Florida Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
(True Group Application)

☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 98854 (Florida Blue HMO): 98854

A. Name of Group: CITY OF POMPANO BEACH FLORIDA

Nature of Business: EXECUTIVE OFFICES SIC Code: 9111

Mailing Address: 100 W ATLANTIC BLVD POMPANO BEACH,FL 33060-6099

Email Address: Cindy.Lawrence@copbfl.com

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

Name	Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as a Policy) by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue and/or Health Options, Inc., D/B/A Florida Blue HMO. Upon acceptance of this application by Florida Blue and/or Florida Blue HMO, it will become part of the Policy issued to the applicant named above.

C. Prior Insurance Carrier: Insurance: UNICARE

HMO:

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

E. Workers Compensation Carrier is: SELF INSURED

II. Effective Date/Eligibility Information

A. Effective Date of this Policy shall be 10/01/1999

Effective Date of this Change to the Policy shall be 10/01/2018

This Policy may be terminated by the applicant or Florida Blue/Florida Blue HMO by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of 30 hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

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

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

E. At least 65 % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet Florida Blue/Florida Blue HMO participation requirements.

F. Florida Blue/Florida Blue HMO shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by Florida Blue/Florida Blue HMO. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: 100 % Dependents: 50 %

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EMPLOYER APPLICATION
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III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in Product	Accept	Decline	
☒	☐	☐	Mental & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☒ Single Plan ☐ Blue Packages

Health Plan Name: **BlueCare NFQ LG GRP Plan 55 - NSTD**

Rx Option *(indicate copayments)*: **BlueCare Rx OOP INT $10/$20/$40C - NSTD**

Benefit Period : 01/01/2018 - 12/31/2018

Deductible :

Per Person	$250 / Not Applicable
Per Family	$500 / Not Applicable
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	90% / 10%
Out-of-Network/Non-Participating	Not Applicable / Not Applicable

Office Visit Copay:

Family Physician	$20 Copayment
All Other Providers	$20 Copayment

Rates

Employee	$614.80	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1647.73
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

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☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueChoice Physician Copay Plan 0702 - NSTD	BlueScript Rx OOP Int $10/$20/$40C - NSTD

Benefit Period : 01/01/2018 - 12/31/2018

Deductible :

Per Person	$250 / Combined w/ In-Network
Per Family	$500 / Combined w/ In-Network
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	70% / 30%

Office Visit Copay:

Family Physician	$25 Copayment
All Other Providers	$25 Copayment

Rates

Employee	$911.82	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$2093.70
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

☒ Single Plan ☐ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueChoice Physician Copay Plan 0727 - NSTD	BlueScript Rx OOP Int $10/$20/$40C - NSTD

Benefit Period : 01/01/2018 - 12/31/2018

Deductible :

Per Person	$500 / Combined w/ In-Network
Per Family	$750 / Combined w/ In-Network
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	70% / 30%

Office Visit Copay:

Family Physician	$25 Copayment
All Other Providers	$25 Copayment

Rates

Employee	$905.07	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$2078.20
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

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

IV. Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA)

A. Are you choosing Florida Blue's integrated HSA, HRA or FSA preferred administrator arrangement? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

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

V. Rate Information

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

B. **Regular Billing** - Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

EMPLOYER APPLICATION
(True Group Application)

C. The Rates established for this Policy will not be changed for the first twelve (12) months following the initial Effective Date of Coverage unless there is a change in benefits or a 15% or more change in the composition of the group. However, Florida Blue/Florida Blue HMO may change the Rates that are to be effective after this initial twelve (12) month period of coverage by providing notice to the employer of such changed Rates forty-five (45) days prior to their Effective Date.

D. Funding Arrangements:

Florida Blue:	**ANNUAL REFND NO SPEC STOP LOSS**
HMO:	**ANNUAL REFND NO SPEC STOP LOSS**

E. Rate Comments:

Florida Blue

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EMPLOYER APPLICATION
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VI. Applicant Responsibilities

A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/ Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.

B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.

D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.

