 3.2.7 Required Forms
- 3.2.8 Additional Documentation

3.3 Proposals shall be submitted via the web-based software, Tyler Munis Self Service. A signed, submitted proposal submitted via Tyler Munis constitutes an offer to perform work and/or deliver the products specified in the proposal solicitation. Click here to access the site in a web browser.

3.4 To be eligible for consideration, electronically locked proposals should be received via Tyler Munis or by mail to the IDEA Public Schools Headquarters no later than 3:00 PM CST on March 23, 2022 along with the requisite signature pages and certification forms.

3.4.1 All proposals must be received by the deadline. Proposals submitted after the opening time and date will not be accepted. Fax or email proposals will not be accepted.

3.4.2 IDEA reserves the right to reject any and all Proposals, award service contracts as may appear advantageous to IDEA and waive all formalities in the procurement process. Written notice of award mailed or otherwise furnished to the successful Vendor(s) results in a binding contract without further action by either party. IDEA further reserves the right to tender its own contract for services.

3.4.3 All supplemental information required by the RFP must be included with the Proposal. Failure to provide complete and accurate information may disqualify Vendor from consideration.

3.4.4 All costs incurred in the preparation and submission of the RFP response shall be borne solely by the Vendor. Where Vendors may be required to perform a presentation, give demonstrations, and provide samples and/or technical literature, or participate in any interview process as related to this RFP, all costs shall be borne by the Vendor.

3.4.5 Vendor shall provide information on any costs that IDEA may incur related to the requested services. Vendor must specify all costs (e.g., administrative fees, processing fees, etc.) associated with providing the services requested herein. Vendor will provide a complete fee and cost detail supporting all elements of its Proposal. The cost detail must include a narrative for each fee or cost element. If Vendor does not expect IDEA to incur any costs, the Proposal shall state "No costs to IDEA."

3.4.6 IDEA is exempt from federal excise tax, state, and local tax. Do not include tax in cost projections. Any taxes included in cost projections will not be included in the tabulation of any awards.

3.5 Any Proposals submitted in response to this RFP will be irrevocable upon the closing time and remain open for acceptance for 90 days from the closing date whether or not another RFP has been accepted.

3.6 Submission of a Proposal shall be construed to mean that the Vendor agrees to carry out all conditions set forth in this document. Any proposed variation from the specifications, terms, and conditions shall be clearly identified. Please provide details of any non-compliance with stated conditions. If no changes are indicated, IDEA shall expect to receive the service(s) exactly as specified.

3.7 IDEA reserves the right to select any offer it deems the best value, regardless of price.

3.8 IDEA may accept multiple offers for the same services.

3.9 RFP Timeline (tentative)

RFP Issue Date: February 23rd, 2022	
Pre-Proposal Meeting: Monday March 7, 2022, at 2:00 PM	
Respondent Question Cut-Off Date:	March 9, at 10:00AM (CST)
Addendum Issue Date:	March 11,2022
Proposal Due Date & Time:	March 23, 2022, at 3:00PM (CST)
Evaluation Period	March 24 – April 25
Finalist Presentations	First 3 weeks of May
Board Meeting	May/June

4. Required Forms (Certifications and Representations)

Vendor shall execute the required forms included with this RFP.

5. RFP Clarification

5.1 Questions must be submitted via email to Mia Harris, Director of Purchasing, at mia.harris@ideapublicschools.org. The email subject line should read: Questions - #12-RFP-GNRL-2022 – Medical Administrative Services Questions submitted by respondents and answers prepared by IDEA, along with Addenda to this RFP, if applicable, will be posted on the Tyler Munis Self Service website.

5.2 Oral answers provided by IDEA, or its agents shall not be binding. No modification or amendment to this RFP shall be valid unless it is set forth in writing, via a signed addendum or amendment from IDEA.

6. Proposer Responsibility

6.1. IDEA expects Vendors to be thoroughly familiar with all specifications and requirements of this RFP. Vendor's failure or omission to examine any relevant form, article, site, or document will not relieve Vendor from any obligation regarding this RFP. By submitting a Proposal, Vendor is presumed to concur with all terms, conditions, and specifications of this RFP. Any exception must be clearly defined and referenced to the proper paragraph in this RFP.

Objections considered by IDEA as excessive or affecting vital terms may reduce or eliminate Vendor's prospects for award.

7. Completeness

7.1. Proposals will represent a true and correct statement and shall contain no cause for claim of omission or error. Request for withdrawal of a Proposal is allowed based on proof of mechanical error; however, Vendor may be removed from approved vendor list.

8. False/Misleading Statements

8.1. Proposals which contain false or misleading statements, or which provide references which do not support an attribute or capability of the proposed system or service, may be rejected. If, in the opinion of IDEA, such information was intended to mislead IDEA in its evaluation of the Proposal and the attribute, condition, or capability as a requirement of the RFP, the Proposal shall be rejected.

9. Proposal Signatures

9.1. The Proposal must be signed by an individual with proper authority. The signature should indicate the title or position that the individual holds in the partner (if applicable).

10. Selection of Vendor(s)

10.1. IDEA may award this RFP to multiple Vendors or to the Vendor IDEA determines, in its sole discretion, provides the best value to IDEA, based upon the evaluation of proposals. Thus, the result will not be determined by price alone but upon the applicable criteria as listed under Evaluation Criteria referenced in this RFP.

11. Partnership Responsibilities

11.1 IDEA reserves the right to cancel service(s) due to unacceptable price variances. Advance notice/notification is expected (from awarded vendor) when a large market price (increase) occurs for a particular item. This will allow IDEA an opportunity to search and approve a substitute item or services of equal or greater quality.

11.2 All pricing and any award under this RFP shall be good for IDEA and any other entity purchasing through IDEA.

11.2.1 Prices may be decreased at any time after award through written contract amendment. If prices are affected by statute, regulaation, administrative or judicial order, vendors may not include additional costs in billing to the end-user. Vendors must first provide IDEA written justification for any increase and IDEA must decide of applicability of the increase to the contract. In the event a vendor offers to provide a decrease in rates to its customers or potential customers for the same services provided for IDEA pursuant to its contract, the vendor must provide the same decrease in rates for IDEA. It is recommended that the vendor provide said rate decreases voluntarily. If IDEA learns of a decrease in rates and the decreased rate from the date of said decrease or the vendor's contract will be subject to cancellation at the discretion of IDEA. Any charges not proposed but required to make this services viable will be considered a hidden cost and will be provided by the vendor at no additional cost to IDEA for the term of the contract.

12. Contract Period

12.1 The agreement(s) resulting from this solicitation will be in effect for an initial term of one (1) year from the date of award or such date established by the agreement. The parties, by mutual consent, may renew the agreement for up to an additional four (4) one-year periods. In addition, IDEA reserves the right to extend the contract for an additional sixty (60) days beyond the final expiration date, if necessary, to ensure no lapse in service.

13. Administrative Procedure for Bidder Complaints

13.1. Members of the public having complaints regarding IDEA's purchasing procedures or operations may present their complaints or concerns to IDEA in writing to the following address:

IDEA Public Schools
Attn. Purchasing Department
2115 West Pike Blvd
Weslaco, TX 78596
956-377-8000

14. Insurance Requirements

14.1. Minimum Requirements: The insurance coverages specified in this Agreement are the minimum requirements, and these requirements do not lessen or limit the liability of the Contractor. The Contractor shall maintain, at its own expense, any additional kinds or amounts of insurance that it may deem necessary to cover its obligations and liabilities under this Agreement.

14.2. Worker's Compensation is required for this RFP. Insurance Certificates must be submitted with vendor's proposal. This document is titled Certificate of Insurance (ACORD 25). IDEA Public Schools reserves the right to review all insurance policies pertaining to this solicitation to guarantee that the proper coverage is obtained by the contractor.

14.2.1. Contractor will be required to maintain in full-force and in-effect the following types of insurance:

14.2.1.1. Worker's Compensation	$100,000 per occurrence for each bodily injury claim $100,000 per occurrence for each bodily injury caused by disease claim, and $500,000 aggregate for all bodily injuries caused by disease
14.2.1.2 Comprehensive General Liability	$1,000,000 Per Occurrence/$2,000,000 aggregate
14.2.1.3 Property Damage Liability (CSL)*	$300,000
14.2.1.4 Abuse and Molestation	$1,000,000

*Combined Single Limit

14.3 Each insurance policy to be furnished by the successful contractor shall include IDEA Public Schools as a certificate holder and include a waiver of subrogation clause. Additionally, each insurance policy shall, by endorsement to the policy, a statement that a notice shall be given to IDEA by certified mail thirty (30) days prior to cancellation or upon any material changes to coverage.

14.4 Contractor may not commence services or work relating to the Agreement prior to placement of coverage. Contractor shall keep the required insurance coverage in force at all times during the term of the Agreement, or any extension thereof, during any warranty period, of the Agreement.

PART II – SCOPE OF WORK AND PERFORMANCE REQUIREMENTS

1. Scope of Service and Performance Requirements

The following describes the service and performance requirements that the selected vendor will be required to meet. Failure to address or to fully describe capabilities to accomplish all elements of this section will result in a loss of evaluation points.

IDEA is seeking qualified vendors to provide Administrative Services Only for Medical and Pharmacy Benefits or Fully Insured Medical for employees and dependents that are enrolled. IDEA has approximately 9,385 full-time employees and 7,734 members enrolled on their medical plan. IDEA's current medical plans are provided through TRS. There are 6 plans employees can opt into. Plan Designs are included in Exhibit B. There are 2 PPO plan options, 2 EPO plan options and 3 HMO plan options. The HMOs are geographically based. One of the PPOs is an HDHP/HSA compatible plan. The ActiveCare2 PPO plan is a grandfathered plan that does not allow new enrollees. IDEA will be leaving the TRS system on September 1, 2022. IDEA currently runs their deductibles by policy year.

IDEA has a subset of employees located outside of the TRS service area called IPS Enterprises, LLC. IPS does not participate in the TRS plans. They currently have 3 plan options. An HDHP and 2 PPO plans. There are 673 full-time

employees and 507 members on the IPS plans. IPS plan designs are included in Exhibit B. On September 1, 2022, the IPS group will join the IDEA group and will participate in the same plans. IPS plans run deductibles on a calendar year basis.

IDEA and IPS employees are included in the attached census (Exhibit A). To obtain census, please request from Jose Perez (jose.perez3@ideapublicschools.org). It will be sent to you through secure email by the broker.

All employees (IDEA and IPS) receive a lump sum flex credit that they can choose to allocate to an HRA if desired.

Proposals for 10, 12 and 16 month contracts are requested. For fully insured proposals, please note that accumulators will need to follow contracts. Please build this into your pricing.

Please include all value added benefits in your proposals, including wellness programs, benefit advocacy, etc.

PART III – PROPOSAL REQUIREMENTS

1. Proposal Requirements

1.2 IDEA is requesting proposers submit proposals for the following plan options.

Option 1: Please quote fully insured Medical to match the plan designs listed on pages 3 of Exhibit B as closely as possible. Please note, all current plan designs are included, but proposals should seek to match the requested plan designs on page 3 of Exhibit B.

And/Or

Option 2: Please submit an Administrative Services Only (ASO) proposal for Medical and Carved- In Pharmacy. Proposals should include Vendor Owned Networks Only. Please include with your proposal a preliminary Stop Loss Quote with a specific deductible of $350,000, $400,000 and $450,000 and an Aggregating Specific at 125%.

It is the intention of IDEA to award a contract for a one (1) year period. IDEA and the awarded contractor shall have the option to renew this contract for an additional four (4) one-year periods.

2. Proposal Opening

2.1 Proposal Opening is scheduled for March 23rd, 2022 at 3:00PM (CST). A formal "opening" will not be held and pricing will not be read. Trade secrets and confidential information contained in proposals shall not generally be open for public inspection, but IDEA's records are a matter of public record.

2.2 Who is eligible to respond:

2.2.1 Respondents who can meet the technical specifications for quality and other terms of this RFP package, and who are not debarred and/or suspended from conducting business with IDEA, federal and state funded agencies are invited to respond. A prospective respondent must affirmatively demonstrate respondent's responsibility. A prospective respondent, by submitting a proposal, represents to IDEA Public Schoools that it meets the following requirements:

2.2.2 Possess or is able to obtain adequate financial resources as required to perform under this RFP

2.2.3 Is able to comply with the required scope of the RFP

2.2.4 Have a satisfactory record of integrity to ethics

2.2.5 Be otherwise qualified and eligible to receive an award

2.2.6 Be in good standing with the applicable national or state associations

PART IV – SUBMITTAL REQUIREMENTS AND EVALUATION CRITERIA

1. Proposal Response

Proposals may be submitted using the Tyler Munis Self Service site, or by sending a hard copy to:

IDEA Public Schools
Attn. Purchasing Department
2115 West Pike Blvd
Weslaco, TX 78596
956-377-8000

2. Proposals sent by mail must be in a sealed envelope marked with the RFP Number and Title and include:
   2.1. One (1) clearly identified hard copy ORIGINAL of the Proposal response.
   2.2. One (1) copy of the proposal on FLASH DRIVES, marked with your company name.

Note: **FAX or e-mail proposals will not be accepted.**

   2.3. The vendor's proposal itself shall be organized in the following order, with each section clearly indexed:

      2.3.1. Section I – Preface: The Proposer shall provide an Executive Summary of two (2) pages or less, which gives in brief, concise terms, a summation of the proposal. Please include business name, address, point of contact and contact information.
      2.3.2. Section II – Summary of Experience: This section shall contain the full name and address of the partner submitting the proposal. In addition, it shall contain names, titles, certifications, location, and years of experience for the personnel who will lead partnership services. Please include all personnel who would be working with IDEA.
      2.3.3. Section III – Proposal Response to Scope of Service and Performance Requirements: The Proposer shall provide a description of services and capabilities as outlined in the Scope of Service and Performance Requirements section of this RFP. Clearly state any exceptions taken to the specifications of this RFP, or any conditions of the proposal. The response shall be clear and succinct. If any service or requirement cannot be performed, the Proposer shall state 'not applicable' or 'unable to perform.' Please include plan designs in this section of the proposal.
      2.3.4. Questionnaire
      2.3.5. Geo-Analysis
      2.3.6. Sample materials: wellness program flyers, user experience flyers (i.e. mobile app, member website, etc.).

3. Cost Summary

Ancillary to the proposal, the Proposer shall provide information on any costs that IDEA may incur. The Proposer must specify all costs (e.g., administrative fees, processing fees, etc.) associated with providing the services required herein. Proposer will provide a complete fee and cost detail supporting all elements of its Proposal. The cost detail must include a narrative for each fee or cost element. If the Proposer does not expect for IDEA to incur any costs, the Proposer shall state 'No costs to IDEA. Pricing template is included in Attachment O.

4. References

The Proposer shall submit a minimum of four (4) verifiable references. It is desired that if the Proposer has performed this type of service previously, those references be listed. It is recommended that the Proposer provide references that are similar or as closely related to this unique agreement, if possible. Each reference provided shall include:
   4.1. Reference's Name
   4.2. Contact Person
   4.3. Address, City, State, and Zip
   4.4. Contact Person Phone Number
   4.5. Contact Person Email Address
   4.6. Brief Project Scope
   4.7. Time Frame

5. Required Forms (Certifications and Representations)

Vendor shall execute the following required forms (located at the end of this solicitation) and return the signed originals with the proposal.

6. Additional Documentation

Additional pages may be included within the Proposal response but must be included within the bound copy of the Proposal response and cross-referenced as necessary. Unnecessarily lengthy documents are discouraged. IDEA reserves the right to tender its own contract.

7. Competitive Selection and Proposal Evaluation

This is a negotiated procurement and as such, award will not necessarily be made to the lowest priced proposal. Award will be made to the partner submitting the best responsive proposal satisfying IDEA's requirements, price, and other factors. If one vendor cannot meet the requirements outlined in this document, the award may be divided among several qualified vendors.

7.1 Proposals will be evaluated on criteria deemed to be in IDEA's best interest, including but not limited to:

- 7.1.1 Purchase price
- 7.1.2 The reputation of the vendor and of the vendor's goods and services
- 7.1.3 The quality of the vendor's goods and services
- 7.1.4 The extent to which the vendor's goods and services meet the needs of IDEA
- 7.1.5 Vendor's past relationship, if any, with IDEA or other charter schools
- 7.1.6 Long term cost to IDEA
- 7.1.7 Vendor's principal place of business
- 7.1.8 Any other relevant factor listed in the RFP

Proposals will be reviewed by McGriff Insurance Services and put into an analysis to be presented to the IDEA team. IDEA will also evaluate each proposal(s) in the areas of the proposed plan, experience/service capabilities, and value on the following pre-determined criteria. McGriff Insurance Services will do an initial analysis of proposals and provide this to an RFP subcommittee consisting of McGriff, HR Staff and Purchasing. Through scoring, finalists will be presented to the full RFP committee. The committee evaluating the proposals submitted in response to this RFP may require any or all vendors to give an oral presentation to clarify or elaborate on their proposal. Upon completion of oral presentations or discussions, vendors may be requested to revise any or all portions of their proposals and submit Best and Final information. IDEA will evaluate the submission in accordance with the selection criteria and will rank the firms on the basis of the submittals. IDEA, reserves the right to consider information obtained in addition to the data submitted in the response. The selection criterion is listed below:

	Evaluation Criteria
51 Points	**Cost Proposal:** The price of the items, to include total administrative costs & fees/fully insured rates, network discounts, rate guarantees, integration fees, EDI file feed set-up costs, wellness & implementation credits.
24 Points	**Demonstrated Experience and Strength of Offeror to Provide Services Requested:** Indicators of probable performance under the contract to include: plan designs match what was requested (fully insured), financial resources and ability to perform, experience or demonstrated capability and responsibility, and the vendor's ability to provide reliable maintenance agreements and support.
10 Points	**Additional Services Offered:** i.e. wellness program, decision supports resources, online resources for employer and members, communication materials, employee customer service support.
5 Points	**Reporting Capabilities:** comprehensive reporting package, frequency of reporting, self service capability, integration with health analytics provider if applicable and ability to provide annual data dump to broker.
5 Points	**Multi-state network strength:** members will have access to vendor's network regardless of the state they are located in.
5 Points	**References:** Requested number and type of references provided. Additional points awarded if references are Texas Agencies
100 Points	Total Possible Score

PART V – GENERAL TERMS AND CONDITIONS

The general terms and conditions set forth in this section shall form a part of the contract documents and/or purchase order for good and/or services included in this RFP.

1. Proposal Submission

1.1 Proposals must be submitted using this document only and must be submitted on or before the hour and date specified. Late submittals will be returned unopened. NOTE: Faxed or Emailed proposals will not be accepted.

1.2 Public Record: All Proposals become the property of IDEA. As a governmental entity, the Texas PublicInformation Act applies to this solicitation. Accepted proposals and any subsequent award will generally be a public record. Proprietary material must be clearly marked as such.

