July 2012

SOLICITATION OF INTEREST

From

HEALTH CHOICES:
Florida's Insurance Marketplace

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PART I: GENERAL INTRODUCTION TO FLORIDA HEALTH CHOICES

A. Established by the State of Florida

The Florida Legislature created Florida Health Choices, Inc. in 2008 by enacting Section 408.910, Florida Statutes. Recent changes adopted by the 2011 Florida Legislature can be found at the following link:

- http://www.leg.state.fl.us/statutes/index.cfm?mode=View%20Statutes&SubMenu=1&App_mode=Display_Statute&Search_String=408.910&URL=0400-0499/0408/Sections/0408.910.html

In establishing the Corporation and the Florida Health Choices Program, the Florida Legislature found that a significant number of the residents of this state did not have adequate access to affordable, quality health care. Specifically, the Florida Health Choices Program was established to:

- Expand opportunities for Floridians to purchase affordable health insurance and health services
- Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits
- Enable individual choice in both the manner and amount of health care purchased
- Provide for the purchase of health care coverage
- Disseminate information to consumers on the price and quality of health services
- Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services

B. Eligibility of Employers and Individuals

Participation is voluntary and, while not specifically limited to the following list of employers and individuals, the Corporation intends to target the organizations named in Section 408.910, Florida Statutes:

- Small employers meeting criteria established by the program
- Employees of enrolled counties designated as fiscally constrained
- Employees of enrolled school districts in fiscally constrained counties
- Employees of enrolled municipalities having fewer than 50,000 residents
- Employees of enrolled statutory rural hospitals

Other individuals that may enroll include:

- Employees of the State of Florida not eligible for state health benefits
- Retirees of the State of Florida

- Medicaid reform participants who select the opt-out provision of Medicaid Reform

C. Eligible Agents

Health Insurance Agents licensed by the State of Florida are eligible to register and participate in the marketplace.

D. Eligible Vendors

The Corporation has established three classifications of vendors eligible for certification in the Marketplace. The Vendor Certification Criteria is provided in Exhibit E. Following are the vendor classifications:

1. Vendors Licensed by the Office of Insurance Regulation

Vendors meeting all requirements of the Florida Insurance Code may offer policies, products or contracts approved by the Office of Insurance Regulation. These vendors include the following:

- Insurers
- Health Maintenance Organizations
- Pre-paid Limited Health Service Organizations
- Discount Medical Plan Organizations
- Prepaid Health Clinics

2. Health Service Vendors

Other health vendors may offer service contracts and arrangements for a specified amount and type of health service or treatment in compliance with applicable state laws and as approved by the Corporation. Health service vendors may include but are not limited to the following:

- Hospitals
- Licensed health facilities
- Health care clinics
- Licensed health professionals
- Pharmacies
- Licensed health care providers
- Provider organizations

- Service networks
- Group practices
- Professional associations
- Other incorporated organizations of providers
- Corporate entities

3. Other Vendors

As increasing Marketplace functionality is developed, other vendors may be invited to offer services in support of participating employers. Examples of other vendors may include but are not limited to the following:

- Payroll service providers
- Human resource compliance providers
- Individual benefit account managers
- Other insurers may offer business insurance products

E. Implementation Is Phased

The Corporation proposes to launch the program in three phases as described below:

The Soft Start/Small Group Pilot Program will support limited offerings. The Corporation proposes to support 3 to 9 vendors during this phase without imposing a specific limit on the number of vendors. Vendors may offer small group policies or contracts that are regulated and approved by the Florida Office of Insurance Regulation. The Marketplace will support medical and dental vendors during this phase.

The Mid-Term Phase will expand the type and number of products offered through the program. The offerings during this phase will include other entities that are regulated by the Florida Office of Insurance Regulation such as discount medical plan organizations.

The Long-Range Phase provides an opportunity for health service vendors to enter the marketplace. Examples of allowable vendors and their offerings may include but are not limited to:

- Hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed care providers.
- Provider organizations including service networks, group practices, professional associations, and other incorporated organizations of providers.
- Corporate entities providing specific health services in accordance with applicable state law.

The following table provides a brief overview of the launch phases, proposed expansions of eligibility, and vendors, products and services for each phase:

HEALTH CHOICES: FLORIDA'S INSURANCE MARKETPLACE				
Period	Phase	Target Population	Vendor Offerings	Products/Services
2012/13	Soft Start/Small Group Pilot	• Small Employers	• Major Medical and Standalone Dental Benefits	Small Group
2013/14	Mid-Term	• Small Employers • Other Eligible Employers	• Major Medical and Standalone Dental Benefits • Vision, and other Risk-Bearing Coverage and other products regulated by the Florida Office of Insurance Regulation	Small Group
2014/15	Long-Term	• Small Employers • Other Eligible Employers • Eligible individuals	• Major Medical Offerings • Employer Offerings • Health Service Offerings	Individual Small Group Service Contracts

F. Potential Impact of Health Care Reform

Vendors are advised that Florida Health Choices, Inc. is not a State-designated American Health Benefit Exchange (AHBE Exchange) for individuals or a Small Business Health Options Programs (SHOP Exchange) as defined by the Patient Protection and Affordable Care Act. Likewise, the program the Corporation will implement is not subject to federal approval.