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

F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]

G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

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

Date	Signature of Applicant	Print/Type Name & Title

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

Florida Blue

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Signature of Agent

Agent License Identification Number

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

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EMPLOYER APPLICATION
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☐ New Business ☒ Renewal Business ☐ Other

I. Group Information

Group # (Florida Blue): 98854 (Florida Blue HMO):

A. Name of Group: CITY OF POMPANO BEACH FLORIDA(RETIREES)

Nature of Business: EXECUTIVE OFFICES SIC Code: 9111

Mailing Address: 100 W ATLANTIC BLVD POMPANO BEACH,FL 33060-6099

Email Address: ~~UNKNOWN@AOL.COM~~ Cindy.lawrence@copbfl.com

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

Name	Address

B. Applicant hereby applies for issuance of a Group Policy (herein referred to as a Policy) by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue and/or Health Options, Inc., D/B/A Florida Blue HMO. Upon acceptance of this application by Florida Blue and/or Florida Blue HMO, it will become part of the Policy issued to the applicant named above.

C. Prior Insurance Carrier: Insurance UNICARE

HMO

D. The Policy excludes expenses for any service or supply to diagnose or treat any Condition from or in connection with an Insured's job or employment (e.g., any service or supply which is covered by Workers' Compensation insurance) except for medically necessary services (not otherwise excluded) for an individual who is not covered by Workers' Compensation and that lack of coverage did not result from any intentional action or omission by that individual. The foregoing exclusion applies to an individual who elects exemption from Workers' Compensation coverage and to an individual who foregoes Workers' Compensation coverage available to employees in the Group.

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A. Effective Date of this Policy shall be 10/01/1999

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This Policy may be terminated by the applicant or Florida Blue/Florida Blue HMO by giving at least 45 days prior written notice to the other party except in the case of non-payment of Premium.

B. Only eligible employees who regularly work a minimum of 30 hours each week and their eligible dependents, shall be eligible for coverage upon the Effective Date of this Policy.

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

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

E. At least 65 % of the eligible employees must be enrolled under the Policy on the Effective Date and throughout the term of the Policy and the Group must meet and continue to meet Florida Blue/Florida Blue HMO participation requirements.

F. Florida Blue/Florida Blue HMO shall have the right to audit the applicant's payroll records at any time to confirm eligibility for coverage, including participation percentage criteria required by Florida Blue/Florida Blue HMO. Applicant agrees to furnish any such request.

G. Employer Contribution: Employee: 0 % Dependents: 0 %

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III. Health Plan Summary Information (select the appropriate box[s]):

Mandated Benefit Offerings:(Optional) Applicant has been advised of the following benefit offerings mandated by the Federal and/or State Law. Applicant's decision to accept or decline these benefits is indicated below.

Included in Product	Accept	Decline	
☒	☐	☐	Mental & Nervous Disorder
☒	☐	☐	Alcohol and drug dependency
☒	☐	☐	Mammograms Waiver of Deductible & Coinsurance
☒	☐	☐	Enteral Formulas

☐ Single Plan ☒ Blue Packages

Health Plan Name	Rx Option *(indicate copayments)*
BlueChoice Physician Copay Plan 0727 - NSTD	**BlueScript Rx OOP Int $10/$20/$40C - NSTD**

Benefit Period : 01/01/2018 - 12/31/2018

Deductible :

Per Person	$500 / Combined w/ In-Network
Per Family	$750 / Combined w/ In-Network
Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	70% / 30%

Office Visit Copay:

Family Physician	$25 Copayment
All Other Providers	$25 Copayment

Rates

Employee	$678.80	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	N/A
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	$1357.60

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Per Person	$500 / Combined w/ In-Network
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Pre-Existing	N/A

Coinsurance:

In-Network / Participating	80% / 20%
Out-of-Network/Non-Participating	70% / 30%

Office Visit Copay:

Family Physician	$25 Copayment
All Other Providers	$25 Copayment

Rates

Employee	$678.80	Employee/Spouse	N/A	Employee/Child(ren)	N/A	Family	$1851.93
Spouse	N/A	Child(ren)	N/A	Spouse/Child(ren)	N/A	Employee + 1	N/A

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

IV. Health Savings Account (HSA), Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA)

A. Are you choosing Florida Blue's integrated HSA, HRA or FSA preferred administrator arrangement? ☐ Yes ☒ No
(if left blank, the response is assumed to be No.)

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

V. Rate Information

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

B. **Regular Billing** - Employee applications should be submitted thirty (30) days prior to proposed Effective Date. Employee cancellations must be submitted within 30 days of the Effective Date of the Termination.