1.3 Rejection/Award: IDEA reserves the right to reject and and/or all submittals, to award contracts as mayappear advantageous to IDEA, and to waive all formalities in the procurement process.

1.4 Written notice of award mailed or otherwise furnished to the successful respondent results in a binding contract without further action by either party.

1.5 Evaluation of Proposals: Proposal evaluation will be completed based on the information provided byVendor. It is very important that Vendor provide all required information as part of the Proposal. Failure to provide necessary information and documents could result in the Proposal being rejected.

1.6 Applicability: These conditions are applicable and form a part of the contract documents in each supply and/or service contract and are a part of the terms of each purchase order for items of equipment and/or service included, in the specifications and solicitation forms issued herewith.

1.7 Supplemental Information: All supplemental information required by the proposal documents must be included with the proposal response. Failure to provide complete and accurate information may disqualify the vendor from consideration.

1.8 Proposal Errors: Proposals will represent a true and correct statement and shall contain no cause for claim of omission or error. Request for withdrawal of proposal is allowed based on proof of mechanical error; however, the vendor may be removed from consideration or from any approved vendor list.

1.9 Changes to Proposal: IDEA reserves the right to negotiate changes in a Proposal by any Vendor, and to reject any or all Proposals.

1.10 Use of Brand Names: The use of brand and manufacturer's names is for the purpose of brevity in establishing type and quality of merchandise and is not restrictive. Manufacturer, trade, and/or brand name mustbe indicated for each article and, when omitted, IDEA will consider bid to be as specified. Illustrations and complete description must be included with the bid if bidding other than specified.

1.11 Undue Influence: In order to ensure the integrity of the selection process, the vendor's officers, employees, agents, or other representatives shall not lobby or attempt to influence a vote or recommendation related to the vendor's proposal, directly or indirectly, through any contact with IDEA board members or other school officials from the date this solicitation is released until the award of a contract by IDEA. By submitting a proposal, the vendor affirms that the vendor has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to any IDEA representative in connection with the proposal submitted.

1.12 Gratuities: IDEA may, by written notice to Vendor, cancel any service agreement without liability to IDEA if it is determined by IDEA that gratuities, in the form of entertainment, gifts, or otherwise, were offeredor given by Vendor, or any agent or representative of Vendor, to any officer or employee of IDEA with a view toward securing a contract or securing favorable treatment with respect to the awarding or amending, or the making of any determination with respect to the performing of such a contract. In the event this contract is cancelled by IDEA pursuant to this provision, IDEA shall be entitled, in addition to any other rights and remedies, to recover or withhold the amount of the cost incurred by Vendor in providing such gratuities.

1.13 Payment Terms: Unless a prompt payment discount with a payment term of at least 10 days is offeredand accepted by IDEA, payment terms shall be Net 30 days from date of acceptance or receipt of a properly prepared and submitted invoice, whichever is later. Vendor must have the ability to execute multiple contracts and provide invoices related to each contracted entity.

1.14 Independent Contractor: Nothing herein shall be construed as creating the relationship of employer or employee between IDEA and the Contractor or between IDEA and the Contractor's employees. IDEA shall not be subject to any obligations or liabilities of the Contractor or the Contractor's employees incurred in the performance of the contract unless otherwise herein authorized. Neither the Contractor nor its employee shall be entitled to any of the benefits established for IDEA employees, nor be covered by IDEA's Workers' Compensation Program.

1.15 Fund Availability: This agreement is conditioned upon continued funding and appropriation and allotment of funds by the Texas State Legislature and/or the Texas Education Agency (TEA) pursuant to IDEA's open enrollment charter. This Agreement is further conditioned on continued allocation of funds by the IDEA's Board of Directors (the "Board"). If the Legislature and/or the TEA fails to appropriate or allot the necessary funds, or the Board fails to allocate the necessary funds at the end of IDEA's fiscal year, then IDEA will issue written notice to Contractor and IDEA may terminate this Agreement without further duty or obligation hereunder.

1.16 Modifications: The contract may only be modified, altered, or changed by a written agreement signed by both parties and their duly authorized agents.

2. GENERAL TERMS & CONDITIONS

2.1.1. INDEMNIFICATION: THE VENDOR SHALL INDEMNIFY, DEFEND AND HOLD HARMLESS IDEA PUBLIC SCHOOLS AND ITS BOARD OF DIRECTORS, OFFICERS, AGENTS, AND EMPLOYEES (COLLECTIVELEY THE "IDEA INDEMNITEES") IN THEIR OFFICIAL AND INDIVIDUAL CAPACITIES FROM AND AGAINST ALL DAMAGE, LOSSES, LIENS, CAUSES OF ACTION, SUITS, JUDGEMENTS, EXPENSES, AND OTHER CLAIMS OF ANY NATURE, KIND, OR DESCRIPTION, INCLUDING ATTORNEYS' FEES INCURRED IN INVESTIGATING, DEFENDING, OR SETTLING ANY OF THE FORGOING BY ANY PERSON OR ENTITY, ARISING OUT OF, CAUSED BY, OR RESULTING FROM THE VENDOR'S PERFORMANCE UNDER OR BREACH OF THIS AGREEMENT AND THAT ARE CAUSED IN WHOLE OR IN PART BY ANY ACT OR OMISSION, OR WILLFUL MISCONDUCT OF THE VENDOR, ANYONE DIRECTLY EMPLOYED BY THE VENDOR, OR ANYONE FOR WHOSE ACTS THE VENDOR MAY BE LIABLE. THE PROVISIONS OF THIS SECTION WILL NOT BE CONSTRUED TO ELIMINATE OR REDUCE ANY OTHER INDEMNIFICATION OR RIGHT WHICH ANY IDEA INDEMNITEE HAS BY LAW OR EQUITY. ALL PARTIES WILL BE ENTITLED TO BE REPRESENTED BY COUNSEL AT THEIR OWN EXPENSE. THE VENDOR'S OBLIGATIONS CONTAINED IN THIS SECTION SURVIVE TERMINATION OR EXPIRATION OF THIS AGREEMENT AND CONTINUE ON INDEFINITELY AND CANNOT BE WAIVED OR VARIED.

2.1.2. Termination: IDEA reserves the right to terminate this agreement upon thirty (30) days written notice to the vendor; (2) upon default by the vendor, for delay or nonperformance by the vendor or, (3) if it is deemed in the best interest of IDEA, for convenience.

2.1.3. Unsatisfactory Performance by Vendor Staff: If any person employed by Vendor fails or refuses to carry out the services contemplated in this agreement or is, in the opinion of IDEA's designated representative(s),

incompetent, unfaithful, intemperate, or disorderly, or uses threatening or abusive language to an IDEA student, parent, or representative, or if otherwise unsatisfactory, he or she shall be removed from the work under this agreement immediately and shall not again provide services to IDEA except upon consent of IDEA's representative.

2.1.4. Criminal Background Check: All Vendors who have a contract for services with continuing duties related to the contract and have direct contact with students must coordinate and cooperate with IDEA to ensure that an appropriate criminal history record information review as required by Texas Education Code § 22.0834 is conducted for Vendor and any of Vendor's personnel who will have continuing duties related to this Agreement and will have direct contact with students. The cost of the review shall be paid by Vendor. Covered employees with disqualifying criminal histories are prohibited from providing services to IDEA. Vendor may also be required to provide a list of personnel who will be assigned to do the work. When requested, this information must be furnished within 48 hours and shall apply to any new personnel due to employee turnover.Vendor shall certify to IDEA that all employees assigned to work under a contract have successfully passed a criminal background check, prior to assignment. Any person or persons not acceptable to IDEA shall be prohibited from working on the contract.

2.1.5. Enforcement: It is acknowledged and agreed that Vendor's services to IDEA are unique, which gives Vendor a peculiar value to IDEA and for the loss of which IDEA cannot be reasonably and adequately compensated in damages. Accordingly, Vendor acknowledges and agrees that a breach by Vendor of the provisions hereof will cause IDEA irreparable injury and damage. Vendor therefore expressly agrees that IDEAshall be entitled to injunctive and/or other equitable relief in any court of competent jurisdiction to prevent or otherwise restrain a breach of this agreement, but only if IDEA is not in breach of this agreement.

2.1.6. LIMITATIONS AND NO WAIVER OF GOVERNMENTAL IMMUNITY: THE PARTIES ARE AWARE THAT THERE ARE CONSTITUTIONAL AND STATUTORY LIMITATIONS ON THE AUTHORITY OF IDEA (A PUBLIC SCHOOL) TO ENTER INTO CERTAIN TYPES OF CONTRACTS, INCLUDING, BUT NOT LIMITED TO, ANY TERMS AND CONDITIONS RELATING TO LIENS ON IDEA'S PROPERTY; DISCLAIMERS AND LIMITATIONS OF WARRANTIES; DISCLAIMERS AND LIMITATIONS OF LIABILITY FOR DAMAGES; WAIVERS, DISCLAIMERS AND LIMITATIONS OF LEGAL RIGHTS, REMEDIES, REQUIREMENTS AND PROCESSES; LIMITATIONS OF PERIODS TO BRING LEGAL ACTION; GRANTING CONTROL OF LITIGATION OR SETTLEMENT TO ANOTHER PARTY; LIABILITY FOR ACTS OR OMISSIONS OF THIRD PARTIES; PAYMENT OF ATTORNEYS' FEES; DISPUTE RESOLUTION; INDEMNITIES; AND CONFIDENTIALITY (COLLECTIVELY, THE "LIMITATIONS"), AND TERMS AND CONDITIONS RELATED TO THE LIMITATIONS WILL NOT BE BINDING ON IDEA EXCEPT TO THE EXTENT AUTHORIZED BY THE LAWS AND CONSTITUTION OF THE STATEOF TEXAS. THE VENDOR FURTHER ACKNOWLEDGES, STIPULATES AND AGREES THAT NOTHING IN THIS SOLICITATION AND/OR IN ANY RESULTING CONTRACT WITH IDEA SHALL BE CONSTRUED AS A WAIVER OF ANY GOVERNMENTAL, STATUTORY OR SOVERIGN IMMUNITY FROM SUIT AND LIABILITY AVAILABLE TO IDEA UNDER APPLICABLE LAW.

2.1.7. Assignment/Delegation: No right or interest in this agreement shall be assigned or delegation of any obligation made by Vendor without the written permission of IDEA. Any attempted assignment or delegation by Vendor shall be wholly void and totally ineffective for all purposes unless made in conformity with this provision.

2.1.8. Waiver: No claim or right arising out of a breach of any contract can be discharged in whole or in part a waiver or renunciation of the claim or right unless the waiver or renunciation is supported by consideration and is in writing signed by the aggrieved party.

2.1.9. Interpretation of Evidence: No course of prior dealings between the parties and no usage of the tradeshall be relevant to supplement or explain any term used in a contract. Acceptance or acquiescence in a course of performance rendered under a contract shall not be relevant to determine the meaning of the contract, even though the accepting or acquiescing party has knowledge of the performance and opportunity for objection.

Whenever a term defined by the Uniform Commercial Code is used in the contract, the definition contained in the Code is to control.

2.1.10. Applicable Law: This contract shall be governed by the policies of IDEA's Board of Directors, laws of the State of Texas and the Uniform Commercial Code, without regard to the conflict of interest principles of the State of Texas. Wherever the term "Uniform Commercial Code" is used, it shall be construed as meaning the Uniform Commercial Code as adopted in the State of Texas as effective and in force on the date of this contract. IDEA Board Policies can be accessed by contacting IDEA.

2.1.11. Record Keeping: IDEA, the United States Department of Education, the Comptroller General of the United States, or any other duly authorized representatives must have access to any books, documents, papers, and records of Vendor that are directly pertinent to a federal program for the purpose of making audits, examinations, excerpts, and transcriptions.

2.1.12. Equal Opportunity: Vendor shall comply with E.O. 11246—Equal Employment Opportunity, as amended by E.O. 11375—Amending Executive Order 11246 Relating to Equal Employment Opportunity, andas supplemented by regulations at 41 CFR Part 60—Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor.

2.1.13. Debarment and Suspension: Neither the vendor nor any of its officer, directors, owners, members, employees, or agents is listed on the General Services Administration's List of Parties Excluded from Federal Procurement or Non-procurement Programs in accordance with E.O 12549 and E.O. 12689—Debarment and Suspension. This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and vendors declared ineligible under statutory or regulatory authority other than E.O. 12549.

2.1.14. Rights to Inventions Made Under a Contract or Agreement: Vendor acknowledges and agrees that any intellectual property, processes, procedures, or product developed in furtherance of this agreement belongsto IDEA as work-for-hire and all rights are reserved by IDEA and/or the federal government in accordance with applicable federal law.

2.1.15. Advertising: The Vendor shall not advertise or publish, without IDEA's prior consent, the fact that IDEA has entered into any contract, except to the extent necessary to comply with proper request for information from an authorized representative of the federal, state, or local government.

2.1.16. Legal Venue: Both parties agree that venue for any litigation arising from the contract shall lie in Hidalgo County, Texas.

2.1.17. Standing: Vendor must be registered to conduct business in Texas and in good standing with the Texas Secretary of State and Comptroller.

2.1.18. Ineligibility for Nonpayment of Child Support: Pursuant to Texas Family Code 231.006(d), regarding child support, the Vendor certifies that the Vendor is not ineligible to receive funds under a contract paid by state funds and acknowledges that any agreement between the successful bidder and IDEA may be terminated and payment may be withheld if this certification is inaccurate.

2.1.19. Signature Authority: By submitting the Response, the Vendor represents and warrants that the individual submitting this document and the documents made part of this Response is authorized to sign such documents on behalf of the Vendor and to bind the Vendor under any contract that may result from the submission on this Response.

2.1.20. Terms and Conditions Attached to Response: Any terms and conditions attached to a Response will not be considered unless specifically referred to in the Response.

PART VI – REQUIRED ATTACHMENTS / EXHIBITS

The attachments and exhibits listed below are required and should be included with the Proposal unless otherwise noted.

ALL FORMS REQUIRING SIGNATURE MUST BE SIGNED AS INDICATED.

1. Attachment A – Title Page. This form must be completed and included as the cover sheet for Proposals submitted in response to this RFP.
2. Attachment B – Vendor Information
3. Attachment C – Vendor Certification
4. Attachment D – Proof of Insurance or Bonding
5. Attachment E – Certification Regarding Drug-Free Workplace
6. Attachment F – IDEA Conflict of Interest Form
7. Attachment G – Conflict of Interest Form CIQ
8. Attachment H – Equal Opportunity and Nondiscrimination
9. Attachment I – Felony Conviction Disclosure Statement
10. Attachment J – Certification Regarding Lobbying
11. Attachment K – Debarment or Suspension Certificate
12. Attachment L – Contract Provisions for Contracts Involving Federal Funds
13. Attachment M – Criminal History Certification
14. Attachment N – Reference Sheet
15. Attachment O – Proposed Pricing
16. Attachment P – W-9 Form
17. Exhibit A – Census (informational, do not submit with response) To obtain this exhibit, please request from Jose Perez (jose.perez3@ideapublicschools.org). It will be sent to you through secure email by the broker.
18. Exhibit B – Current and Requested Plan Designs (please reference the requested plan design section when submitted fully insured plan designs)
19. Exhibit C – IDEA Claims (informational, do not submit with response) To obtain this exhibit, please request from Jose Perez (jose.perez3@ideapublicschools.org). It will be sent to you through secure email by the broker.
20. Exhibit D – IPS Claims (informational, do not submit with response) To obtain this exhibit, please request from Jose Perez (jose.perez3@ideapublicschools.org). It will be sent to you through secure email by the broker.
21. Exhibit E – IDEA Current Plan Summaries and Employee Rates (informational, do not submit with response)
22. Exhibit F – IPS Current Plan Summaries and Employee Rates (informational, do not submit with response)
23. Exhibit G – Questionnaire

Attachment A – Title Page

A Proposal Submitted in Response to

IDEA

Request for Proposals

#12-RFP-GNRL-2022

Medical Administrative Services

Submitted By:

_____

(Full Legal Name of Vendor)

_____

(Date of Submission)

Attachment B – Vendor Information

Enter Vendor's name and address below.

1. Vendor Name: _____

2. Street Address: _____

3. City, State, and Zip Code: _____

4. Email Address: _____

5. Phone Number: _____

Additional Requirements:

Proposal must include name of each person with at least 25% ownership of Vendor.

Name: _____

Name: _____

Name: _____

Name: _____

Attachment C – Vendor Certification

I, the undersigned, submit this Proposal and have read the specifications, which are a part of this RFP. My signature also certifies that I am authorized to submit this Proposal, sign as a representative for Vendor, and carry out services solicited in this RFP.

Signature of Authorized Agent: _____

Printed Name and Title of Agent: _____

Vendor Name: _____

Address: _____

Telephone Number: _____

Contact Person: _____

Email Address (if applicable): _____

Web Site Address (if applicable): _____

Attachment D – Proof of Insurance or Bonding

Please provide proof of insurance or bonding.

Attachment E – Certification Regarding Drug-Free Workplace

This certification is required by the Federal Regulations Implementing Sections 5151-5160 of the Drug-Free Workplace Act, 41 U.S.C. 701, for the Department of Agriculture (7 CFR Part 3017), Department of Labor (29 CFR Part 98), Department of Education (34 CFR Parts 85, 668 and 682), Department of Health and Human Services (45 CFR Part 76).

The undersigned Vendor certifies it will provide a drug-free workplace by:

- Publishing a policy statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the workplace and specifying the consequences of any such action by an employee.

- Establishing an ongoing drug-free awareness program to inform employees of the dangers of drug abusein the workplace, Vendor's policy of maintaining a drug-free workplace, the availability of counseling,rehabilitation and employee assistance programs, and the penalties that may be imposed on employeesfor drug violations in the workplace.

- Providing each employee with a copy of Vendor's policy statement.

- Notifying the employees through Vendor's policy statement that as a condition of services to IDEA, employees shall abide by the terms of the policy statement and notifying Vendor in writing within fivedays after any conviction for a violation by the employee of a criminal drug abuse statue in the workplace.

- Notifying IDEA within ten (10) days of Vendor's receipt of a notice of a conviction of any employee; and,

- Taking appropriate personnel action against an employee convicted of violating a criminal drug statue or requires such employee to participate in a drug abuse assistance or rehabilitation program.