G. Purpose of this Solicitation of Interest: Small Group Pilot

The goal of this Solicitation of Interest is to assist the Corporation in identifying potential vendors and the products or services they may choose to offer during the Soft Start/Small Group Pilot.

Vendors that are not interested in offering products or services during the Soft Start/Small Group Pilot are encouraged to express interest in later phases. Vendors doing so will be notified when additional Solicitations of Interest are issued.

In developing the Small Group Pilot, the Corporation's board of directors convened several meetings and sought the input of potential vendors, agents, and health care professionals and advocates. Membership of the Vendor Steering Committee is listed in Exhibit A.

PART II: SOFT START/SMALL GROUP PILOT

I. CALENDAR OF EVENTS

Soft Start Phase

Risk Bearing Medical and Dental Plans

Vendor Mini-Conference		June 28, 2012
Vendor Office Hours (Reservation required)		June 28-29, 2012
Conference 1:	June 28, 2012 4:10-5:00 p.m.	
Conference 2:	June 28, 2012 5:10-6:00 p.m.	
Conference 3:	June 28, 2012 6:10-7:00 p.m.	
Conference 4:	June 28, 2012 8:00-9:00 a.m.	
Conference 5:	June 29, 2012 9:00-10:00 a.m.	
Conference 6:	June 29, 2012 10:00-11:00 a.m.	
Conference 7:	June 29, 2012 11:00-12:00 a.m.	
Execute Non-disclosure Agreement		July 2012
Vendor On-Boarding		July 2012
Submission of Vendor and Plan Detail		July 2012
Implementation Meeting		July 2012
Plan Data Import, Standardization, Quality Assurance		July 2012
Vendor Review		August 2012
Execute Vendor Contract		August 2012
Portal Go Live - Shop and Compare		August 31, 2012
Agent/Pathfinder Registration		September 1, 2012
Employer Registration		October 1, 2012
Medical Underwriting Commences		October 1, 2012
Employee Enrollment		Employer Option
First Coverage Effective Date		January 1, 2013

II. DESIGNATED CONTACT

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III. INTENT OF THE SMALL GROUP PILOT PROJECT

The Corporation elects to phase in a program to gradually establish the marketplace. Marketplace operation is proposed to begin with a Small Group Pilot Project which would permit the Corporation to:

- Test the strength of the value proposition with small employers
- Test a web-based, uniform application for health coverage
- Test the web-based quoting hub
- Test the web-based portal and its usability
- Test the scalability of the administrative platform
- Test the agent interfaces and electronic verification of agent eligibility
- Test the vendor certification and on-boarding process
- Test the marketing plan and approach
- Test reporting interfaces with the evaluator

The Small Group Pilot Project will encompass the entire State of Florida without geographic limitations where plans are available. There will not be a limit placed on the number of employers, employees or dependents enrolled during the pilot. The Corporation plans to support 3 to 9 vendors; however, there will be no specific limitation on the number of vendors.

The duration of the pilot will be a minimum six-month period and may be extended. Regardless of the pilot duration, coverage issued during the pilot must continue for a full plan year.

IV. VALUE PROPOSITION

For employers:

- Informing qualified small employers about the potential financial benefit of small business tax credits for health insurance may reduce the cost impact on their business even further
- We cut the paperwork when we provide a one-stop shop where employers can find an agent and get quotes from several vendors using one on-line questionnaire
- As is more common with large employers, small employers can offer a wider range of choices to eligible employees

For employees:

- They can shop from among an expanded list of health plans when the employer recommends four
- The employee share of the monthly premium can be treated on a pre-tax basis

For agents:

- We introduce agents to new client groups who are seeking assistance with coverage and services
- We streamline the process and save agents time spent seeking multiple quotes

For vendors:

- The marketplace will provide access to a distribution channel focused on the promotion of a competitive marketplace
- Provides convenient access to their products

V. ELIGIBLE VENDORS

During the Soft Start/Small Group Pilot, vendors meeting all requirements of the Florida Insurance Code may offer policies, products or contracts approved by the Office of Insurance Regulation. Vendor certification criteria can be found in Exhibit E. Vendors include the following:

- Insurers
- Health Maintenance Organizations
- Pre-paid Limited Health Service Organizations
- Prepaid Health Clinics
- Standalone Dental Plans

VI. SMALL GROUP OFFERINGS

The Corporation, through the centralized marketplace, will offer various products that enable employers and employees to pay for health care.

Initially during the Small Group Pilot, the Marketplace will accept major medical small group plans and standalone dental plans.

As functionality of the web-based portal increases, the Marketplace will support ancillary and Section 125 products.

VII. PROGRAM OPTIONS

The Corporation proposes establishing options for employers and their eligible employees.

During the Small Group Pilot Project the eligible employer may shop and compare all vendors available in the Marketplace and may recommend up to four plan options offered by a single vendor by line of business.

Eligible employees of a participating employer will shop and compare from among as many as four plan options as recommended by the employer.