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

E. Rate Comments:

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VI. Applicant Responsibilities

A. The applicant shall: 1) Notify each enrollee to the benefits selected by the applicant, their Effective Date, and the termination date of coverage (in this regard, applicant acts as the agent of the enrollee, and in no event shall the applicant be deemed an agent of Florida Blue/Florida Blue HMO for this or any other purpose, nor shall Florida Blue/Florida Blue HMO be responsible for such notification to retirees). 2) Deliver to covered enrollees identification cards and certificates of coverage furnished by Florida Blue/ Florida Blue HMO. 3) Notify Florida Blue/Florida Blue HMO promptly of any changes in the eligibility of enrollees covered under this Agreement. 4) List any absentees at the time of initial enrollment on the appropriate Florida Blue/Florida Blue HMO form. Applications from absentees will be accepted at Florida Blue/Florida Blue HMO Corporate Headquarters no later than thirty (30) days from the group's Effective Date. 5) Collect enrollee contribution, if required, and remit Premium payment/prepayment fees to Florida Blue/Florida Blue HMO as specified in this application.

B. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

C. Applicant hereby establishes an Employee Welfare Benefit Plan for the purpose of providing for its employees or their beneficiaries medical, surgical, hospital care, or benefits in the event of sickness.

D. If applicant chose an HSA, HRA or FSA integrated arrangement with Florida Blue's preferred administrator, applicant agrees to obtain from each employee enrolling in a health plan issued or administered by Florida Blue and establishing an HSA, HRA or FSA in conjunction therewith, the employee's signed HIPAA compliant authorization form that authorizes Florida Blue to disclose to Florida Blue's preferred administrator such information, including protected health information, of the employee as the administrator may require in order to establish and maintain the employee's HSA, HRA or FSA accounts. Applicant acknowledges and agrees that Florida Blue does not provide banking or administrative services for HSA, HRA of FSAs and that Florida Blue is not responsible for the provision of HSA,HRA or FSA services. HSA, HRA or FSA services are provided by the administrator of applicant's choice subject to the terms and conditions of such agreements, including any fees that the administrator may require.

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

F. Applicant agrees to receive group invoices and other communications from Florida Blue/Florida Blue HMO electronically through your BlueBiz account. You agree to keep your email address up-to-date in order to access and receive required communications through your BlueBiz account. Applicant understands that failing to update your email address may result in delay of notification of important information including premium invoices. [Applicant may change this mailing preference at any time by calling Florida Blue/Florida Blue HMO or logging into your BlueBiz account.]

G. If applicant is applying for BlueOptions which includes a pharmacy plan with an Exclusive Provider Provision (EPP), applicant acknowledges that all eligible employees live, reside or work in the Service Area. Applicant acknowledges receipt of 1) a description of the exclusive providers; 2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; 3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; 4) a description of limitations on referrals to restricted exclusive providers and to other providers; and 5) a description of Florida Blue's quality assurance program and grievance procedure. Applicant further acknowledges that applicant understands the restrictions of the BlueOptions Exclusive Provider Organization for pharmacy plans that include this provision.

VII. Final Premiums, Benefits and Effective Dates are Subject to Approval by Florida Blue Corporate Headquarters

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

Date	Signature of Applicant	Print/Type Name & Title

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

Florida Blue

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Signature of Agent	Agent License Identification Number

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

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

May 31, 2018

Ed Beecher
City of Pompano Beach
100 W Atlantic Blvd #451
Pompano Beach, FL, 33061

RE: Group Policy Number:
253L20

Renewal Date: October 01, 2018

Dear Ed Beecher :

Thank you for choosing Florida Combined Life Insurance Company, Inc. for your group Dental Insurance benefits. We value you as a customer and appreciate your business.

Your Group Dental Insurance Plan is about to renew. We have completed our annual review of your coverage with FCL, taking into account a variety of factors that affect rate development. After careful consideration and analysis, we have established your renewal rates for the next plan year. Your current and renewal rates are shown below. The renewal rates will take effect on your renewal date and are guaranteed for the following 12 months, subject to the terms and conditions of your group contract.

BlueDental Choice True Group 253L20

	Current Rates	New Rates
Employee	$ 26.00	$ 26.00
Family	$ 84.59	$ 84.59

We look forward to continuing our relationship well into the future. Should you have any questions regarding this letter, please contact your local Florida Blue representative or telephone our office at 1-800-772-8244.

Sincerely,

Amy Cain

Group Dental Underwriting
cc:
Sales Rep: George Eppl

Florida Blue

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ENROLLMENT SUMMARY

For Groups with 51+ Eligible Employees

Medicare Secondary Payor Compliance

Multiple Employer Plan: a plan sponsored by more than one employer. **Multi-employer plan:** a plan jointly sponsored by employers and unions.