_____
Vendor Name

_____ _____
Signature of Authorized Representative Date

_____
Printed Name and Title of Authorized Representative

Attachment F – IDEA Conflict of Interest Form

By signature of this Proposal, Vendor covenants and affirms that:

- No manager, employee or paid consultant of Vendor is a member of the IDEA Board of Directors or anemployee of IDEA.
- No manager or paid consultant of Vendor is married to a member of the IDEA Board of Directors,IDEA's Chief Executive officer, or an employee of IDEA.
- No member of the IDEA Board of Directors, IDEA's Chief Executive Officer, or employee of IDEA isa manager or paid consultant of Vendor.
- Neither any member of the IDEA Board of Directors, IDEA's Chief Executive officer, nor anyemployee of IDEA owns or controls more than 10% in Vendor.
- Neither any member of the IDEA Board of Directors, IDEA's Chief Executive officer, nor any employee of IDEA receives compensation from Vendor for lobbying activities as defined in Chapter 305 of the Texas Government Code.
- Vendor has disclosed within the Proposal any interest, fact or circumstance which does or may presenta potential conflict of interest.
- Should Vendor fail to abide by the foregoing covenants and affirmations regarding conflict of interest,Vendor shall not be entitled to the recovery of any costs or expenses incurred in relation to any contractwith IDEA and shall further be liable for any costs incurred or damages sustained by IDEA relating to that contract.

_____

Vendor Name

_____ _____

Signature of Authorized Representative Date

_____

Printed Name and Title of Authorized Representative

Attachment G – Conflict of Interest Form CIQ

This questionnaire reflects changes made to the law by H.B. 23, 84th Leg., Regular Session. This questionnaire is being filed in accordance with Chapter 176, Local Government Code, by a vendor who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity and the vendor meets requirements under Section 176.006(a). By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the vendor becomes aware of facts that require the statement to be filed. See Section 176.006(a-1), Local Government Code. A vendor commits an offense if the vendor knowingly violates Section 176.006, Local Government Code. An offense under this section is a misdemeanor.

Respondent must fill-out the Conflict-of-Interest Form CIQ and submit with their proposal.
The Conflict-of-Interest Form CIQ can be found at the following link:

https://www.ethics.state.tx.us/data/forms/conflict/CIQ.pdf

Attachment H – Equal Opportunity and Nondiscrimination

Vendor promotes employment opportunity through a program designed to provide equal opportunity without regard to race, color, sex, religion, national origin, age, disability, or political affiliation or belief. Additionally,discrimination is prohibited against any beneficiary of programs funded under Title I of the Workforce Investment Act of 1998, on the basis of the beneficiary's citizenship/status as a lawfully admitted immigrant authorized to work in the United States, or his/her participation in any WIA Title I financially assisted programor activity. Vendor conforms to all applicable federal and state laws, rules, guidelines, regulations, and providesequal employment opportunity in all employment and employee relations.

EEO Laws, Rules, Guidelines, Regulations

Vendor provides equal opportunities consistent with applicable federal and state laws, rules, guidelines, regulations, and executive orders. Such regulations include:

- Title VI of the Civil Rights Act of 1964, as amended, which prohibits discrimination under any programor activity receiving federal financial assistance.
- Title VII of the Civil Rights Act of 1964, as amended, and its implementing regulations at 29 CFRPart 37 which prohibit discrimination based on race, color, religion, sex, or national origin in any term,condition, or privilege of employment.
- Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination againstqualified individuals because of disability.
- Age Discrimination in Employment Act of 1967, as amended, which prohibits discrimination against individuals 40 years of age and older.
- Americans with Disabilities Act of 1990, which prohibits discrimination against qualified individuals with disabilities.
- Age Discrimination Act of 1975, as amended, which prohibits discrimination based on age in programsreceiving federal financial assistance.
- Texas Commission on Human Rights Act, as amended, which prohibits discrimination in employmentbased on race, color, handicap, religion, sex, national origin, or age.
- Equal Pay Act of 1963, as amended, which requires equal pay for men and women performing equalwork.
- Pregnancy Discrimination Act of 1978, which prohibits discrimination against pregnant women.

Vendor is committed to promoting equal employment opportunity through a progressive program designed to provide equal opportunity without regard to race, color, sex, religion, national origin, age, disability, or politicalaffiliation or belief. Vendor takes positive steps to eliminate any systematic discrimination from personnel practices. Vendor recruits, hires, trains, and promotes into all job levels the most qualified persons without regard to race, color, religion, sex, national origin, age, or disability status. Staff at all levels is responsible for active program support and personal leadership in establishing, maintaining,and carrying out an effective equal employment opportunity program.

_____

Vendor Name

_____ _____

Signature of Authorized Representative Date

_____

Printed Name and Title of Authorized Representative

Attachment I – Felony Conviction Disclosure Statement

Instruction to respondent: This form must be completed legibly, either handwritten or typed. A duly authorized of Respondent must sign this form in blue ink. Failure to complete this form pursuant to this and other instruction shall disqualify the proposal.

Pursuant to Texas Education Code Section 44.034, Notification of Criminal History of Contractor, "A person or business entity that enters into a contract with a school district must give advance notice to the district if the person or an owner or operator of the business entity has been convicted of a felony. The notice must include a general description of the conduct resulting in the conviction of a felony." Additionally, in accordancewith this state law, "A school district may terminate a contract with a person or business entity if the district determines that the person or business entity failed to give notice as required […] or misrepresented the conduct resulting in the conviction." In this event, "The district must compensate the person or business entityfor services performed before the termination of the contract." Section 44.034 "does not apply to a publicly held corporation."

I, the undersigned agent for _____ ("Respondent"), certify that the information concerning notification of felony conviction has been reviewed by me and the following information furnished is true to the best of my knowledge.

☐ Respondent is a publicly held corporation; therefore, this reporting requirement is not applicable.

☐ Respondent is not owned or operated by anyone who has been convicted of a felony.

☐ Respondent is owned or operated by the following individual(s) who has/have been convicted of a felony,as disclosed below:

Name of Individual(s): _____

General description of the conduct resulting in the conviction of a felony:

_____

Name of Individual: _____

General description of the conduct resulting in the conviction of a felony:

_____

_____ _____

Signature of Authorized Representative Date Signed

Attachment J – Certification Regarding Lobbying

Submission of this certification is a prerequisite for making or entering into this transaction and is imposed by section 1352, Title 31, U.S. Code. This certification is a material representation of fact upon which reliance wasplaced when this transaction was made or entered into. Any person who fails to file the required certifications shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

The undersigned certifies, to the best of his or her knowledge and belief, that:

No Federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any personfor influencing or attempting to influence an office or employee of any agency, a Member of Congress, or an officer or employee of Congress, an employee of a Member of Congress, or any Board Member, officer, or employee of IDEA in connection with the awarding of Federal contract, the making of a Federal grant, the making of a Federal Loan, the entering into a cooperative agreement, and the extension, continuation, renewal,amendment, or modification of a Federal contract, grant, loan, or cooperative agreement.

If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencingor attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employeeof Congress, an employee of a Member of Congress, or any Board Member, officer, or employee of IDEA in connection with this Federal grant or cooperative agreement, the undersigned shall complete and submit Standard Form –LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions.

The undersigned shall require that the language of this certification be included in the awarded documents for all covered sub-awards exceeding $100,000 in Federal funds at all appropriate tiers and that all sub-recipients shall certify and disclose accordingly.

_____

Vendor Name

_____ _____

Signature of Authorized Representative Date

_____

Printed Name and Title of Authorized Representative

Attachment K – Debarment or Suspension Certificate

IDEA is prohibited from contracting with or making sub-awards under covered transaction to parties that are suspended or debarred or whose owners/members/principals and certain employees are suspended or debarred.Vendor must certify that it and its owners/members/principals are not suspended or debarred under federal lawand rule.

By submitting signing contract and this certificate, Vendor certifies that no suspension or debarment is in place,which would otherwise preclude Vendor or its Owner/Members/Principals or employees from receiving a federally funded contract under applicable federal regulations and federal OMB Circulars.

_____

Vendor Name

_____ _____

Signature of Authorized Representative Date

_____

Printed Name and Title of Authorized Representative

Attachment L – Contract Provisions for Contracts Involving Federal Funds

IDEA Public Schools
Edgar Certifications and Representations
(Education Department General Administrative Guidelines)

With respect to the use of federal funds for the procurement of goods and services, 2 CFR 200.326 and Appendix II to 2 CFR 200 require the inclusion of the following contract provisions.

1. *Remedies for Contract Breach or Violations.* Contracts for more than the simplified acquisition threshold currently set at $250,000 must address administrative, contractual, or legal remedies in instances where contractors violate or breach contract terms and provide for such sanctions and penalties as appropriate.

2. *Termination for Cause and Convenience.* All contracts in excess of $10,000 must address termination for cause and for convenience by THE SCHOOL including the manner by which it will be affected and the basis for settlement.

3. *Equal Employment Opportunity.* Except as otherwise provided under 41 CFR 60, all contracts that meet the definition of ''federally assisted construction contract'' in41 CFR 60–1.3 must include the equal opportunity clause provided under 41 CFR60–1.4(b), in accordance with Executive Order 11246, ''Equal Employment Opportunity'' (30 FR 12319, 12935, 3 CFR 1964–1965 Comp., p. 339), as amended by Executive Order 11375, ''Amending Executive Order 11246 Relating to Equal Employment Opportunity,'' and implementing regulations at 41 CFR 60, ''Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor.''

4. *Davis-Bacon Act.* When required by Federal program legislation, all prime construction contracts in excess of $2,000 awarded by the school and the charter districts must include a provision for compliance with the Davis-Bacon Act (40U.S.C. 3141–3144, and 3146–3148) as supplemented by Department of Labor regulations (29 CFR 5, ''Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction''). In accordance with the statute, contractors must be required to pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor. In addition, contractors must be required to pay wages not less than once a week. The school and the charter districts must place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation. The decision to award a contract or subcontract must be conditioned upon the acceptance of the wage determination. The school and the charter districts must report all suspected or reported violations to the Federal awarding agency. The contracts must also include a provision for compliance with the Copeland ''Anti-Kickback'' Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR 3, ''Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States''). The Act provides that each contractor or subrecipient must be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The school and the charter districts must report all suspected or reported violations to the Federal awarding agency.

5. *Contract Work Hours and Safety Standards Act.* Where applicable, all contracts awarded by the school and the charter districts in excess of $100,000 that involve the employment of mechanics or laborers must include a provision for compliance with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations(29 CFR 5). Under 40 U.S.C. 3702 of the Act, each contractor must be required to compute the wages of every mechanic and laborer on the basis of a standard workweek of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the workweek. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous, or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

6. *Rights to Inventions Made Under a Contract or Agreement.* If the Federal award meets the definition of "funding agreement" under 37 CFR 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that ''funding agreement,'' the recipient or subrecipient must comply with the requirements of 37 CFR 401, ''Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements,'' and any implementing regulations issued by the awarding agency.

7. *Clean Air Act and the Federal Water Pollution Control Act*. Contracts and subgrants of amounts in excess of $150,000 must contain a provision that requires the contractor to agree to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401–7671q)and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251–1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

8. *Energy Efficiency Standards and Policies*. Mandatory standards and policies relating to energy efficiency which are contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (42 U.S.C. 6201).

9. *Debarment and Suspension*. A contract award (see 2 CFR 180.220) must not be made to parties listed on the governmentwide Excluded Parties List System in the System for Award Management (SAM), inaccordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR Part 1986 Comp., p. 189) and 12689 (3 CFR Part 1989 Comp., p. 235), ''Debarment and Suspension.''The Excluded Parties List System in SAM contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

10. *Byrd Anti-Lobbying*. Contractors that apply or bid for an award of $100,000 or more must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwardedfrom tier to tier.

11. *Procurement of Recovered Materials*. The school, the charter districts and their contractors must complywith section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelinesof the Environmental Protection Agency (EPA) at 40 CFR 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired by the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement ofrecovered materials identified in the EPA guidelines.

Vendor agrees to comply with all federal, state, and local laws, rules, regulations, and ordinances, as applicable. It is further acknowledged that vendor certifies compliance with all provisions, laws, acts, regulations, etc. as specifically noted above.

Vendor's Name/Company Name: _____

Address, City, State, and Zip Code: _____

Phone Number: _____

Email Address: _____

Printed Name and Title of Authorized Representative:

_____

Signature of Authorized Representative: _____ Date: _____

Attachment M – Criminal History Review of Contractor Employees

Texas Education Code §22.0834 requires entities that contract with school districts or charter schools to provide services to obtain named based criminal history and/or fingerprinting record information regarding "covered employees."

Definitions:

"Covered Employees": Any employee of a contractor or subcontractor who (1) has or will have continuing duties related to the contracted services and (2) has or will have direct contact with students. IDEA Public Schools (the "School") retains the discretion to determine what constitutes direct contact with students.

"Disqualifying Criminal History": Any conviction or other criminal information designated by the School, including one or more of the following offenses:

1. A felony or misdemeanor offense that would prevent a person from obtaining certification as an educator under Texas Education Code§21.060, including:
   1.1. Crimes involving moral turpitude;
   1.2. Crimes involving any form of sexual or physical abuse or neglect of a student or minor or other illegal conduct with a student or minor;
   1.3. Crimes involving felony possession or conspiracy to possess, or any misdemeanor or felony transfer, sale, distribution, or conspiracy to transfer, sell, or distribute any controlled substance defined in Chapter481, Texas Health and Safety Code;
   1.4. Crimes involving school property or funds;
   1.5. Crimes involving any attempt by fraudulent or unauthorized means to obtain or alter any certificate or permit that would entitle any person to hold or obtain a position as an educator;
   1.6. Crimes occurring wholly or in part on school property or at a school-sponsored activity; and
   1.7. Felonies involving driving while intoxicated.

2. A felony offense under Title 5, Penal Code.
3. An offense on conviction of which a defendant is required to register as a sex offender.
4. An offense under the laws of another state or federal law that is equivalent to an offense under items (2) and (3) above where, at the time the offense occurred, the victim of the offense was under 18years of age or was enrolled in a public school.
5. Any other offense that the School believes might compromise the safety of students, staff, or property.

All contractors must work with the School to comply with the requirements of Texas Education Code §22.0834 prior to beginning services to the School.

Criminal History Review of Contractor Employees

Please complete the information below:

I, the undersigned agent for _____ ("Contractor"), certify that [check one]:
<<Contractor Name>>

[_____] None of the employees of Contractor and any subcontractors are "covered employees" as defined above. If this box is checked, I further certify that Contractor has taken precautions or imposed conditions to ensure that the employees of Contractor and any subcontractor will not become covered employees. Contractor will maintain these precautions or conditions throughout the time the contracted services are provided.

Or

[_____] Some or all of the employees of Contractor and any subcontractor are "covered employees." If this box is checked, I further certify that:

1. If Contractor receives information that a covered employee subsequently has a reported criminal history, Contractor will immediately remove the covered employee from contract duties and notify the School in writing within three business days.
2. Upon request, Contractor will provide the School with the name and any other requested information regarding covered employees so that the School may obtain criminal history record information on the covered employees.
3. If the School objects to the assignment of a covered employee on the basis of the covered employee's criminal history record information, Contractor agrees to discontinue using that covered employee to provide services to the School.
4. All covered employees hired after January 1, 2008 have completed the required background check process prior to performing any duties related to the School or having any direct contact with students.

I understand that non-compliance with this certification by Contractor may be grounds for contract termination and/or barring disqualified persons from performing the work.

_____ _____

Signature of Contractor Official Date

Attachment N – Reference Sheet

Please list a minimum of three references of agencies (governments, charter schools or ISDs) that have used your services. We would prefer some of the references to be new customers in the last year, and Texas agencies are preferred:

1. _____
Company Name

_____
Street Address City State Zip

_____
Contact Person Phone Number Email Address

_____
Project Scope

_____
Dates of Contract

2. _____
Company Name

_____
Street Address City State Zip

_____
Contact Person Phone Number Email Address

_____
Project Scope

_____
Dates of Contract

3. _____
Company Name

_____
Street Address City State Zip

_____
Contact Person Phone Number Email Address

_____

Project Scope

_____

Dates of Contract

4. _____

Company Name

_____

Street Address City State Zip

_____

Contact Person Phone Number Email Address

_____

Project Scope

_____

Dates of Contract

Attachment O – Proposed Pricing

Respondent shall provide pricing / price schedule referencing: “ATTACHMENT “O” in their submitted proposal.”

Attachment P – Respondent's W-9

The W-9 is an official form furnished by the IRS for employers or other entities to verify the name, address, and tax identification number of an individual receiving income. The information taken from a W-9 form is often used to generate a 1099 tax form, which is required for income tax filing purposes.

Respondent must fill-out the W-9 and submit with their proposal.
Respondent can obtain the W-9 Form at the following link:
https://www.irs.gov/pub/irs-pdf/fw9.pdf

END OF IDEA PUBLIC SCHOOLS RFP

IDEA Public Schools & IPS Current Medical Plan Designs

Benefits	IDEA Public Schools - TRS Current Plan								
	Central and North Texas Scott & White Care	Blue Essentials - South Texas	Blue Essentials - West Texas	TRS ActiveCare Primary	TRS ActiveCare Primary+	TRS ActiveCare Primary HD		TRS ActiveCare 2 (grandfathered - no new enrollments)	
	In-Network	In-Network	In-Network	In-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	Regional TRS Network (HMO)	Regional TRS Network (HMO)	Regional TRS Network (HMO)	TRS Statewide Network (EPO)	TRS Statewide Network (EPO)	TRS Statewide Network (PPO)		TRS Statewide Network (PPO)	
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited	
Coinsurance	80%	80%	75%	70%	80%	70%	50%	80%	60%
Cal Yr Deductible									
Per Individual	$1,150	$500	$950	$2,500	$1,200	$3,000	$5,500	$1,000	$2,000
Per Family	$3,450	$1,000	$2,850	$5,000	$3,600	$6,000	$11,000	$3,000	$6,000
Out-of-Pocket Max									
Individual	$7,450	$4,500	$7,450	$8,150	$6,900	$7,000	$20,250	$7,900	$23,700
Family	$14,900	$9,000	$14,900	$16,300	$13,800	$14,000	$40,500	$15,800	$47,400
Hospital Charges									
Inpatient Charges	80% after ded	80% after ded	75% after ded	70% after ded	80% after ded	70% after ded	50% after ded	$150/day + 80% after ded	60% after ded
Outpatient Charges	80% after ded	80% after ded	75% after ded	70% after ded	80% after ded	70% after ded	50% after ded	$150/day + 80% after ded	60% after ded
Urgent Care	$50 copay	$75 copay	$50 copay	$50 copay	$50 copay	70% after ded	50% after ded	$50 copay	60% after ded
Emergency Charges	$500 copay after ded	80% after ded	$500 copay + 75% after ded	70% after ded	80% after ded	70% after ded		$250 copay + 80% after ded	
Office Visits									
Preventive Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	50% after ded	No Charge	60% after ded
Physician Charges	$20 copay	$25 copay	$20 copay	$30 copay	$30 copay	70% after ded	50% after ded	$30 copay	60% after ded
Specialist Charges	$70 copay	$60 copay	$70 copay	$70 copay	$70 copay	70% after ded	50% after ded	$70 copay	60% after ded
Prescription Drugs	$200 ded. (excl. generics)	$100 ded.	$150 ded.	Incl. in Medical	$200 brand ded.	Incl. in Medical		$200 brand ded.	
Drug Deductible									
Generic Formulary	$10 copay	$10 copay	$5 copay ($0 for certain generics)	$15 copay ($0 for certain generics)	$15 copay	80% after ded*($0 for certain generics)		$20 copay	
Brand Formulary	70% after ded	$40 copay	70% after ded	70% after ded	75% after ded	75% after ded		75% after ded ($40 min/$80 max)	
Non Formulary	50% after ded	$65 copay	50% after ded	50% after ded	50% after ded	50% after ded		50% after ded ($100 min/$200 max)	
Specialty	85% after ded Pref 75% after ded NonPref	80% after ded	85% after ded Pref 75% after ded NonPref	70% after ded	80% after ded	80% after ded		80% after ded ($200 min/$900 max)	
Mail Order									
Generic Formulary	$25 copay	$30 copay	$12.50 copay	$45 copay	$45 copay	80% after ded		$45 copay	
Brand Formulary	70% after ded	$120 copay	70% after ded	70% after ded	75% after ded	75% after ded		75% after ded ($105 min/$210 max)	
Non Formulary	50% after ded	$195 copay	50% after ded	50% after ded	50% after ded	50% after ded		50% after ded ($215 min/$430 max)	
Specialty	75% after ded	80% after ded	75% after ded	70% after ded	80% after ded	80% after ded		80% after ded ($200 min/$900 max)	

Rates	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Current Rates**	**Current Rates**	**Current Rates**	**Current Rates**	**Current Rates**	**Current Rates**	**Current Rates**
Employee Only	66	909	7	2,369	574	1,975	3	159	176	57	$542.48	$524.90	$596.54	$417.00	$542.00	$429.00	$1,013.00
Employee + Spouse	1	23	0	52	16	27	0	12	13	6	$1,362.70	$1,264.28	$1,443.66	$1,176.00	$1,334.00	$1,209.00	$2,402.00
Employee + Child(ren)	19	441	1	508	190	246	2	31	22	11	$872.16	$819.60	$936.18	$751.00	$879.00	$772.00	$1,507.00
Employee + Family	3	148	2	87	23	42	0	10	8	2	$1,568.42	$1,345.58	$1,532.74	$1,405.00	$1,675.00	$1,445.00	$2,841.00
Monthly Total	**89**	**1,521**	**10**	**3,016**	**803**	**2,290**	**5**	**212**	**219**	**76**							

IDEA Public Schools & IPS Current Medical Plan Designs

Benefits	IPS Enterprises - BCBS of Louisiana Current Plan					
	BCBS Bronze HDHP		BCBS Gold PPO		BCBS Platnium PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	(HDHP)		(PPO)		(PPO)	
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Coinsurance	80%	60%	80%	60%	80%	60%
Cal Yr Deductible						
Per Individual	$3,300	$6,600	$1,000	$2,000	$500	$1,000
Per Family	$6,600	$13,200	$3,000	$6,000	$1,500	$3,000
Out-of-Pocket Max						
Individual	$5,500	$11,000	$5,250	$10,500	$2,750	$5,500
Family	$11,000	$22,000	$10,500	$21,000	$5,500	$11,000
Hospital Charges						
Inpatient Charges	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Outpatient Charges	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Urgent Care	80% after ded	60% after ded	$55 copay	60% after ded	$55 copay	60% after ded
Emergency Charges	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Office Visits						
Preventive Care	No Charge	60% after ded	No Charge	60% after ded	No Charge	60% after ded
Physician Charges	80% after ded	60% after ded	$40 copay	60% after ded	$40 copay	60% after ded
Specialist Charges	80% after ded	60% after ded	$55 copay	60% after ded	$55 copay	60% after ded
Prescription Drugs						
Drug Deductible						
Generic Formulary	80% after ded		$15 copay		$15 copay	
Brand Formulary	60% after ded		$40 copay		$40 copay	
Non Formulary	N/A		$70 copay		$70 copay	
Specialty	N/A		90% after ded ($150 max)		90% after ded ($150 max)	
Mail Order						
Generic Formulary	80% after ded		$45 copay		$45 copay	
Brand Formulary	60% after ded		$120 copay		$120 copay	
Non Formulary	N/A		$210 copay		$210 copay	
Specialty	N/A		90% after ded ($150 Max per script)		90% after ded ($150 Max per script)	

Rates	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Current Rates**	**Current Rates**	**Current Rates**
Employee Only	66	909	7	2,369	574	1,975	3	159	176	57	$409.44	$543.91	$602.78
Employee + Spouse	1	23	0	52	16	27	0	12	13	6	$818.88	$1,098.40	$1,205.56
Employee + Child(ren)	19	441	1	508	190	246	2	31	22	11	$757.46	$1,016.01	$1,115.15
Employee + Family	3	148	2	87	23	42	0	10	8	2	$1,166.89	$1,565.21	$1,717.93
Monthly Total	**89**	**1,521**	**10**	**3,016**	**803**	**2,290**	**5**	**212**	**219**	**76**			

Requested Plan Designs

	State of Texas Coverage			HDHP		HDHP		PPO		PPO	
	HMO	HMO	HMO								
	In-Network	In-Network	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited		Unlimited		Unlimited		Unlimited	
Coinsurance	80%	75%	70%	80%	60%	80%	60%	80%	60%	80%	60%
Cal Yr Deductible											
Per Individual	$500	$950	$2,500	$2,500	$5,000	$3,300	$6,600	$1,000	$2,000	$500	$1,000
Per Family	$1,000	$2,850	$5,000	$5,000	$10,000	$6,600	$13,200	$3,000	$6,000	$1,500	$3,000
Out-of-Pocket Max											
Individual	$4,500	$7,450	$8,150	$8,150	$16,300	$5,500	$11,000	$5,250	$10,500	$2,750	$5,500
Family	$9,000	$14,900	$16,300	$16,300	$32,600	$11,000	$22,000	$10,500	$21,000	$5,500	$11,000
Hospital Charges											
Inpatient Charges	80% after ded	75% after ded	70% after ded	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Outpatient Charges	80% after ded	75% after ded	70% after ded	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Urgent Care	$75 copay	$50 copay	$50 copay	$55 copay	60% after ded	80% after ded	60% after ded	$55 copay	60% after ded	$55 copay	60% after ded
Emergency Charges	80% after ded	$500 copay + 75% after ded	70% after ded	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded	80% after ded	60% after ded
Office Visits											
Preventive Care	No Charge	No Charge	No Charge	No Charge	60% after ded	No Charge	60% after ded	No Charge	60% after ded	No Charge	60% after ded
Physician Charges	$25 copay	$20 copay	$30 copay	$40 copay	60% after ded	80% after ded	60% after ded	$40 copay	60% after ded	$40 copay	60% after ded
Specialist Charges	$60 copay	$70 copay	$70 copay	$55 copay	60% after ded	80% after ded	60% after ded	$55 copay	60% after ded	$55 copay	60% after ded
Prescription Drugs											
Drug Deductible	$100	$150	Incl. in Medical	$0		$0		$0		$0	
Generic Formulary	$10	$5*	$15* copay	$15 copay		80% after ded		$15 copay		$15 copay	
Brand Formulary	$40	70% after ded	70% after ded	$40 copay		60% after ded		$40 copay		$40 copay	
Non Formulary	$65	50% after ded	50% after ded	$70 copay		N/A		$70 copay		$70 copay	
Specialty	80% after ded	85% after ded (Pref) 75% after ded (Non-Pref)	70% after ded	90% after ded ($150 Max per script)		N/A		90% after ded ($150 Max per script)		90% after ded ($150 Max per script)	
Mail Order											
Generic Formulary	$30 copay	$12.50 copay	$45 copay	$45 copay		$45 copay		$45 copay		$45 copay	
Brand Formulary	$120 copay	70% after ded	70% after ded	$120 copay		$120 copay		$120 copay		$120 copay	
Non Formulary	$195 copay	50% after ded	50% after ded	$210 copay		$210 copay		$210 copay		$210 copay	
Specialty	80% after ded	75% after ded	70% after ded	90% after ded ($150 Max per script)		90% after ded ($150 Max per script)		90% after ded ($150 Max per script)		90% after ded ($150 Max per script)	

MEDICAL

TRS ACTIVECARE PPO/EPO PLANS

Available to all regions.

> In-network services only are illustrated in the chart below. This is meant to be a brief summary only—for full plan details refer to the SPD.
>
> If you're currently enrolled in the ActiveCare 2 plan, you can remain in it. However, **as of 09/01/2018, the ActiveCare 2 plan is closed to new enrollees.**

Name of Plan	ActiveCare Primary	ActiveCare HD	ActiveCare Primary+	ActiveCare 2*
Type of Plan	**EPO**	**PPO**	**EPO**	**PPO**
Deductible In-Network	$2,500 individual | $5,000 family	$3,000 individual | $6,000 family	$1,200 individual | $3,600 family	$1,000 individual | $3,000 family
Out-of-Network	This plan does not cover out-of-network services	$5,500 individual | $11,000 family	This plan does not cover out-of-network services except for emergencies	$2,000 individual | $6,000 family
Out-of-Pocket Maximum (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum) In-Network	The individual out-of-pocket maximum only included covered expenses incurred by that individual. $8,150 individual | $16,300 family	The individual out-of-pocket maximum only included covered expenses incurred by that individual. $7,000 individual | $14,000 family	$6,900 individual | $13,800 family	$7,900 individual | $15,800 family
Out-of-Network	This plan does not cover out-of-network services	$20,250 individual | $40,500 family	This plan does not cover out-of-network services except for emergencies	$23,700 individual | $47,400 family
Coinsurance In-Network (Participant pays, after deductible)	30%	30%	20%	20%
Out-of-Network (Participant pays, after deductible)	This plan does not cover out-of-network services	50% of allowed amount	This plan does not cover out-of-network services except for emergencies	40% of allowed amount
Office Visit Copay (Participant pays)	$30 copay for primary $70 copay for specialist	30% after deductible	$30 copay for primary $70 copay for specialist	$30 copay for primary $70 copay for specialist
Diagnostic Lab (Participant pays)	Office/Independent Lab: You pay $0 Outpatient: You pay 30% after deductible	30% after deductible	20% after deductible	20% after deductible
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
TRS Virtual Health Services	$0 consultation fee	$30 consultation fee (counts toward deductible and out-of-pocket maximum)	Plan pays $0	Plan pays $0
High-Tech Radiology (CT scans, MRI, Nuclear medicine, Participant pays)	30% after deductible	30% after deductible	20% after deductible	$100 + 20% after deductible
Inpatient Hospital Facility Charges Only (Preauthorization required, In-Network)	30% after deductible	30% after deductible	20% after deductible	$150 copay/day + 20% after deductible ($750 maximum copay per admission; $2,250 maximum copay per plan year)
Freestanding Emergency Room (Participant pays)	$500 copay per visit + 30% after deductible	30% after deductible + $500 copay	$500 copay per visit + 20% after deductible	$500 copay per visit + 20% after deductible
Emergency Room (True emergency use only, Participant pays)	30% after deductible	30% after deductible	20% after deductible	$250 copay per visit + 20% after deductible (copay waived if admitted)
Outpatient Surgery (Participant pays)	30% after deductible	30% after deductible	20% after deductible	$150 copay per visit + 20% after deductible
Prescriptions				
Drug Deductible	Integrated with medical	Integrated with medical	$200 brand deductible	$200 brand deductible
Prescription Retail Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	$15 copay; $0 for certain generics 30% after deductible 50% after deductible 30% after deductible	20% after deductible; $0 for certain gen. 25% after deductible 50% after deductible 20% after deductible	$15 copay 25% after deductible 50% after deductible 20% after deductible	$20 copay 25% after ded. ($40 min/$80 max) 50% after ded. ($100 min/$200 max) 20% after ded. ($200 min/$900 max)
Prescription Mail Order Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	$45 copay 30% after deductible 50% after deductible 30% after deductible	20% after deductible; 25% after deductible 50% after deductible 20% after deductible	$45 copay 25% after deductible 50% after deductible 20% after deductible	$45 copay 25% after ded. ($105 min/$210 max) 50% after ded. ($215 min/$430 max) 20% after ded. ($200 min/$900 max)

**No new enrollments allowed.*

HOW MUCH DOES IT COST?

Monthly Premium	ActiveCare Primary	ActiveCare HD	ActiveCare Primary+	ActiveCare 2
Employee Only	$0.00	$0.00	$122.00	$593.00
Employee + Spouse	$501.00	$534.00	$659.00	$1,727.00
Employee + Child(ren)	$176.00	$197.00	$304.00	$932.00
Family	$605.00	$645.00	$875.00	$2,041.00

TRS ACTIVECARE HMO PLANS

In-network services only are illustrated in the chart below. This is meant to be a brief summary only—for full plan details refer to the SPD.

Name of Plan	Central and North Texas Baylor Scott & White HMO	South Texas Blue Essentials HMO	West Texas Blue Essentials HMO
Type of Plan	**HMO**	**HMO**	**HMO**
Deductible In-Network	$1,150 individual | $3,450 family	$500 individual | $1,000 family	$950 individual | $2,850 family
Out-of-Pocket Maximum In-Network	$7,450 individual | $14,900 family	$4,500 individual | $9,000 family	$7,450 individual | $14,900 family
Coinsurance	20%	20%	25%
Office Visits Primary Care Physician Specialist Urgent Care	 $20 copay $70 copay $50 copay	 $25 copay $60 copay $75 copay	 $20 copay $70 copay $50 copay
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%
Emergency Room	$500 copay after deductible	20% after deductible	$500 copay before deductible + 25% after deductible
Prescriptions			
Drug Deductible	$200 (excl. generics)	$100	$150
Prescription Retail Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	 $10 copay 30% after deductible 50% after deductible 15% after deductible (preferred/non-preferred)	 $10 copay $40 copay $65 copay 20% after deductible	 $5 copay; $0 for certain generics 30% after deductible 50% after deductible 15% after deductible (preferred/non-preferred)
Prescription Mail Order Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	 $25 copay 30% after deductible 50% after deductible 25% after deductible	 $30 copay $120 copay $195 copay 20% after deductible	 $12.50 copay 30% after deductible 50% after deductible 25% after deductible

HOW MUCH DOES IT COST?

Monthly Premium	Central and North Texas Baylor Scott & White HMO	South Texas Blue Essentials HMO	West Texas Blue Essentials HMO
Employee Only	$122.48	$104.90	$176.54
Employee + Spouse	$687.70	$589.28	$768.66
Employee + Child(ren)	$297.16	$244.60	$361.18
Family	$768.42	$545.58	$732.74

Preventive Care
Some examples of preventive care frequency and services:

- Routine physicals - annually age 12+
- Mammograms - one every year age 35+
- Smoking cessation counseling - 8 visits/year
- Well-child care - unlimited up to age 12
- Colonoscopy - 1 every 10 years, age 45+
- Healthy diet counseling - unlimited for -22 (Age 22+ - 26 visits per year)
- Wellwoman exam & pap sear - age 18+ 1/per year
- Prostate cancer screening - 1/year age 50+
- Breastfeeding support - 6 visits/year

Remember. Log into Blue Access for MembersSM at **www.bcbstx.com/trsactivecare** to use the cost estimator tool. This will help you find the best prices.

Wellness Benefits at No Extra Cost.

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia® pregnancy support
- TRS Virtual Health
- Mental health support
- And much more!

2021-22 TRS-ActiveCare Plan Highlights Sept. 1, 2021 – Aug. 31, 2022

TRS ACTIVECARE
TEACHER RETIREMENT SYSTEM OF TEXAS

How to Calculate Your Monthly Premium

Total Monthly Premium
− Your District and State Contributions
= **Your Premium**

Ask your Benefits Administrator for your district's premiums.

Wellness Benefits at No Extra Cost

Being healthy is easy with:

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia® pregnancy support
- TRS Virtual Health
- Mental health support
- And much more!

Available for all plans.
See your Benefits Booklet for more details.

Things to Know

- TRS's Texas-sized purchasing power creates broad networks without county boundaries.
- Specialty drug insurance means you're covered, no matter what life throws at you.

All TRS-ActiveCare participants have **three plan options**. Each includes a wide range of wellness benefits.

	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD
Plan summary	• Lowest premium of the plans • Copays for doctor visits before you meet deductible • Statewide network • PCP referrals required to see specialists • Not compatible with a health savings account (HSA) • No out-of-network coverage	• Lower deductible than the HD and Primary plans • Copays for many services and drugs • Higher premium than the other plans • Statewide network • PCP referrals required to see specialists • Not compatible with a health savings account (HSA) • No out-of-network coverage	• Compatible with a health savings account (HSA) • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals • Must meet your deductible before plan pays for non-preventive care

Monthly Premiums	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee Only	$417	$	$542	$	$429	$
Employee and Spouse	$1,176	$	$1,334	$	$1,209	$
Employee and Children	$751	$	$879	$	$772	$
Employee and Family	$1,405	$	$1,675	$	$1,445	$

Plan Features				
Type of Coverage	In-Network Coverage Only	In-Network Coverage Only	In-Network	Out-of-Network
Individual/Family Deductible	$2,500/$5,000	$1,200/$3,600	$3,000/$6,000	$5,500/$11,000
Coinsurance	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible
Individual/Family Maximum Out-of-Pocket	$8,150/$16,300	$6,900/$13,800	$7,000/$14,000	$20,250/$40,500
Network	Statewide Network	Statewide Network	Nationwide Network	
Primary Care Provider (PCP) Required	Yes	Yes	No	

Doctor Visits				
Primary Care	$30 copay	$30 copay	You pay 30% after deductible	You pay 50% after deductible
Specialist	$70 copay	$70 copay	You pay 30% after deductible	You pay 50% after deductible
TRS Virtual Health	$0 per consultation	$0 per consultation	$30 per consultation	

Immediate Care				
Urgent Care	$50 copay	$50 copay	You pay 30% after deductible	You pay 50% after deductible
Emergency Care	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	
TRS Virtual Health	$0 per consultation	$0 per consultation	$30 per consultation	

Prescription Drugs			
Drug Deductible	Integrated with medical	$200 brand deductible	Integrated with medical
Generics (30-Day Supply/90-Day Supply)	$15/$45 copay; $0 for certain generics	$15/$45 copay	You pay 20% after deductible; $0 for certain generics
Preferred Brand	You pay 30% after deductible	You pay 25% after deductible	You pay 25% after deductible
Non-preferred Brand	You pay 50% after deductible	You pay 50% after deductible	You pay 50% after deductible
Specialty	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible

This plan is closed and not accepting new enrollees. If you're currently enrolled in TRS-ActiveCare 2, you can remain in this plan.