If you are a single employer plan:

☑ Yes ☐ No — Our Company employed 20 or more employees** each working day in 20 or more calendar weeks during the current or preceding calendar year.

If you are a single employer, multiple employer, or multi-employer plan:

☑ Yes ☐ No — Our Company employed 100 or more employees** on 50 percent or more of the business days during the preceding calendar year.

If you are a multiple employer or a multi-employer plan:

☐ Yes ☐ No — All employers in our Group Health Plan (GHP) employed 20 or more employees** for 20 or more weeks in either the current or proceding calendar year.

☐ Yes ☐ No — At least one of the employers in our GHP employed 20 or more employees** for 20 or more weeks in either the current or preceding calendar year.

☐ Yes ☐ No — All employers in our GHP employed fewer than 20 employees** for 20 or more weeks in either the current or preceding calendar year.

**"Employees" includes all full and/or part time employees

Common Ownership/Controlled Group Compliance

☐ Yes ☑ No — Our Company is part of a common ownership or Controlled Group as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") states that all persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

General Information

Group Name	CITY OF POMPANO			**Tax ID #**	59-600041
Group Number	98854	**Group Sales Rep/Agent**	GEORGE EPPL	**Effective Date**	Oct 1, 2018
Employer Contribution Toward Employees Premium **a. Small Group (required) 100% 1-3 employees, 50% 4-50 employees** **b. Large Group (recommended) 50% 51+ employees**					100
What was the average total number of all employees (full-time, part-time, and seasonal) in the previous calendar year?					979

II. Recap of Employee Participation

Participation must be collected in certain scenarios. Please use the drop down and select the option that most fits your company.

Renewal w/76 or more Enrolled with Benefit Changes

1. How many TOTAL EMPLOYEES ON PAYROLL do you have?		979
2. How many TOTAL COBRA CONTINUANTS are currently enrolled in your Group Health Plan (GHP)?		1
3. The form will calculate the TOTAL INELIGIBLE EMPLOYEES according to answers in 3A through 3C below.		226
A. How many Total Part Time and Seasonal Employee(s) do you have currently have?	200	
B. How many Total New Employees (in Waiting Period) do you currently have?	26	
C. How many Total Other Employee(s) are not eligible or accounted for in 3A & 3B?		
4. The form will calculate the TOTAL ELIGIBLE EMPLOYEES according to above answers to determine Group size.		754
A. How many Total Employees with Other Coverage are not enrolling in this GHP?		
B. Indicate Other employee(s) totals not accounted for above that are eligible.		
C. How many employees are Not Covered by BCBSF/HOI? (Provide Total from Common Ownership Groups.)		
5. The form will calculate the TOTAL ELIGIBLE FOR PARTICIPATION according to the above answers.		754
A. Enter the number of Total Refusals. This represents employees refusing coverage without other coverage.		
6. The form will calculate the TOTAL ENROLLED according to the answers provided above.		754
7. The form will calculate the total EMPLOYEE PARTICIPATION using the answers provided. **a. Small Group (required) 100% 1-3 employees, 70% 4-50 employees** **b. Large Group (recommended) 65% 51+ employees**		100%
8. The form will calculate the ENROLLED PERCENT OF TOTAL (6/4) (50% RULE) using the answers provided.		100%

Florida Blue

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Blue Cross and Blue Shield Association

ENROLLMENT SUMMARY

For Groups with 51+ Eligible Employees

Please read the information below and provide electronic signatures when the document is completed.

I certify that the above information is correct to the best of my knowledge. I understand that this information will be used to determine my company's compliance with Blue Cross Blue Shield of Florida, INC. and/or Health Options, INC. eligibility and Underwriting Guidelines, as well as the applicability of State and Federal laws relating to my company and plan. Blue Cross Blue Shield of Florida INC. and/or Health Options, INC. reserves the right to request a UCT-6 or other documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and Underwriting Guidelines, as well as validate the applicability of State and Federal laws.

I certify that the applicant is a single employer under section 414 of Internal Revenue Code of 1986 (26 U.S.C. 414 (b), (c), (m), or (o)), and under any applicable state law.