TRS-ActiveCare 2
• Closed to new enrollees • Current enrollees can choose to stay in this plan • Lower deductible • Copays for many drugs and services • Nationwide network with out-of-network coverage • No requirement for PCPs or referrals

Total Premium	Your Premium
$1,013	$
$2,402	$
$1,507	$
$2,841	$

In-Network / Out-of-Network
$1,000/$3,000 / $2,000/$6,000
You pay 20% after deductible / You pay 40% after deductible
$7,900/$15,800 / $23,700/$47,400
Nationwide Network
No

$30 copay / You pay 40% after deductible
$70 copay / You pay 40% after deductible
$0 per consultation

$50 copay / You pay 40% after deductible
You pay a $250 copay plus 20% after deductible
$0 per consultation

$200 brand deductible
$20/$45 copay
You pay 25% after deductible ($40 min/$80 max)/ You pay 25% after deductible ($105 min/$210 max)
You pay 50% after deductible ($100 min/$200 max)/ You pay 50% after deductible ($215 min/$430 max)
You pay 20% after deductible ($200 min/$900 max)

Compare Prices for Common Medical Services

REMEMBER: Log into Blue Access for Members℠ at www.bcbstx.com/trsactivecare to use the cost estimator tool. This will help you find the best prices.

Benefit	TRS-ActiveCare Primary	TRS-ActiveCare Primary+	TRS-ActiveCare HD		TRS-ActiveCare 2	
	In-Network Only	In-Network Only	In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic Labs*	Office/Indpendent Lab: You pay $0 Outpatient: You pay 30% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	Office/Indpendent Lab: You pay $0 Outpatient: You pay 20% after deductible	You pay 40% after deductible
High-Tech Radiology	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible + $100 per procedure copay	You pay 40% after deductible + $100 per procedure copay
Outpatient Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible	You pay 20% after deductible ($150 facility copay per incident)	You pay 40% after deductible ($150 facility copay per incident)
Inpatient Hospital Costs	You pay 30% after deductible	You pay 20% after deductible	You pay 30% after deductible	You pay 50% after deductible ($500 facility per day maximum)	You pay 20% after deductible ($150 facility copay per day)	You pay 40% after deductible ($500 facility per day maximum)
Freestanding Emergency Room	You pay $500 copay + 30% after deductible	You pay $500 copay + 20% after deductible	You pay 30% after deductible + $500 copay	You pay 50% after deductible + $500 copay	You pay $500 copay + 20% after deductible	You pay $500 copay + 40% after deductible
Bariatric Surgery	Facility – You pay 30% after deductible Professional Services – You pay $5,000 copay + 30% after deductible Only covered if rendered at a BDC+ facility.	Facility – You pay 20% after deductible Professional Services – You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility.	Not Covered	Not Covered	Facility – You pay 20% after deductible ($150 facility copay per day) Professional Services – You pay $5,000 copay + 20% after deductible Only covered if rendered at a BDC+ facility.	Not Covered
Annual Vision Examination (one per plan year; performed by an ophthalmologist or optometrist)	You pay $70 copay	You pay $70 copay	You pay 30% after deductible	You pay 50% after deductible	You pay $70 copay	You pay 40% after deductible
Annual Hearing Exam (one per plan year)	$30 PCP copay $70 specialist copay	$30 PCP copay $70 specialist copay	You pay 30% after deductible	You pay 50% after deductible	$30 PCP copay $70 specialist copay	You pay 40% after deductible

Pre-certification for genetic and specialty testing may apply. Contact your Personal Health Guide at **1-866-355-5999 with questions.*

2021-22 Health Maintenance Organizations: Premiums for Regional Plans

REMEMBER: When you choose an HMO, you're choosing a regional network.

TRS also contracts with HMOs in certain regions of the state to bring participants in those areas another option.

	Central and North Texas Scott and White Care Plan *Brought to you by TRS-ActiveCare*	Blue Essentials - South Texas HMO℠ *Brought to you by TRS-ActiveCare*	Blue Essentials - West Texas HMO℠ *Brought to you by TRS-ActiveCare*
	**You can choose this plan if you live in one of these counties:** Austin, Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Collin, Coryell, Dallas, Denton, Ellis, Erath, Falls, Freestone, Grimes, Hamilton, Hays, Hill, Hood, Houston, Johnson, Lampasas, Lee, Leon, Limestone, Madison, McLennan, Milam, Mills, Navarro, Robertson, Rockwall, Somervell, Tarrant, Travis, Walker, Waller, Washington, Williamson	**You can choose this plan if you live in one of these counties:** Cameron, Hildalgo, Starr, Willacy	**You can choose this plan if you live in one of these counties:** Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Callahan, Carson, Castro, Childress, Cochran, Coke, Coleman, Collingsworth, Comanche, Concho, Cottle, Crane, Crockett, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Eastland, Ector, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Howard, Hutchinson, Irion, Jones, Kent, Kimble, King, Knox, Lamb, Lipscomb, Llano, Loving, Lubbock, Lynn, Martin, Mason, McCulloch, Menard, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reagan, Reeves, Roberts, Runnels, San Saba, Schleicher, Scurry, Shackelford, Sherman, Stephens, Sterling, Stonewall, Sutton, Swisher, Taylor, Terry, Throckmorton, Tom Green, Upton, Ward, Wheeler, Winkler, Yoakum

Total Monthly Premiums	Total Premium	Your Premium	Total Premium	Your Premium	Total Premium	Your Premium
Employee Only	$542.48	$	$524.90	$	$596.54	$
Employee and Spouse	$1,362.70	$	$1,264.28	$	$1,443.66	$
Employee and Children	$872.16	$	$819.60	$	$936.18	$
Employee and Family	$1,568.42	$	$1,345.58	$	$1,532.74	$

Plan Features			
Type of Coverage	In-Network Coverage Only	In-Network Coverage Only	In-Network Coverage Only
Individual/Family Deductible	$1,150/$3,450	$500/$1,000	$950/$2,850
Coinsurance	You pay 20% after deductible	You pay 20% after deductible	You pay 25% after deductible
Individual/Family Maximum Out-of-Pocket	$7,450/$14,900	$4,500/$9,000	$7,450/$14,900

Doctor Visits			
Primary Care	$20 copay	$25 copay	$20 copay
Specialist	$70 copay	$60 copay	$70 copay

Immediate Care			
Urgent Care	$50 copay	$75 copay	$50 copay
Emergency Care	$500 copay after deductible	You pay 20% after deductible	$500 copay before deductible and 25% after deductible

Prescription Drugs			
Drug Deductible	$200 (excl. generics)	$100	$150
Days Supply	30-day supply/90-day supply	30-day supply/90-day supply	30-day supply/90-day supply
Generics	$10/$25 copay	$10/$30 copay	$5/$12.50 copay; $0 for certain generics
Preferred Brand	You pay 30% after deductible	$40/$120 copay	You pay 30% after deductible
Non-preferred Brand	You pay 50% after deductible	$65/$195 copay	You pay 50% after deductible
Specialty	You pay 15%/25% after deductible (preferred/non-preferred)	You pay 20% after deductible	You pay 15%/25% after deductible (preferred/non-preferred)

MEDICAL

BLUE CROSS BLUE SHIELD PLANS

Available to all employees.

Name of Plan	Bronze Plan		Gold Plan		Platinum Plan	
Type of Plan	HDHP		PPO		PPO	
Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$3,300 individual | $6,600 family	$6,600 individual | $13,200 family	$1,000 individual | $3,000 family	$2,000 individual | $6,000 family	$500 individual | $1,500 family	$1,000 individual | $3,000 family
Out-of-Pocket Maximum (per plan year; medical and prescription drug deductibles, copays, and coinsurance count toward the out-of-pocket maximum)	$5,500 individual | $11,000 family	$11,000 individual | $22,000 family	$5,250 individual | $10,500 family	$10,500 individual | $21,000 family	$2,750 individual | $5,500 family	$5,500 individual | $11,000 family
Coinsurance (Participant pays, after deductible)	20%	40%	20%	40%	20%	40%
Office Visit Copay (Participant pays)	Ded + Coin for primary Ded + Coin for specialist	Ded + Coin for primary Ded + Coin for specialist	$40 for primary $55 for specialist	Ded + Coin for primary Ded + Coin for specialist	$40 for primary $55 for specialist	Ded + Coin for primary Ded + Coin for specialist
Urgent Care	Ded + Coin	Ded + Coin	$55 copay	Ded + Coin	$55 copay	Ded + Coin
Preventive Care	Plan pays 100%	40% after deductible	Plan pays 100%	40% after deductible	Plan pays 100%	40% after deductible
Ambulatory Surgery Center	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin
Physician/Surgeon Fees	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin
Emergency Room Care	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin
Emergency Transportation	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin
Hospital Room	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin	Ded + Coin
Prescriptions						
Prescription Retail Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand Tier 4: Specialty	Ded + 20% Coin Ded + 40% Coin N/A N/A		$15 copay $40 copay $70 copay 10% Coin up to $150 per prescription		$15 copay $40 copay $70 copay 10% Coin up to $150 per prescription	

HOW MUCH DOES IT COST?

Coverage Tiers - Monthly Premium	Bronze Plan	Gold Plan	Platinum Plan
Employee Only	$0.00	$123.91	$182.78
Employee + Spouse	$143.88	$423.40	$530.56
Employee + Child(ren)	$182.46	$441.01	$540.15
Family	$366.89	$765.21	$917.93

Coverage Tiers - Bi-Weekly Premium	Bronze Plan	Gold Plan	Platinum Plan
Employee Only	$0.00	$61.96	$91.39
Employee + Spouse	$71.94	$211.70	$265.28
Employee + Child(ren)	$91.23	$220.51	$270.08
Family	$183.45	$382.61	$458.97

Preventive Care
Some examples of preventive care frequency and services:

- Routine physicals - annually age 12+
- Mammograms - one every year age 35+
- Smoking cessation counseling - 8 visits/year
- Well-child care - unlimited up to age 12
- Colonoscopy - 1 every 10 years, age 45+
- Healthy diet counseling - unlimited for -22 (Age 22+ - 26 visits per year)
- Wellwoman exam & pap sear - age 18+ 1/per year
- Prostate cancer screening - 1/year age 50+
- Breastfeeding support - 6 visits/year

Wellness Benefits at No Extra Cost.

- $0 preventive care
- 24/7 customer service
- One-on-one health coaches
- Weight loss programs
- Nutrition programs
- Ovia® pregnancy support
- TRS Virtual Health
- Mental health support
- And much more!

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, visit www.bcbsla.com or call 1-800-495-2583. 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.healthcare.gov/sbc-glossary or call 1-800-495-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $500 individual or $1,500 family; for out-of-network providers $1,000 individual or $3,000 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 **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 and Wellness are covered before you meet your deductible.	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 https://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?	For network providers $2,750 individual / $5,500 family; for out-of-network providers $5,500 individual / $11,000 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?	Premiums, Balance Billing 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 **www.bcbsla.com** or call **1-800-495-2583** 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.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copayment	40% Coinsurance	If you have a copayment plan, the PCP copayment may be reduced or waived when services are rendered by a Quality Blue Primary Care Provider (QBPC).
	Specialist Visit	$55 Copayment	40% Coinsurance	None
	Preventive care/screening/immunization	No charge. **Deductible** does not apply.	40% Coinsurance. **Deductible** does not apply.	Prostate Cancer Screening, Colorectal Cancer Screening, Flexible Sigmoidoscopy, Colonoscopy, Abdominal Aortic Aneurysm Screening, Mammography, Osteoporosis Screening, Routine Pap Smear, Autism Screening, Developmental Screening, Hearing Screening, Lead Screening, Tuberculosis Screening, Vision Screening. For more information about Preventive Care & Wellness limitations and exceptions, see the brochure at https://www.bcbsla.com/preventive. 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)	20% Coinsurance	40% Coinsurance	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Must obtain authorization

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 http://www.bcbsla.com/pharmacy-4tier-formulary2021	Tier 1	$15 Copayment	$15 Copayment	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Tier 1 Drug Copayment amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 2	$40 Copayment	$40 Copayment	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3	$70 Copayment	$70 Copayment	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4	10% Coinsurance up to $150 per prescription	10% Coinsurance up to $150 per prescription	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 5	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/Surgeon Fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	None
	Urgent care	$55 Copayment	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None

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	Mental/Behavioral health outpatient services	$40 Copayment /office visit and 20% Coinsurance other outpatient services	40% Coinsurance	May be required to obtain authorization
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder outpatient services	$40 Copayment /office visit and 20% Coinsurance other outpatient services	40% Coinsurance	May be required to obtain authorization
If you are pregnant	Office visits	$55 Copayment /office visit	40% Coinsurance	None
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	40% Coinsurance	None
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Prior authorization may be required
	Hospice services	20% Coinsurance	40% Coinsurance	Must obtain authorization
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight Loss Programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

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 Minimum Value Standards? **Yes**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-495-2583

Tagalog(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

Chinese(中文): 如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-495-2583.

---------- *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**	**$500**
• **Specialist copayment**	**$55**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Service
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	$500
Copayments	$10
Coinsurance	$2,110
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,680**

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

• **The plan's overall deductible**	**$500**
• **Specialist copayment**	**$55**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$10
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,670**

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

• **The plan's overall deductible**	**$500**
• **Specialist copayment**	**$55**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$120
Coinsurance	$360
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$980**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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, visit www.bcbsla.com or call 1-800-495-2583. 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.healthcare.gov/sbc-glossary or call 1-800-495-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 individual or $3,000 family; for out-of-network providers $2,000 individual or $6,000 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 **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 and Wellness are covered before you meet your deductible.	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 https://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?	For network providers $5,250 individual / $10,500 family; for out-of-network providers $10,500 individual / $21,000 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?	Premiums, Balance Billing 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 **www.bcbsla.com** or call **1-800-495-2583** 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.

		What You Will Pay		
Common Medical Event	**Services You May Need**	**Network Provider (You will pay the least)**	**Out-of-Network Provider (You will pay the most)**	**Limitations, Exceptions, & Other Important Information**
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copayment	40% Coinsurance	If you have a copayment plan, the PCP copayment may be reduced or waived when services are rendered by a Quality Blue Primary Care Provider (QBPC).
	Specialist Visit	$55 Copayment	40% Coinsurance	None
	Preventive care/screening/immunization	No charge. **Deductible** does not apply.	40% Coinsurance. **Deductible** does not apply.	Prostate Cancer Screening, Colorectal Cancer Screening, Flexible Sigmoidoscopy, Colonoscopy, Abdominal Aortic Aneurysm Screening, Mammography, Osteoporosis Screening, Routine Pap Smear, Autism Screening, Developmental Screening, Hearing Screening, Lead Screening, Tuberculosis Screening, Vision Screening. For more information about Preventive Care & Wellness limitations and exceptions, see the brochure at https://www.bcbsla.com/preventive. 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)	20% Coinsurance	40% Coinsurance	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Must obtain authorization

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 http://www.bcbsla.com/pharmacy-4tier-formulary2021	Tier 1	$15 Copayment	$15 Copayment	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Tier 1 Drug Copayment amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. The Brand-Name Drug Copayment is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 2	$40 Copayment	$40 Copayment	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3	$70 Copayment	$70 Copayment	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 4	10% Coinsurance up to $150 per prescription	10% Coinsurance up to $150 per prescription	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 5	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/Surgeon Fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	None
	Urgent care	$55 Copayment	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None

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	Mental/Behavioral health outpatient services	$40 Copayment /office visit and 20% Coinsurance other outpatient services	40% Coinsurance	May be required to obtain authorization
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder outpatient services	$40 Copayment /office visit and 20% Coinsurance other outpatient services	40% Coinsurance	May be required to obtain authorization
If you are pregnant	Office visits	$55 Copayment /office visit	40% Coinsurance	None
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	40% Coinsurance	None
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Prior authorization may be required
	Hospice services	20% Coinsurance	40% Coinsurance	Must obtain authorization
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight Loss Programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

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 Minimum Value Standards? **Yes**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-495-2583

Tagalog(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

Chinese(中文): 如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-495-2583.

---------- *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**	**$1,000**
• **Specialist copayment**	**$55**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Service
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	$1,000
Copayments	$10
Coinsurance	$2,010
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,080**

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

• **The plan's overall deductible**	**$1,000**
• **Specialist copayment**	**$55**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$10
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,670**

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

• **The plan's overall deductible**	**$1,000**
• **Specialist copayment**	**$55**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$120
Coinsurance	$260
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,380**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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, visit www.bcbsla.com or call 1-800-495-2583. 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.healthcare.gov/sbc-glossary or call 1-800-495-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $3,300 individual; for out-of-network providers $6,600 individual.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care and Wellness are covered before you meet your deductible.	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 https://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?	For network providers $5,500 individual; for out-of-network providers $11,000 individual.	The **out-of-pocket limit** is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, Balance Billing 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 **www.bcbsla.com** or call **1-800-495-2583** 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	None
	Specialist Visit	20% Coinsurance	40% Coinsurance	None
	Preventive care/screening/immunization	No charge. **Deductible** does not apply.	40% Coinsurance. **Deductible** does not apply.	Prostate Cancer Screening, Colorectal Cancer Screening, Flexible Sigmoidoscopy, Colonoscopy, Abdominal Aortic Aneurysm Screening, Mammography, Osteoporosis Screening, Routine Pap Smear, Autism Screening, Developmental Screening, Hearing Screening, Lead Screening, Tuberculosis Screening, Vision Screening. For more information about Preventive Care & Wellness limitations and exceptions, see the brochure at https://www.bcbsla.com/preventive. 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)	20% Coinsurance	40% Coinsurance	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Must obtain authorization

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 http://www.bcbsla.com/pharmacy-2tier-formulary2021	Tier 1	20% Coinsurance	20% Coinsurance	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. The Brand-Name Drug coinsurance is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 2	40% Coinsurance	40% Coinsurance	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3	Not Applicable	Not Applicable	
	Tier 4	Not Applicable	Not Applicable	
	Tier 5	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/Surgeon Fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None

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	Mental/Behavioral health outpatient services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder outpatient services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	None
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	40% Coinsurance	None
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Prior authorization may be required
	Hospice services	20% Coinsurance	40% Coinsurance	Must obtain authorization
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight Loss Programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

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 Minimum Value Standards? **Yes**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-495-2583

Tagalog(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

Chinese(中文): 如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-495-2583.

---------- *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**	**$3,300**
• **Specialist coinsurance**	**20%**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Service
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	$3,300
Copayments	$0
Coinsurance	$1,860
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,220**

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

• **The plan's overall deductible**	**$3,300**
• **Specialist coinsurance**	**20%**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$770
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,130**

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

• **The plan's overall deductible**	**$3,300**
• **Specialist coinsurance**	**20%**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$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**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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, visit www.bcbsla.com or call 1-800-495-2583. 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.healthcare.gov/sbc-glossary or call 1-800-495-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $3,300 individual or $6,600 family; for out-of-network providers $6,600 individual or $13,200 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 and Wellness are covered before you meet your deductible.	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 https://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?	For network providers $5,500 individual / $11,000 family; for out-of-network providers $11,000 individual / $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?	Premiums, Balance Billing 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 **www.bcbsla.com** or call **1-800-495-2583** 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	None
	Specialist Visit	20% Coinsurance	40% Coinsurance	None
	Preventive care/screening/immunization	No charge. **Deductible** does not apply.	40% Coinsurance. **Deductible** does not apply.	Prostate Cancer Screening, Colorectal Cancer Screening, Flexible Sigmoidoscopy, Colonoscopy, Abdominal Aortic Aneurysm Screening, Mammography, Osteoporosis Screening, Routine Pap Smear, Autism Screening, Developmental Screening, Hearing Screening, Lead Screening, Tuberculosis Screening, Vision Screening. For more information about Preventive Care & Wellness limitations and exceptions, see the brochure at https://www.bcbsla.com/preventive. 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)	20% Coinsurance	40% Coinsurance	May be required to obtain authorization.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Must obtain authorization

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 http://www.bcbsla.com/pharmacy-2tier-formulary2021	Tier 1	20% Coinsurance	20% Coinsurance	Certain drugs may be subject to Quantity Level Limits, Step Therapy, Prior Authorization and/or Specialty Pharmacy Program. When a Brand-Name Drug is dispensed and a Generic equivalent exists, Members must pay the Generic Drug Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its Generic equivalent. The Brand-Name Drug coinsurance is not applicable, and Member's payment will be applied to the Out-of-Pocket Amount.
	Tier 2	40% Coinsurance	40% Coinsurance	See Drug Tier 1 Limitations, Exceptions, & Other Important Information.
	Tier 3	Not Applicable	Not Applicable	
	Tier 4	Not Applicable	Not Applicable	
	Tier 5	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	None
	Physician/Surgeon Fees	20% Coinsurance	40% Coinsurance	None
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	None
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	None
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	None

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	Mental/Behavioral health outpatient services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Substance use disorder outpatient services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you are pregnant	Office visits	20% Coinsurance	40% Coinsurance	None
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	May be required to obtain authorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	40% Coinsurance	None
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Must obtain authorization
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Prior authorization may be required
	Hospice services	20% Coinsurance	40% Coinsurance	Must obtain authorization
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids (Adult)
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care
- Weight Loss Programs

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

- Acupuncture
- Chiropractic care
- Hearing aids (Child)
- Non-emergency care when traveling outside the United States
- Private-Duty Nursing

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300. 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or Louisiana Department of Insurance, Office of Consumer Services, P.O. Box 94214, Baton Rouge La 70804-9214 or call 1-800-259-5300.

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 Minimum Value Standards? **Yes**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-495-2583

Tagalog(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-495-2583.

Chinese(中文): 如果需要中文的帮助，请拨打这个号码 1-800-495-2583.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-495-2583.

---------- *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**	**$3,300**
• **Specialist coinsurance**	**20%**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Service
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	$3,300
Copayments	$0
Coinsurance	$1,860
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,220**

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

• **The plan's overall deductible**	**$3,300**
• **Specialist coinsurance**	**20%**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,300
Copayments	$0
Coinsurance	$770
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,130**

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

• **The plan's overall deductible**	**$3,300**
• **Specialist coinsurance**	**20%**
• **Hospital (facility) coinsurance**	**20%**
• **Other coinsurance**	**20%**

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

Total Example Cost	**$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**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

SCHEDULE OF BENEFITS

Health Plan

Group Care

Group Number: **78Q02ERC 0000**

Group's Anniversary Date: **09/01**

A001

Group's Original Effective Date: **09/01/2019**

Group's Amended Effective Date: **09/01/2021**

Group's Name: **IPS ENTERPRISES LLC.**

SUMMARY OF BENEFITS

Benefit Plan Form Number 40HR1797 R01/21

Your Network: Preferred Care Network

Benefit Period: Calendar Year for all Providers

BENEFIT PERIOD DEDUCTIBLE AMOUNTS

Individual Deductible Amount:

Network Providers	$500.00
Non-Network Providers	$1,000.00

Family Deductible Amount:

A Member does not have to meet the individual Deductible Amount to be eligible for the aggregate family Deductible Amount.

Network Providers	$1,500.00
Non-Network Providers	$3,000.00

The Benefit Period Deductible Amount does not apply to the following:

Preventive or Wellness Care

COPAYMENT AMOUNTS

Physician Office Visit Copayment

Primary Care Physicians	$40.00 per visit
Quality Blue Primary Care Providers	$25.00 per visit
Specialists	$55.00 per visit
Urgent Care Center	$55.00 per visit

COINSURANCE

	Company	Member
Network Providers	80%	20%
Non-Network Providers	60%	40%

Emergency Medical Services performed in the Emergency Department of a Hospital (Includes Hospital facility charge and Professional / Physician charges):

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

	Company	Member
Network Providers	80%	20%
Non-Network Providers	80%	20%

Special Coinsurance:

	Company	Member
Preventive or Wellness Care	100%	0%

OUT-OF-POCKET AMOUNT (Includes Copayments, Coinsurance and Deductible Amounts)

Network Providers

Individual	$2,750.00
Maximum Out-of-Pocket for a Class of Coverage with more than one (1) Member	$5,500.00

Non-Network Providers

Individual	$5,500.00
Maximum Out-of-Pocket for a Class of Coverage with more than one (1) Member	$11,000.00

Special Notes:

Benefits for services of a Network Provider that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers.

Benefits for services of Non-Network Providers that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

Services for Essential Health Benefits of all Providers will accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

BENEFIT LIMITATIONS:

Organ, Tissue, and Bone Marrow Transplant Benefits:

Benefits are subject to applicable Deductible, Coinsurance, Inpatient and Outpatient Copayments.

Organ, tissue and bone marrow transplants and evaluation for a Member's suitability for organ, tissue and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.

Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

MENTAL HEALTH and SUBSTANCE USE DISORDERS

	Network	Non-Network

Continued....

Physician Office Visit for Mental Health and Substance Use Disorder	$40.00 per visit	60%-40%
Non-Physician Office Visit for Mental Health and Substance Use Disorder	$40.00 per visit	60%-40%
Outpatient Mental Health and Substance Use Disorder (includes Outpatient facility, and Outpatient therapies not performed in a Physician office)	80%-20%	60%-40%
All other Mental Health and Substance Use Disorder services	Payable same as medical Benefits.	Payable same as medical Benefits.

CARE MANAGEMENT

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, We will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Member must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services.

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-523-6435.

If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for the penalty and all charges not covered. The Member remains responsible for any applicable Copayment or his Deductible and Coinsurance percentage.

NOTE: Benefits for Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all covered Inpatient charges. The Member is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage.

Additional Member responsibility if Authorization is not requested for an Inpatient Admission to a Non-Participating Provider Hospital: $1,000.00 reduction of the Allowable Charges.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all Outpatient services and supplies requiring an Authorization except where indicated in the list below. The Network Provider is responsible for the penalty and all charges not covered. The Member remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

Thirty (30%) reduction of the Allowable Charges.

If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on this Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

The following list of Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received. The list of services requiring Authorization may change from time to time. Providers may request a pre-determination of Medical Necessity prior to rendering services. Requests for Authorization or a pre-determination of Medical Necessity must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-376-7973.

- Air Ambulance - Non-Emergency (no Benefit without prior Authorization)
- Applied Behavior Analysis
- Arterial Ultrasound
- Arthroscopy and Open procedures (Shoulder & Knee)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Compound Drugs equal to or greater than $100.00
- Coronary Arteriography
- CT Scans
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic Testing
- Hip Arthroscopy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Insulin Pumps
- Intensive Outpatient Programs
- Interventional Spine Pain Management
- Joint Replacement (Hip, Knee & Shoulder)
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee
- MRI / MRA
- Nuclear Cardiology
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty
- PET Scans
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

- Radiation Therapy for Oncology
- Residential Treatment Centers
- Resting Transthoracic Echocardiography
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery
- Stress Echocardiography
- Surgical Treatment of Erectile Dysfunction (including penile implants)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects
- Vacuum Assisted Wound Closure Therapy

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

ELIGIBILITY WAITING PERIODS

The eligibility date is the first billing date on or after date of employment.

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

BY ACCEPTING BENEFITS UNDER THIS BENEFIT PLAN, GROUP / POLICYHOLDER AGREES TO THE FOLLOWING:

1. **Participation Requirements**

   It is agreed that the Group will maintain standard percentage of enrollment of 75% of all eligible Employees, unless Company's records designate otherwise. The Company reserves the right to terminate the Group when participation is less than two (2) Employees. In cases where there is only one (1) Employee (or owner, if covered) employed by the Group, termination will be effective on the Group's next anniversary date. A Group terminated for these reasons will be given sixty (60) days written notification prior to termination.

2. **Employer Contribution**

   It is agreed that new Employees will apply for coverage immediately upon hire, to be effective according to the eligibility requirements as stated in the Eligibility section of this Schedule of Benefits, with the Employer paying a minimum of 50% of each Employee's premium, unless the Company's records designate otherwise.

3. **Eligibility Requirements**

   New Employees who do not exercise the option to enroll themselves or their eligible Dependents during their initial period of eligibility will be subject to the eligibility requirements as stated in the Eligibility section of the Benefit Plan.

4. **Effective Date of Coverage**

   It is agreed that the Effective Date of the Benefit Plan and of an Employee's coverage are subject to the approval of Our home office.

5. **Employees Eligible for Coverage**

   All Employees in the Group are those persons who meet the definition of Employee in the Benefit Plan, usually full-time, thirty (30) hours per week minimum, unless the Company's records designate otherwise.

6. **Termination of a Member's Coverage and Refund of Premium**

   Group must notify Our Membership & Billing Department (which ever the Group is required to notify) of a Member's termination of coverage by submitting to Us a cancellation form (or other form of notification acceptable to Us) no later than within the next billing cycle immediately following the billing cycle in which the Member (or any of the Member's Dependents) is terminated from the Group or eligibility for coverage ends. Company is under no obligation to refund any premium paid by Group or any Member because of the Group's failure to timely notify Company of a Member's or his Dependent's termination of coverage. If terminations are notified or requested by Group beyond the period here provided Group will be responsible for paying all corresponding premiums until the Effective Date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply.

   Whenever the Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the

Continued....

date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual for continuation coverage in a separate process.

7. Member Election of Continuation of Coverage

Group will submit to the Membership & Billing Department evidence of a Member's election of any available COBRA or other continuation of coverage within three (3) business days of Group's receipt of signed continuation forms from the Member.

8. Rebates

In the event federal or state law requires Company to rebate a portion of any premium payment, Company may pay the rebate to the Group / Policyholder. Group / Policyholder will use or distribute rebates in accordance with law.

Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section of the Group Health Benefit Plan.

9. Summary of Benefits and Coverage

Company will provide the Summary of Benefits and Coverage to the Group / Policyholder for distribution to participants and beneficiaries in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation to distribute the Summary of Benefits and Coverage at Open Enrollment in accordance with the law.

SCHEDULE OF BENEFITS

Health Plan

Group Care

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

SUMMARY OF BENEFITS

Benefit Plan Form Number 40HR1797 R01/21

Your Network: Preferred Care Network

Benefit Period: Calendar Year for all Providers

BENEFIT PERIOD DEDUCTIBLE AMOUNTS

Individual Deductible Amount:

Network Providers	$1,000.00
Non-Network Providers	$2,000.00

Family Deductible Amount:

A Member does not have to meet the individual Deductible Amount to be eligible for the aggregate family Deductible Amount.

Network Providers	$3,000.00
Non-Network Providers	$6,000.00

The Benefit Period Deductible Amount does not apply to the following:

Preventive or Wellness Care

COPAYMENT AMOUNTS

Physician Office Visit Copayment

Primary Care Physicians	$40.00 per visit
Quality Blue Primary Care Providers	$25.00 per visit
Specialists	$55.00 per visit
Urgent Care Center	$55.00 per visit

COINSURANCE

	Company	Member
Network Providers	80%	20%
Non-Network Providers	60%	40%

Emergency Medical Services performed in the Emergency Department of a Hospital (Includes Hospital facility charge and Professional / Physician charges):

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

	Company	Member
Network Providers	80%	20%
Non-Network Providers	80%	20%

Special Coinsurance:

	Company	Member
Preventive or Wellness Care	100%	0%

OUT-OF-POCKET AMOUNT (Includes Copayments, Coinsurance and Deductible Amounts)

Network Providers

Individual	$5,250.00
Maximum Out-of-Pocket for a Class of Coverage with more than one (1) Member	$10,500.00

Non-Network Providers

Individual	$10,500.00
Maximum Out-of-Pocket for a Class of Coverage with more than one (1) Member	$21,000.00

Special Notes:

Benefits for services of a Network Provider that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers.

Benefits for services of Non-Network Providers that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

Services for Essential Health Benefits of all Providers will accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

BENEFIT LIMITATIONS:

Organ, Tissue, and Bone Marrow Transplant Benefits:

Benefits are subject to applicable Deductible, Coinsurance, Inpatient and Outpatient Copayments.

Organ, tissue and bone marrow transplants and evaluation for a Member's suitability for organ, tissue and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.

Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

MENTAL HEALTH and SUBSTANCE USE DISORDERS

	Network	Non-Network

Continued....

Physician Office Visit for Mental Health and Substance Use Disorder	$40.00 per visit	60%-40%
Non-Physician Office Visit for Mental Health and Substance Use Disorder	$40.00 per visit	60%-40%
Outpatient Mental Health and Substance Use Disorder (includes Outpatient facility, and Outpatient therapies not performed in a Physician office)	80%-20%	60%-40%
All other Mental Health and Substance Use Disorder services	Payable same as medical Benefits.	Payable same as medical Benefits.

CARE MANAGEMENT

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, We will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Member must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services.

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-523-6435.

If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for the penalty and all charges not covered. The Member remains responsible for any applicable Copayment or his Deductible and Coinsurance percentage.

NOTE: Benefits for Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all covered Inpatient charges. The Member is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage.

Additional Member responsibility if Authorization is not requested for an Inpatient Admission to a Non-Participating Provider Hospital: $1,000.00 reduction of the Allowable Charges.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all Outpatient services and supplies requiring an Authorization except where indicated in the list below. The Network Provider is responsible for the penalty and all charges not covered. The Member remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

Thirty (30%) reduction of the Allowable Charges.

If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on this Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

The following list of Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received. The list of services requiring Authorization may change from time to time. Providers may request a pre-determination of Medical Necessity prior to rendering services. Requests for Authorization or a pre-determination of Medical Necessity must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-376-7973.

- Air Ambulance - Non-Emergency (no Benefit without prior Authorization)
- Applied Behavior Analysis
- Arterial Ultrasound
- Arthroscopy and Open procedures (Shoulder & Knee)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Compound Drugs equal to or greater than $100.00
- Coronary Arteriography
- CT Scans
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic Testing
- Hip Arthroscopy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Insulin Pumps
- Intensive Outpatient Programs
- Interventional Spine Pain Management
- Joint Replacement (Hip, Knee & Shoulder)
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee
- MRI / MRA
- Nuclear Cardiology
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty
- PET Scans
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

- Radiation Therapy for Oncology
- Residential Treatment Centers
- Resting Transthoracic Echocardiography
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery
- Stress Echocardiography
- Surgical Treatment of Erectile Dysfunction (including penile implants)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects
- Vacuum Assisted Wound Closure Therapy

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

ELIGIBILITY WAITING PERIODS

The eligibility date is the first billing date on or after date of employment.

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

BY ACCEPTING BENEFITS UNDER THIS BENEFIT PLAN, GROUP / POLICYHOLDER AGREES TO THE FOLLOWING:

1. Participation Requirements

It is agreed that the Group will maintain standard percentage of enrollment of 75% of all eligible Employees, unless Company's records designate otherwise. The Company reserves the right to terminate the Group when participation is less than two (2) Employees. In cases where there is only one (1) Employee (or owner, if covered) employed by the Group, termination will be effective on the Group's next anniversary date. A Group terminated for these reasons will be given sixty (60) days written notification prior to termination.

2. Employer Contribution

It is agreed that new Employees will apply for coverage immediately upon hire, to be effective according to the eligibility requirements as stated in the Eligibility section of this Schedule of Benefits, with the Employer paying a minimum of 50% of each Employee's premium, unless the Company's records designate otherwise.

3. Eligibility Requirements

New Employees who do not exercise the option to enroll themselves or their eligible Dependents during their initial period of eligibility will be subject to the eligibility requirements as stated in the Eligibility section of the Benefit Plan.

4. Effective Date of Coverage

It is agreed that the Effective Date of the Benefit Plan and of an Employee's coverage are subject to the approval of Our home office.

5. Employees Eligible for Coverage

All Employees in the Group are those persons who meet the definition of Employee in the Benefit Plan, usually full-time, thirty (30) hours per week minimum, unless the Company's records designate otherwise.

6. Termination of a Member's Coverage and Refund of Premium

Group must notify Our Membership & Billing Department (which ever the Group is required to notify) of a Member's termination of coverage by submitting to Us a cancellation form (or other form of notification acceptable to Us) no later than within the next billing cycle immediately following the billing cycle in which the Member (or any of the Member's Dependents) is terminated from the Group or eligibility for coverage ends. Company is under no obligation to refund any premium paid by Group or any Member because of the Group's failure to timely notify Company of a Member's or his Dependent's termination of coverage. If terminations are notified or requested by Group beyond the period here provided Group will be responsible for paying all corresponding premiums until the Effective Date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply.

Whenever the Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the

Continued....

date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual for continuation coverage in a separate process.

7. Member Election of Continuation of Coverage

Group will submit to the Membership & Billing Department evidence of a Member's election of any available COBRA or other continuation of coverage within three (3) business days of Group's receipt of signed continuation forms from the Member.

8. Rebates

In the event federal or state law requires Company to rebate a portion of any premium payment, Company may pay the rebate to the Group / Policyholder. Group / Policyholder will use or distribute rebates in accordance with law.

Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section of the Group Health Benefit Plan.

9. Summary of Benefits and Coverage

Company will provide the Summary of Benefits and Coverage to the Group / Policyholder for distribution to participants and beneficiaries in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation to distribute the Summary of Benefits and Coverage at Open Enrollment in accordance with the law.

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

SUMMARY OF BENEFITS

Benefit Plan Form Number 40HR1796 R01/21

Your Network: Preferred Care Network

Benefit Period: Calendar Year for all Providers

BENEFIT PERIOD DEDUCTIBLE AMOUNTS

Individual Deductible Amounts:

Network Providers	$3,300.00
Non-Network Providers	$6,600.00

Family Deductible Amounts:

Network Providers	$6,600.00
Non-Network Providers	$13,200.00

Per Member within a Family Deductible Amount:

Network Providers	$6,600.00

COINSURANCE

Inpatient and Outpatient Services:

	Company	-	Member
Network Providers	80%	-	20%
Non-Network Providers	60%	-	40%

Emergency Medical Services performed in the Emergency Department of a Hospital (Includes Hospital facility charge and Professional / Physician charges):

	Company	-	Member
Network Providers	80%	-	20%
Non-Network Providers	80%	-	20%

Preventive or Wellness Care Services (Deductible Waived):

	Company	-	Member
Network Providers	100%	-	0%
Non-Network Providers	60%	-	40%

OUT-OF-POCKET AMOUNT - Includes the Deductible Amount and if applicable, all eligible Coinsurance Amounts, including Prescription Drug Coinsurance

Individual Out-of-Pocket Amounts:

Network Providers	$5,500.00
Non-Network Providers	$11,000.00

Continued....