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Health insurance is offered by Blue Cross and Blue Shield of Florida, Inc., D/B/A Florida Blue. HMO coverage is offered by Health Options, Inc., D/B/A Florida Blue HMO, an HMO subsidiary of Florida Blue. These companies are independent licensees of the Blue Cross and Blue Shield Association.

Officer of the Company's Signature

Date/Time Field

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.
HEALTH OPTIONS, INC.

ACCOUNTING AND RETENTION AGREEMENT
(Proshare)

This is an Agreement (hereinafter "Agreement") between Blue Cross Blue Shield of Florida, Inc. d/b/a Florida Blue and Health Options, Inc., (hereinafter jointly referred to as "Florida Blue"), located at 4800 Deerwood Campus Parkway, Jacksonville, Florida 32246 and City of Pompano Beach, (hereinafter "the Group") located at 100 W. Atlantic Blvd., Pompano Beach FL 33060.

WHEREAS, the Group requests Florida Blue to provide a health maintenance organization (hereinafter "HMO") and a Point-of-Service insurance program, (hereinafter jointly referred to as GHP "the Group Health Plan") to its employees and their covered dependents (hereinafter "Group Member(s)"); and

WHEREAS, Health Options, Inc., has agreed to provide the HMO part of the GHP, and Florida Blue has agreed to provide the insurance part of the GHP; and

WHEREAS, each of the parties to this Agreement seeks to set forth in writing the terms and conditions of their Agreement.

NOW THEREFORE, for good and valuable consideration, the parties agree to these terms and conditions:

I. TERM

The initial term of this Agreement shall begin on October 1, 2018, (the effective date) and shall end on September 30, 2019, (the termination date), unless otherwise terminated or renewed in accordance with the provisions of this Agreement.

During the term of this Agreement, the Group agrees to: a) maintain enrollment that does not decline to one hundred (100) or fewer contracts for two consecutive months or three nonconsecutive months during a single contract period, and b) meet or exceed the minimum participation guidelines set forth in the True Group Application. In the event the Group is unable to maintain adequate enrollment, this Agreement may be terminated and no settlement will be prepared and the Group will not be eligible for this funding arrangement in the future.

II. BENEFIT PLAN

Florida Blue will pay benefits to all eligible Group Members in accordance with the provisions of this Agreement and the GHP.

III. PREMIUM PAYMENTS

The Premium Rates, Prepayment Fees, and Supplemental Charges for the GHP are payable in advance to Florida Blue at the address set forth above. The premiums for the program are set forth in Exhibit A.

IV. SETTLEMENT ACCOUNTING

Within one hundred twenty (120) days after the end of the entire term of the Agreement, Florida Blue shall prepare and furnish to the Group a Settlement Accounting of their operations of the term. This Settlement Accounting shall include operations under all coverages of the Agreement and shall set forth the following:

(a) Earned Premium
(b) Incurred Claims less claims in excess of the pooling point
(c) Capitation Charges, if applicable
(d) Pooling Charges (not included in administrative charges)
(e) Administrative Charges as set forth on Exhibit A

If Earned Premium is greater than the sum of Incurred Claims less claims in excess of the pooling point, Capitation Charges, Pooling Charges and Administrative Charges, 50% of this excess will be returned to the Group.

The accounting is an aggregation of the contract periods encompassed in the term of the Agreement. If the Group cancels prior to January 31, 2020, any such excess will not be available for return to the Group.

If Earned Premium is less than the sum of Incurred Claims less claims in excess of the pooling point, Capitation Charges, Pooling Charges and Administrative Charges, the deficit will be retained by Florida Blue.

V. TERMINATION

This Agreement may be terminated at any anniversary of the effective date by either party by giving the other party at least 45 days prior written notice of such termination.

VI. MODIFICATION OF RATES

Rates for the first twelve (12) months of this Agreement will remain in effect, as set forth in Exhibit A, provided there is no material change to the Benefit Contracts, the enrollment, or any other risk factor, as determined by Florida Blue. Thereafter, all rates set forth in this Exhibit A of this Agreement or subsequent contract periods are subject to change by

Florida Blue at any time following at least forty-five (45) days prior written notice to the Group.

The administrative charge shall remain the same for the duration of the Agreement. The rates and pooling charge for subsequent contract periods after the initial contract period of the term of the Agreement will be set forth and presented to the Group on a revised Exhibit A. All other provisions of this Agreement shall remain in effect without modification.