Family Out-of-Pocket Amounts:	
Network Providers	$11,000.00
Non-Network Providers	$22,000.00
Per Member within a Family Out-of-Pocket Amount:	
Network Providers	$7,900.00

Special Notes:

If the Plan covers more than one (1) Member, the Individual Deductible and Individual Out-of-Pocket Amount Is not applicable

Benefits for services of a Network Provider that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers.

Benefits for services of Non-Network Providers that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

Services for Essential Health Benefits of all Providers will accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

BENEFIT LIMITATIONS:

Mental Health:

Benefits are payable the same as any other illness.

Organ, Tissue, and Bone Marrow Transplant Benefits:

Benefits are subject to applicable Deductible and Coinsurance.

Organ, tissue and bone marrow transplants and evaluation for a Member's suitability for organ, tissue and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.

Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

Substance Use Disorder:

Benefits are payable the same as any other illness.

CARE MANAGEMENT

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, We will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

Continued....

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Member must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services.

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-523-6435.

If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for the penalty and all charges not covered. The Member remains responsible for any applicable Copayment or his Deductible and Coinsurance percentage.

NOTE: Benefits for Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all covered Inpatient charges. The Member is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage.

Additional Member responsibility if Authorization is not requested for an Inpatient Admission to a Non-Participating Provider Hospital: $1,000.00 reduction of the Allowable Charges.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all Outpatient services and supplies requiring an Authorization except where indicated in the list below. The Network Provider is responsible for the penalty and all charges not covered. The Member remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

Thirty (30%) reduction of the Allowable Charges.

If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on this Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

The following list of Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received. The list of services requiring Authorization may change from time to time. Providers may request a pre-determination of Medical Necessity prior to rendering services. Requests for Authorization or a pre-determination of Medical Necessity must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-376-7973.

- Air Ambulance - Non-Emergency (no Benefit without prior Authorization)
- Applied Behavior Analysis

Continued....

- Arterial Ultrasound
- Arthroscopy and Open procedures (Shoulder & Knee)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Compound Drugs equal to or greater than $100.00
- Coronary Arteriography
- CT Scans
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic Testing
- Hip Arthroscopy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Insulin Pumps
- Intensive Outpatient Programs
- Interventional Spine Pain Management
- Joint Replacement (Hip, Knee & Shoulder)
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee
- MRI / MRA
- Nuclear Cardiology
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty
- PET Scans
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology
- Residential Treatment Centers
- Resting Transthoracic Echocardiography
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery
- Stress Echocardiography
- Surgical Treatment of Erectile Dysfunction (including penile implants)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects
- Vacuum Assisted Wound Closure Therapy

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

ELIGIBILITY WAITING PERIODS

The eligibility date is the first billing date on or after date of employment.

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

BY ACCEPTING BENEFITS UNDER THIS BENEFIT PLAN, GROUP / POLICYHOLDER AGREES TO THE FOLLOWING:

1. Participation Requirements

It is agreed that the Group will maintain standard percentage of enrollment of 75% of all eligible Employees, unless Company's records designate otherwise. The Company reserves the right to terminate the Group when participation is less than two (2) Employees. In cases where there is only one (1) Employee (or owner, if covered) employed by the Group, termination will be effective on the Group's next anniversary date. A Group terminated for these reasons will be given sixty (60) days written notification prior to termination.

2. Employer Contribution

It is agreed that new Employees will apply for coverage immediately upon hire, to be effective according to the eligibility requirements as stated in the Eligibility section of this Schedule of Benefits, with the Employer paying a minimum of 50% of each Employee's premium, unless the Company's records designate otherwise.

3. Eligibility Requirements

New Employees who do not exercise the option to enroll themselves or their eligible Dependents during their initial period of eligibility will be subject to the eligibility requirements as stated in the Eligibility section of the Benefit Plan.

4. Effective Date of Coverage

It is agreed that the Effective Date of the Benefit Plan and of an Employee's coverage are subject to the approval of Our home office.

5. Employees Eligible for Coverage

All Employees in the Group are those persons who meet the definition of Employee in the Benefit Plan, usually full-time, thirty (30) hours per week minimum, unless the Company's records designate otherwise.

6. Termination of a Member's Coverage and Refund of Premium

Group must notify Our Membership & Billing Department (which ever the Group is required to notify) of a Member's termination of coverage by submitting to Us a cancellation form (or other form of notification acceptable to Us) no later than within the next billing cycle immediately following the billing cycle in which the Member (or any of the Member's Dependents) is terminated from the Group or eligibility for coverage ends. Company is under no obligation to refund any premium paid by Group or any Member because of the Group's failure to timely notify Company of a Member's or his Dependent's termination of coverage. If terminations are notified or requested by Group beyond the period here provided Group will be responsible for paying all corresponding premiums until the Effective Date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply.

Whenever the Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the

Continued....

date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual for continuation coverage in a separate process.

7. Member Election of Continuation of Coverage

Group will submit to the Membership & Billing Department evidence of a Member's election of any available COBRA or other continuation of coverage within three (3) business days of Group's receipt of signed continuation forms from the Member.

8. Rebates

In the event federal or state law requires Company to rebate a portion of any premium payment, Company may pay the rebate to the Group / Policyholder. Group / Policyholder will use or distribute rebates in accordance with law.

Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section of the Group Health Benefit Plan.

9. Summary of Benefits and Coverage

Company will provide the Summary of Benefits and Coverage to the Group / Policyholder for distribution to participants and beneficiaries in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation to distribute the Summary of Benefits and Coverage at Open Enrollment in accordance with the law.

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

SUMMARY OF BENEFITS

Benefit Plan Form Number 40HR1796 R01/21

Your Network: Preferred Care Network

Benefit Period: Calendar Year for all Providers

BENEFIT PERIOD DEDUCTIBLE AMOUNTS

Individual Deductible Amounts:

Network Providers	$3,300.00
Non-Network Providers	$6,600.00

Family Deductible Amounts:

Network Providers	$6,600.00
Non-Network Providers	$13,200.00

Per Member within a Family Deductible Amount:

Network Providers	$6,600.00

COINSURANCE

Inpatient and Outpatient Services:

	Company	-	Member
Network Providers	80%	-	20%
Non-Network Providers	60%	-	40%

Emergency Medical Services performed in the Emergency Department of a Hospital (Includes Hospital facility charge and Professional / Physician charges):

	Company	-	Member
Network Providers	80%	-	20%
Non-Network Providers	80%	-	20%

Preventive or Wellness Care Services (Deductible Waived):

	Company	-	Member
Network Providers	100%	-	0%
Non-Network Providers	60%	-	40%

OUT-OF-POCKET AMOUNT - Includes the Deductible Amount and if applicable, all eligible Coinsurance Amounts, including Prescription Drug Coinsurance

Individual Out-of-Pocket Amounts:

Network Providers	$5,500.00
Non-Network Providers	$11,000.00

Continued....

Family Out-of-Pocket Amounts:	
Network Providers	$11,000.00
Non-Network Providers	$22,000.00
Per Member within a Family Out-of-Pocket Amount:	
Network Providers	$7,900.00

Special Notes:

If the Plan covers more than one (1) Member, the Individual Deductible and Individual Out-of-Pocket Amount Is not applicable

Benefits for services of a Network Provider that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers.

Benefits for services of Non-Network Providers that accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Non-Network Providers will not accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

Services for Essential Health Benefits of all Providers will accrue to the Deductible Amount and/or the Out-of-Pocket Amount for Network Providers.

BENEFIT LIMITATIONS:

Mental Health:

Benefits are payable the same as any other illness.

Organ, Tissue, and Bone Marrow Transplant Benefits:

Benefits are subject to applicable Deductible and Coinsurance.

Organ, tissue and bone marrow transplants and evaluation for a Member's suitability for organ, tissue and bone marrow transplants will not be covered unless a Member obtains written Authorization from Us prior to services being rendered.

Non-Network Benefits are not available for Organ, Tissue and Bone Marrow Transplants.

Substance Use Disorder:

Benefits are payable the same as any other illness.

CARE MANAGEMENT

If a required Authorization is not requested prior to Admission or receiving other Covered Services and supplies, We will have the right to determine if the Admission or other Covered Services or supplies were Medically Necessary.

Continued....

If the Admission or other Covered Services and supplies were not Medically Necessary, the Admission or other Covered Services and supplies will not be covered and the Member must pay all charges incurred.

If the Admission or other Covered Services and supplies were Medically Necessary, Benefits will be provided based on the participating status of the Provider rendering the services.

Authorization of Inpatient and Emergency Admissions:

Inpatient Admissions must be Authorized. Refer to "Care Management" and if applicable "Pregnancy Care and Newborn Care Benefits" sections of the Benefit Plan for complete information. Requests for Authorization of Inpatient Admissions and for Concurrent Review of an Admission in progress must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-523-6435.

If a Network Provider or a Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the penalty amount stipulated in the Provider's contract with Us or with another Blue Cross and Blue Shield plan. This penalty applies to all covered Inpatient charges. The Network Provider or Participating Provider is responsible for the penalty and all charges not covered. The Member remains responsible for any applicable Copayment or his Deductible and Coinsurance percentage.

NOTE: Benefits for Participating Providers will be paid at the lower Non-Network level shown on this Schedule of Benefits.

If a Non-Participating Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all covered Inpatient charges. The Member is responsible for all charges not covered and for any applicable Copayment, Deductible and Coinsurance percentage.

Additional Member responsibility if Authorization is not requested for an Inpatient Admission to a Non-Participating Provider Hospital: $1,000.00 reduction of the Allowable Charges.

Authorization of Outpatient Services, Including Other Covered Services and Supplies:

If a Network Provider fails to obtain a required Authorization, We will reduce Allowable Charges by the amount shown below. This penalty applies to all Outpatient services and supplies requiring an Authorization except where indicated in the list below. The Network Provider is responsible for the penalty and all charges not covered. The Member remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

Thirty (30%) reduction of the Allowable Charges.

If a Non-Network Provider fails to obtain a required Authorization, Benefits will be paid at the lower Non-Network level shown on this Schedule of Benefits. The Member is responsible for all charges not covered and remains responsible for his applicable Copayment, Deductible and Coinsurance percentage.

The following list of Outpatient services and supplies require Authorization prior to the services being rendered or supplies being received. The list of services requiring Authorization may change from time to time. Providers may request a pre-determination of Medical Necessity prior to rendering services. Requests for Authorization or a pre-determination of Medical Necessity must be made to Blue Cross and Blue Shield of Louisiana by calling 1-800-376-7973.

- Air Ambulance - Non-Emergency (no Benefit without prior Authorization)
- Applied Behavior Analysis

Continued....

- Arterial Ultrasound
- Arthroscopy and Open procedures (Shoulder & Knee)
- Bone Growth Stimulator
- Cardiac Rehabilitation
- Cellular Immunotherapy
- Compound Drugs equal to or greater than $100.00
- Coronary Arteriography
- CT Scans
- Day Rehabilitation Programs
- Electric & Custom Wheelchairs
- Gene Therapy
- Genetic Testing
- Hip Arthroscopy
- Home Health Care
- Hospice
- Hyperbarics
- Implantable Medical Devices over $2,000.00 (including but not limited to defibrillators)
- Insulin Pumps
- Intensive Outpatient Programs
- Interventional Spine Pain Management
- Joint Replacement (Hip, Knee & Shoulder)
- Low Protein Food Products
- Meniscal Allograft Transplantation of the Knee
- MRI / MRA
- Nuclear Cardiology
- Partial Hospitalization Programs
- Percutaneous Coronary Interventions such as Coronary Stents and Balloon Angioplasty
- PET Scans
- Private Duty Nursing
- Prosthetic Appliances
- Pulmonary Rehabilitation
- Radiation Therapy for Oncology
- Residential Treatment Centers
- Resting Transthoracic Echocardiography
- Sleep Studies, except for those performed as a home sleep study
- Spine Surgery
- Stress Echocardiography
- Surgical Treatment of Erectile Dysfunction (including penile implants)
- Temporomandibular Joint Syndrome (TMJ) Surgical Treatment
- Transesophageal Echocardiography
- Transplant Evaluation and Transplants
- Treatment of Osteochondral Defects
- Vacuum Assisted Wound Closure Therapy

Continued....

ELIGIBILITY WAITING PERIODS

The eligibility date is the first billing date on or after date of employment.

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

BY ACCEPTING BENEFITS UNDER THIS BENEFIT PLAN, GROUP / POLICYHOLDER AGREES TO THE FOLLOWING:

1. Participation Requirements

It is agreed that the Group will maintain standard percentage of enrollment of 75% of all eligible Employees, unless Company's records designate otherwise. The Company reserves the right to terminate the Group when participation is less than two (2) Employees. In cases where there is only one (1) Employee (or owner, if covered) employed by the Group, termination will be effective on the Group's next anniversary date. A Group terminated for these reasons will be given sixty (60) days written notification prior to termination.

2. Employer Contribution

It is agreed that new Employees will apply for coverage immediately upon hire, to be effective according to the eligibility requirements as stated in the Eligibility section of this Schedule of Benefits, with the Employer paying a minimum of 50% of each Employee's premium, unless the Company's records designate otherwise.

3. Eligibility Requirements

New Employees who do not exercise the option to enroll themselves or their eligible Dependents during their initial period of eligibility will be subject to the eligibility requirements as stated in the Eligibility section of the Benefit Plan.

4. Effective Date of Coverage

It is agreed that the Effective Date of the Benefit Plan and of an Employee's coverage are subject to the approval of Our home office.

5. Employees Eligible for Coverage

All Employees in the Group are those persons who meet the definition of Employee in the Benefit Plan, usually full-time, thirty (30) hours per week minimum, unless the Company's records designate otherwise.

6. Termination of a Member's Coverage and Refund of Premium

Group must notify Our Membership & Billing Department (which ever the Group is required to notify) of a Member's termination of coverage by submitting to Us a cancellation form (or other form of notification acceptable to Us) no later than within the next billing cycle immediately following the billing cycle in which the Member (or any of the Member's Dependents) is terminated from the Group or eligibility for coverage ends. Company is under no obligation to refund any premium paid by Group or any Member because of the Group's failure to timely notify Company of a Member's or his Dependent's termination of coverage. If terminations are notified or requested by Group beyond the period here provided Group will be responsible for paying all corresponding premiums until the Effective Date of termination. All requests for termination of coverage, whether timely or not, will be subject to any other terms, conditions and legal requirements that may apply.

Whenever the Group submits a request to Company to terminate a Member's coverage or that of any of Member's Dependents, the Group will be deemed to be making a representation that neither the Member nor his Dependent has made payments towards the cost of premiums for any coverage period beyond the

Continued....

date on which the Group desires the coverage to be terminated, and that no information was given or representation was made to the Member or his Dependent that would create an expectation that the individual would continue coverage beyond that date, except for legally required disclosures regarding any rights to COBRA or other mandated continuation coverage. In the event that the individual should have a right to continue coverage under COBRA or any similar mandate, the Group will be required to timely request the individual's termination of coverage under the regular process created by Company for such purpose, and to submit any election from the individual for continuation coverage in a separate process.

7. Member Election of Continuation of Coverage

Group will submit to the Membership & Billing Department evidence of a Member's election of any available COBRA or other continuation of coverage within three (3) business days of Group's receipt of signed continuation forms from the Member.

8. Rebates

In the event federal or state law requires Company to rebate a portion of any premium payment, Company may pay the rebate to the Group / Policyholder. Group / Policyholder will use or distribute rebates in accordance with law.

Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section of the Group Health Benefit Plan.

9. Summary of Benefits and Coverage

Company will provide the Summary of Benefits and Coverage to the Group / Policyholder for distribution to participants and beneficiaries in accordance with law. Group will indemnify the Company in the event the Company suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligation to distribute the Summary of Benefits and Coverage at Open Enrollment in accordance with the law.

SCHEDULE OF BENEFITS

Pharmacy Benefits

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

SUMMARY OF BENEFITS

PRESCRIPTION DRUG BENEFITS - CLOSED FORMULARY

See Benefit Plan for Tier Descriptions	COMPANY / MEMBER
Tier 1	80% / 20%
Tier 2*	60% / 40%

	RETAIL	MAIL
Day Supply Limitation per prescription or refill:	A 30 or 90 day supply for maintenance Prescription Drugs; up to a 30 day supply of all other Prescription Drugs	Up to a ninety (90) day supply

* When a Brand-Name Drug is dispensed and a generic equivalent exists, Members must pay the Tier 1 Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its generic equivalent. The Coinsurance for the Brand-Name Drug will not apply. The Member's payment will apply to the Out-of-Pocket Amount.

Specialty Drugs may be limited to a thirty (30) day supply per fill, and may be subject to prior Authorization requirements. Specialty Drugs may fall within any tier.

Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.

Certain Generic preventive care (safe harbor) drugs in selected Prescription Drug categories are available at 100%, Deductible waived (no cost share to the Member) when a certain Generic Drug is purchased In-Network.

PRESCRIPTION DRUG STEP THERAPY

As currently provided in the Benefit Plan's Prescription Drug Utilization Program, in some cases the Company may require the Member to first try one or more Prescription Drugs to treat a medical condition before the Company will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, the Company may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then the Company will cover a Prescription written for Drug B. However, if Your Physician request for a Step B Drug does not meet the necessary criteria to start a Step B Drug without first trying a Step A Drug, or if You choose a Step B Drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the Drug.

Categories of Prescription Drugs that require Step Therapy. As these categories may change from time to time, the Member may wish to call the customer service number on their ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs are subject to Step Therapy.

Examples may include but are not limited to:
- Blood Pressure Medications: (example: Angiotensin Converting Enzyme Inhibitors, Angiotensin II Receptor Blockers, Direct Renin Inhibitors)
- Pain Medications: (example: Non-Steroidal Anti-Inflammatory Drugs, COX-2 Inhibitors)
- Cholesterol Medications: (example: HMG-CoA Reductase Inhibitors)
- Sleep Medications: (example: Sedatives, Hypnotics)
- Stomach Acid Medications: (example: Proton Pump Inhibitors)
- Respiratory/Allergy Medications: (example: Nasal Antihistamines, Non-Sedating Antihistamines, Nasal Steroids)

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

- Depression Medications: (example: Selective Serotonin Reuptake Inhibitors, Serotonin/ Norepinephrine Reuptake Inhibitors)

AUTHORIZATION FOR PRESCRIPTION DRUGS

The following categories of Prescription Drugs require prior Authorization. The Member's Physician must call 1-800-376-7741 to obtain the Authorization. Call the customer service number on the Member's ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs require prior Authorization.