VII. LATE PAYMENT/CHARGE

In the event the Group fails to make any payment due under this Agreement, in full, prior to the applicable due date, such payment may be made to Florida Blue up to ten (10) days after such due date without a late payment charge. Payments received by Florida Blue eleven (11) to thirty-one (31) days after such due date are subject to a late payment charge. The Group shall pay any late payment charge to Florida Blue immediately upon receipt of the notice of such charge.

In the event any charge under this Agreement is not paid, in full, by the Group to Florida Blue within thirty-one (31) days after the applicable due date, this Agreement will automatically terminate as of the applicable due date. In the event this Agreement terminates retrospectively for any reason, the Group shall be liable, in addition to all other liabilities set forth in this Agreement, for any claim(s) paid by Florida Blue which were incurred after the termination date.

All payments due for charges during the Agreement period must be received by Florida Blue in order for the Group to share in any excess.

VIII. RENEWAL

This Agreement does not automatically renew or extend upon completion of the term of the Agreement. A revised Exhibit A for subsequent periods after the initial period showing renewal rates, administrative charge and pooling charge for such subsequent period will be provided to the Group after renewal for each subsequent period within the term of the Agreement. Any revised Exhibit A does not represent a renewal or extension of the original term of the Agreement.

IX. INCONSISTENCIES

If the provisions of this Agreement are, in any way, inconsistent with the provisions of the Benefit Contract(s), then the provisions of this Agreement shall prevail, and the other provisions shall be deemed modified but only to the extent necessary to implement the intent of the parties expressed herein.

X. SURVIVAL

The rights and obligations of the parties, as set forth herein, shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

XI. WAIVER OF BREACH

The failure by either party, at any time, to enforce or to require the strict adherence to any provision of this Agreement shall not be deemed to be a waiver of such provision or any other provision of this Agreement.

XII. GOVERNING LAW

This Agreement, and the rights of the parties hereunder, shall be construed according to the laws of the State of Florida.

XIII. SEVERABILITY

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

XIV. AMENDMENT

This Agreement may be amended at any time upon mutual, written agreement of both parties, except that Florida Blue may make changes necessary to comply with State and Federal laws upon sixty (60) days' notice to the Group.

XV. ENTIRE AGREEMENT

This Agreement, including its Exhibits, the application(s) for coverage, and the Benefit Contract(s) constitute the entire Agreement between the Group and Florida Blue. Any prior agreements, promises, or representations, either oral or written, relating to the subject matter of this Agreement, and not expressly set forth in this Agreement, are of no force or effect.

XVI. NOTICES

Any notice, required or permitted under this Agreement, shall be deemed given if hand delivered or if mailed by United States mail, or an overnight mail service (e.g., Federal Express), postage prepaid, to the applicable address as set forth above or to such other address as a party may designate, in writing, to the other party. Such notice shall be deemed effective as of the date so deposited or delivered.

XVII. SEPARATE CORPORATIONS

Florida Blue and Health Options, Inc., are separate corporations. Nothing in this Agreement shall be construed, for any purpose whatsoever, to make either liable for the actions of the other.

XVIII. PROVIDER NETWORKS

Florida Blue's Health Care Provider Networks are subject to change and may be modified at any time during the term of this Agreement without notice to or consent of the Group or any Group Member.

BLUE CROSS & BLUE SHIELD OF FLORIDA, INC.
d/b/a FLORIDA BLUE & HEALTH OPTIONS, INC.

By: _____

Name: Joseph C. Gregor, Esq.

Title: Vice President, Commercial Segments

Date: _____

CITY OF POMPANO BEACH

By: _____

Name: _____
Printed

Title: _____

Date: _____

EXHIBIT A
TO THE
ANNUAL ACCOUNTING AND RETENTION AGREEMENT
WITH
CITY OF POMPANO BEACH
GROUP NO. 98854

A. Premium rates effective: October 1, 2018, through September 30, 2019

Blue Care Plan 55:	Single:	$ 614.80
	Family:	$ 1,647.73
Blue Choice Plan 0702:	Single:	$ 911.82
	Family:	$ 2,093.70
Blue Choice Plan 0727:	Single:	$ 905.07
Divisions RM3 and RM4	E + 1:	$ 1,357.60
	Family:	$ 2,078.20

B. Administrative charges effective: October 1, 2018, through September 30, 2019
13.90% of earned premium

C. Pooling effective: October 1, 2018, through September 30, 2019
Pooling Level: $220,000 Per Individual
Pooling Charges: 6.28% of earned premium