Categories of Prescription Drugs that require prior Authorization.

Specialty Drugs - Examples may include, but are not limited to:
- Growth hormones*
- Anti-tumor necrosis factor Drugs*
- Intravenous immune globulin*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*
- Chemotherapeutic Drugs
- Proprotein convertase subtilisin/kexin type 9 (PCSK-9) inhibitors (e.g. Praluent®, Repatha-)*

* Shall include all Drugs that are in this category.

Compound Drugs equal to or greater than $100.00

Traditional Drugs that are not considered to be Specialty Drugs, are typically self-administered, and commonly dispensed by retail pharmacies. Examples may include but are not limited to:
- Provigil®, Nuvigil®, Symlin®, Byetta®, Victoza®

Controlled Dangerous Substances - Examples may include, but are not limited to:
- Actiq®, OxyContin®

Therapeutic/Treatment Vaccines - Examples include, but are not limited to vaccines to treat the following conditions:
- Allergic Rhinitis
- Alzheimer's Disease
- Cancers
- Multiple Sclerosis
- Substance Use Disorder

SCHEDULE OF BENEFITS

Pharmacy Benefits

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

SUMMARY OF BENEFITS

PRESCRIPTION DRUG BENEFITS - CLOSED FORMULARY

See Benefit Plan for Tier Descriptions	COMPANY / MEMBER
Tier 1	80% / 20%
Tier 2*	60% / 40%

	RETAIL	MAIL
Day Supply Limitation per prescription or refill:	A 30 or 90 day supply for maintenance Prescription Drugs; up to a 30 day supply of all other Prescription Drugs	Up to a ninety (90) day supply

* When a Brand-Name Drug is dispensed and a generic equivalent exists, Members must pay the Tier 1 Coinsurance amount, plus the difference in cost between the Brand-Name Drug dispensed and its generic equivalent. The Coinsurance for the Brand-Name Drug will not apply. The Member's payment will apply to the Out-of-Pocket Amount.

Specialty Drugs may be limited to a thirty (30) day supply per fill, and may be subject to prior Authorization requirements. Specialty Drugs may fall within any tier.

Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance.

Certain Generic preventive care (safe harbor) drugs in selected Prescription Drug categories are available at 100%, Deductible waived (no cost share to the Member) when a certain Generic Drug is purchased In-Network.

PRESCRIPTION DRUG STEP THERAPY

As currently provided in the Benefit Plan's Prescription Drug Utilization Program, in some cases the Company may require the Member to first try one or more Prescription Drugs to treat a medical condition before the Company will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, the Company may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then the Company will cover a Prescription written for Drug B. However, if Your Physician request for a Step B Drug does not meet the necessary criteria to start a Step B Drug without first trying a Step A Drug, or if You choose a Step B Drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the Drug.

Categories of Prescription Drugs that require Step Therapy. As these categories may change from time to time, the Member may wish to call the customer service number on their ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs are subject to Step Therapy.

Examples may include but are not limited to:
- Blood Pressure Medications: (example: Angiotensin Converting Enzyme Inhibitors, Angiotensin II Receptor Blockers, Direct Renin Inhibitors)
- Pain Medications: (example: Non-Steroidal Anti-Inflammatory Drugs, COX-2 Inhibitors)
- Cholesterol Medications: (example: HMG-CoA Reductase Inhibitors)
- Sleep Medications: (example: Sedatives, Hypnotics)
- Stomach Acid Medications: (example: Proton Pump Inhibitors)
- Respiratory/Allergy Medications: (example: Nasal Antihistamines, Non-Sedating Antihistamines, Nasal Steroids)

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

- Depression Medications: (example: Selective Serotonin Reuptake Inhibitors, Serotonin/ Norepinephrine Reuptake Inhibitors)

AUTHORIZATION FOR PRESCRIPTION DRUGS

The following categories of Prescription Drugs require prior Authorization. The Member's Physician must call 1-800-376-7741 to obtain the Authorization. Call the customer service number on the Member's ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs require prior Authorization.

Categories of Prescription Drugs that require prior Authorization.

Specialty Drugs - Examples may include, but are not limited to:
- Growth hormones*
- Anti-tumor necrosis factor Drugs*
- Intravenous immune globulin*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*
- Chemotherapeutic Drugs
- Proprotein convertase subtilisin/kexin type 9 (PCSK-9) inhibitors (e.g. Praluent®, Repatha-)*

* Shall include all Drugs that are in this category.

Compound Drugs equal to or greater than $100.00

Traditional Drugs that are not considered to be Specialty Drugs, are typically self-administered, and commonly dispensed by retail pharmacies. Examples may include but are not limited to:
- Provigil®, Nuvigil®, Symlin®, Byetta®, Victoza®

Controlled Dangerous Substances - Examples may include, but are not limited to:
- Actiq®, OxyContin®

Therapeutic/Treatment Vaccines - Examples include, but are not limited to vaccines to treat the following conditions:
- Allergic Rhinitis
- Alzheimer's Disease
- Cancers
- Multiple Sclerosis
- Substance Use Disorder

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

SUMMARY OF BENEFITS

PRESCRIPTION DRUGS - CLOSED FORMULARY

PRESCRIPTION DRUG COVERAGE - (FOUR TIER)

Copayment and/or Coinsurance per Outpatient Prescription or refill: See Benefit Plan for Tier Descriptions	RETAIL	MAIL
Tier 1	$15.00	$45.00
Tier 2*	$40.00	$120.00
Tier 3*	$70.00	$210.00
Tier 4	10% Up to $150.00 max	10% Up to $150.00 max

* When a Brand-Name Drug is dispensed and a generic equivalent exists, Members must pay the Tier 1 Copayment amount, plus the difference in cost between the Brand-Name Drug dispensed and its generic equivalent. The Copayment for the Brand-Name Drug will not apply. The Member's payment will apply to the Out-of-Pocket Amount.

	RETAIL	MAIL
Day supply limitation per Prescription or refill:	A 30 or 90 day supply for maintenance Prescription Drugs; up to a 30 day supply of all other Prescription Drugs	Up to a 90 day supply

Member's maximum out-of-pocket cost for oral anti-cancer Drugs purchased from a pharmacy is $100.00 per fill.

Specialty Drugs may be limited to a thirty (30) day supply per fill, and may be subject to prior Authorization requirements.

Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance or Copayment.

Zero Dollar Drug Copay: Certain drugs in selected Prescription Drug categories commonly used to treat selected chronic conditions (i.e. Asthma, COPD - Chronic Obstructive Pulmonary Disease, CHD - Coronary Heart Disease, Diabetes, Heart Failure, etc.) are available at 100%, Deductible/Copayment waived (no cost share to the Member) when a certain drug is purchased at a Network Pharmacy.

PRESCRIPTION DRUG STEP THERAPY

As currently provided in the Benefit Plan's Prescription Drug Utilization Program, in some cases the Company may require the Member to first try one or more Prescription Drugs to treat a medical condition before the Company will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, the Company may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then the Company will cover a Prescription written for Drug B. However, if Your Physician request for a Step B Drug does not meet the necessary criteria to start a Step B Drug without first trying a Step A

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

Drug, or if You choose a Step B Drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the Drug.

Categories of Prescription Drugs that require Step Therapy. As these categories may change from time to time, the Member may wish to call the customer service number on their ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs are subject to Step Therapy.

Examples may include but are not limited to:
- Blood Pressure Medications: (example: Angiotensin Converting Enzyme Inhibitors, Angiotensin II Receptor Blockers, Direct Renin Inhibitors)
- Pain Medications: (example: Non-Steroidal Anti-Inflammatory Drugs, COX-2 Inhibitors)
- Cholesterol Medications: (example: HMG-CoA Reductase Inhibitors)
- Sleep Medications: (example: Sedatives, Hypnotics)
- Stomach Acid Medications: (example: Proton Pump Inhibitors)
- Respiratory/Allergy Medications: (example: Nasal Antihistamines, Non-Sedating Antihistamines, Nasal Steroids)
- Depression Medications: (example: Selective Serotonin Reuptake Inhibitors, Serotonin/ Norepinephrine Reuptake Inhibitors)

AUTHORIZATION FOR PRESCRIPTION DRUGS

The following categories of Prescription Drugs require prior Authorization. The Member's Physician must call 1-800-376-7741 to obtain the Authorization. Call the customer service number on the Member's ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs require prior Authorization.

Categories of Prescription Drugs that require prior Authorization.

Specialty Drugs - Examples may include, but are not limited to:
- Growth hormones*
- Anti-tumor necrosis factor Drugs*
- Intravenous immune globulin*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*
- Chemotherapeutic Drugs
- Proprotein convertase subtilisin/kexin type 9 (PCSK-9) inhibitors (e.g. Praluent®, Repatha-)*

* Shall include all Drugs that are in this category.

Compound Drugs equal to or greater than $100.00

Traditional Drugs that are not considered to be Specialty Drugs, are typically self-administered, and commonly dispensed by retail pharmacies. Examples may include but are not limited to:
- Provigil®, Nuvigil®, Symlin®, Byetta®, Victoza®

Controlled Dangerous Substances - Examples may include, but are not limited to:
- Actiq®, OxyContin®

Therapeutic/Treatment Vaccines - Examples include, but are not limited to vaccines to treat the following conditions:
- Allergic Rhinitis

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

- Alzheimer's Disease
- Cancers
- Multiple Sclerosis
- Substance Use Disorder

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

SUMMARY OF BENEFITS

PRESCRIPTION DRUGS - CLOSED FORMULARY

PRESCRIPTION DRUG COVERAGE - (FOUR TIER)

Copayment and/or Coinsurance per Outpatient Prescription or refill: See Benefit Plan for Tier Descriptions	RETAIL	MAIL
Tier 1	$15.00	$45.00
Tier 2*	$40.00	$120.00
Tier 3*	$70.00	$210.00
Tier 4	10% Up to $150.00 max	10% Up to $150.00 max

* When a Brand-Name Drug is dispensed and a generic equivalent exists, Members must pay the Tier 1 Copayment amount, plus the difference in cost between the Brand-Name Drug dispensed and its generic equivalent. The Copayment for the Brand-Name Drug will not apply. The Member's payment will apply to the Out-of-Pocket Amount.

	RETAIL	MAIL
Day supply limitation per Prescription or refill:	A 30 or 90 day supply for maintenance Prescription Drugs; up to a 30 day supply of all other Prescription Drugs	Up to a 90 day supply

Member's maximum out-of-pocket cost for oral anti-cancer Drugs purchased from a pharmacy is $100.00 per fill.

Specialty Drugs may be limited to a thirty (30) day supply per fill, and may be subject to prior Authorization requirements.

Therapeutic/Treatment Vaccines are subject to payment of Deductible and Coinsurance or Copayment.

Zero Dollar Drug Copay: Certain drugs in selected Prescription Drug categories commonly used to treat selected chronic conditions (i.e. Asthma, COPD - Chronic Obstructive Pulmonary Disease, CHD - Coronary Heart Disease, Diabetes, Heart Failure, etc.) are available at 100%, Deductible/Copayment waived (no cost share to the Member) when a certain drug is purchased at a Network Pharmacy.

PRESCRIPTION DRUG STEP THERAPY

As currently provided in the Benefit Plan's Prescription Drug Utilization Program, in some cases the Company may require the Member to first try one or more Prescription Drugs to treat a medical condition before the Company will cover another Prescription Drug for that condition. For example, if Drug A and Drug B both treat the Member's medical condition, the Company may require the Member's Physician to prescribe Drug A first. If Drug A does not work for the Member, then the Company will cover a Prescription written for Drug B. However, if Your Physician request for a Step B Drug does not meet the necessary criteria to start a Step B Drug without first trying a Step A

Group Number:	**78Q02ERC 0000**	**Group's Anniversary Date:**	**09/01**
			A001
Group's Original Effective Date:	**09/01/2019**	**Group's Amended Effective Date:**	**09/01/2021**
Group's Name:	**IPS ENTERPRISES LLC.**		

Continued....

Drug, or if You choose a Step B Drug included in the Step Therapy program without first trying a Step A alternative, You will be responsible for the full cost of the Drug.

Categories of Prescription Drugs that require Step Therapy. As these categories may change from time to time, the Member may wish to call the customer service number on their ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs are subject to Step Therapy.

Examples may include but are not limited to:
- Blood Pressure Medications: (example: Angiotensin Converting Enzyme Inhibitors, Angiotensin II Receptor Blockers, Direct Renin Inhibitors)
- Pain Medications: (example: Non-Steroidal Anti-Inflammatory Drugs, COX-2 Inhibitors)
- Cholesterol Medications: (example: HMG-CoA Reductase Inhibitors)
- Sleep Medications: (example: Sedatives, Hypnotics)
- Stomach Acid Medications: (example: Proton Pump Inhibitors)
- Respiratory/Allergy Medications: (example: Nasal Antihistamines, Non-Sedating Antihistamines, Nasal Steroids)
- Depression Medications: (example: Selective Serotonin Reuptake Inhibitors, Serotonin/ Norepinephrine Reuptake Inhibitors)

AUTHORIZATION FOR PRESCRIPTION DRUGS

The following categories of Prescription Drugs require prior Authorization. The Member's Physician must call 1-800-376-7741 to obtain the Authorization. Call the customer service number on the Member's ID card or check Our website at www.bcbsla.com/pharmacy to determine what categories of Prescription Drugs require prior Authorization.

Categories of Prescription Drugs that require prior Authorization.

Specialty Drugs - Examples may include, but are not limited to:
- Growth hormones*
- Anti-tumor necrosis factor Drugs*
- Intravenous immune globulin*
- Interferons
- Monoclonal antibodies
- Hyaluronic acid derivatives for joint injection*
- Chemotherapeutic Drugs
- Proprotein convertase subtilisin/kexin type 9 (PCSK-9) inhibitors (e.g. Praluent®, Repatha-)*

* Shall include all Drugs that are in this category.

Compound Drugs equal to or greater than $100.00

Traditional Drugs that are not considered to be Specialty Drugs, are typically self-administered, and commonly dispensed by retail pharmacies. Examples may include but are not limited to:
- Provigil®, Nuvigil®, Symlin®, Byetta®, Victoza®

Controlled Dangerous Substances - Examples may include, but are not limited to:
- Actiq®, OxyContin®

Therapeutic/Treatment Vaccines - Examples include, but are not limited to vaccines to treat the following conditions:
- Allergic Rhinitis

Group Number: 78Q02ERC 0000

Group's Anniversary Date: 09/01

A001

Group's Original Effective Date: 09/01/2019

Group's Amended Effective Date: 09/01/2021

Group's Name: IPS ENTERPRISES LLC.

Continued....

- Alzheimer's Disease
- Cancers
- Multiple Sclerosis
- Substance Use Disorder

If responses to questions differ from Fully Insured and ASO please indicate in your response.

General

1. Will there be a dedicated customer service unit for the IDEA? If so, where will it be located and how will it be staffed?

2. Please outline your online tools and resources available to members. Is an interactive website available to the CITY staff and members?

3. Do you have the capability to connect with an online benefits administration system? Can you accept eligibility data files from these carriers? What is the cost and timeline needed for setting up the data feeds?

4. Detail how your organization will provide support to IDEA during open enrollments and/or health fairs, etc.

5. What is the average turnaround time for supplying ID cards directly to participants or live/online access to evidence of membership?

6. Please indicate your process for handling subrogation claims.

7. Describe the appeal process of a contested claim.

8. Are reports available online?

9. What standard reports would be generated for IDEA leadership and MIS review, and at what frequency? Please provide a sample of your standard reporting package.

10. Can you accommodate a full claims dump annually?

11. Can you integrate with Cotiviti (healthcare analytics)?

12. Do you currently offer on-line access to claims and eligibility information?

13. Provide a detailed implementation plan outlining specific events and timetable to ensure a smooth transition. Be sure to include dates for issuance of identification cards (where applicable), contracts and Summary Plan Descriptions/Certificate booklets.

14. Will you provide an implementation credit in your proposal? Will you provide any wellness credits? If so, please provide details.

15. What programs do you have in place to increase employee engagement in health and wellness and to mitigate costs? Include incentive options.

16. Does your wellness program allow non plan participants to participate? Is there an additional charge?

17. What, if any, services that are proposed will be subcontracted with outside vendors (i.e. network, prescription drugs, mental health, disease management, etc.)?

18. Please provide your current AM Best Rating/recent published financial statement.

Medical & Prescription

1. If IDEA moved to a calendar year plan could you accommodate a rolling deductible through the first contract year, or would the deductible start over on 1/1? How would you handle this request?

2. How do you contract with the COE's? Through your own network or another type of arrangement? How will our employees access needed treatment? Please list the clinical areas that you have COE's for? Is there any additional costs to access them? Include information about geographical location of COEs.

3. Is a nurse advisory toll free number available? Please provide hours of operation and advantages to both the member and client.

4. Will you work with IDEA on wellness programs and initiatives? If so, provide a suggested plan or sample plan you have used for other employers. Are there additional services available for an additional cost? If so, please describe.

5. Can an employee view all EOB's online?

6. What type of claim audit procedure is currently in place? Please indicate the percentage of total claims audited.

9. Does your proposal include a Telemedicine benefit?

10. Please describe your retail pharmacy network including its relationship to you (e.g. owned or leased)?

11. Which nationally recognized pharmacies are in your network and what is their contracting arrangement? Do you have smaller/performance networks that provide a lower cost? If so, please describe?

12. List chain pharmacies excluded from your network.

13. Does the pharmacy plan proposed use a formulary or preferred-drug list.

14. How often do you update your formulary?

15. Describe your process for notifying affected members of formulary changes. How do you assist members with finding an alternate medication if available?

16. Describe your process for implementing a new formulary with a new client. Are you able to grandfather certain drugs? If so, for how long?

17. Do you offer alternatives in the pharmacy program (i.e. step therapy or mandatory generic) that can help control or reduce the plan costs? If so, please provide details and approximate savings for each feature.

18. Describe your programs to manage drug utilization, identify potential abuse patterns by members, assess over-prescribing physicians, and identify potential fraud by dispenser and/or members.

19. Outline your performance guarantees and financial costs at risk.

20. How are manufacturer rebates handled? Will IDEA share in the rebates? If so, what percentage? Can you offset your medical administration fee if you maintain the rebates? How often are rebates distributed?

21. What disease states has your specialty pharmacy built care programs around?

22. How do you handle case management?

23. Please describe your disease management programs.

24. Based off of the enrollment census provided in this RFP, provide average network discounts in the primary geographic areas listed.

25. Please outline the process for transition of care if a member is in treatment and that provider is out of your network.