Additional options may be developed in subsequent phases of the program.

VIII. ELIGIBLE AGENTS AND BROKERS

Health Insurance Agents licensed by the State of Florida are eligible to register and participate in the marketplace.

- The system will compare an agent's last name and Florida license number against data provided by the Florida Department of Financial Services. Confirmation of an agent's active license status will determine the agent's eligibility.

- Continuing agent eligibility will be re-determined monthly.

- When they enroll, agents pay a one-time registration fee and a monthly fee thereafter. Initially, the agent registration fee is $150.00. Monthly participation fees are $25.00. A recommendation to waive all agent fees will be considered at the July 18, 2012 meeting of the Florida Health Choices board of directors meeting.

- The agent can assist a small employer with the shopping experience and vendor selection. The Corporation will provide the group's agent identifying information on each enrollment transmission. The Corporation will not pay agent commissions on behalf of vendors and does not set the commission structure. Vendors will direct compensation to agents as is their customary practice. Vendors will compensate agents at the same rate of commission both inside and outside the marketplace.

IX. ELIGIBLE EMPLOYERS

Florida law outlines the target population for enrollment in the Florida Health Choices Program and the Corporation elects to phase in the program gradually. Small employers that meet the following eligibility requirements may participate in the initial phase of the marketplace:

Employer Group Size

- Group size will be 4-50 participating employees, when the group also meets all other eligibility requirements.

Employer Does Business in Florida

- A company authorized to conduct business in the State of Florida and which shows evidence of business activity in the previous 24 months
- Eighty-five percent of employees must live in the State of Florida

Employer Establishes Waiting Period

- The waiting period established by the employer is 0-3 months. Coverage must be offered to all eligible employees who have satisfied the employer's waiting period.
- The waiting period applies for any new hires made after initial enrollment of group.

Employer Contribution Requirements

- The employer's contribution toward employee premiums must be at least 50 percent of the lowest price plan offered by the selected vendor.

Group Participation Requirements

- At least 70 percent of eligible employees must participate in the health plans offered by their employer.
  - All active employees working 25 hours or more per week, who have also satisfied the waiting period, are considered when determining group size.
  - Employees excluded when calculating the participation requirement:
    - Employees with other group coverage
    - Employees with Medicaid, SCHIP or Medicare coverage

Other Group Requirements

- Groups with Common Ownership/Controlled Groups where the total eligible employees for all groups commonly owned are 50 or less will still be rated as a small group. One or all of the groups may be enrolled with common ownership. A subset of the groups, i.e. 2 out of 3, may not be covered.
- If a participating employer exceeds 50 employees after initial enrollment, it may continue to be treated as a small employer for the remainder of the plan year. Upon renewal, the group's status will be reassessed and subsequently redefined, if necessary, in accordance with Florida's Small Group law, 627.669, F.S.

X. ELIGIBLE EMPLOYEES

Eligible Employees
Eligible employees are identified as employees actively engaged in the conduct of the business of an enrolled employer who works at least 25 hours per week. This includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor if included as an employee under a health benefit plan of a small employer. For example, an individual whose income is reported by a 1099 and who works at least 25 hours each week should be included as an eligible employee.

Employer Eligibility Waiting Period
Eligible employees include those that have satisfied the eligibility waiting period established by the employer.

XI. INELIGIBLE EMPLOYERS AND EMPLOYEES

Employees who have not satisfied the employer's chosen eligibility waiting period and those working less than 25 hours per week, temporary, or substitute employees are not considered eligible employees.

Groups formed strictly for purposes of insurance are not eligible (clubs, fraternal organizations, and consortia). Groups offering employee benefits through other mechanisms such as a professional employer organization are also excluded.

XII. ENROLLMENT AND ELIGIBILITY PERIODS

Enrollment periods are summarized in Exhibit B and include the following:

Initial Open Enrollment Period

- A maximum 60-day period established by the eligible employer
- For new groups purchasing through the marketplace, coverage is effective on the group's original enrollment date, provided the eligibility waiting period has been satisfied and application is made during the initial enrollment period
- Employees that do not submit an application within the open enrollment period are not eligible to enroll until the next annual open enrollment.

Annual Open Enrollment Period

- A maximum 60-day period, occurring no less than 60 days prior to the group anniversary date

Waiting Periods

- The eligibility waiting period is 3 months unless the employer elects a waiting period that is 0, 1 or 2 months at the time of initial set-up

- A group may not waive the waiting period for key employees, unless the waiting period is waived for all employees of the group
- Small groups can only have one eligibility waiting period

Special Enrollment Periods

- A qualifying life event will establish a special enrollment period.
- During special enrollment periods participants are permitted to add or delete coverage for eligible family members during the plan year (Qualifying life events are listed in Exhibit C).
- The duration of the special enrollment period is a maximum 60-day period for adding a new child as a dependent and 30 days for all other qualifying life events. The special enrollment period begins immediately following a special event.
- If the reported change causes a change in the monthly premium, the system will calculate the revised premium based on the rating methodology utilized during the current benefit year's calculation.
- After the initial enrollment of a new group, employees must apply for coverage within 60 days of satisfying their eligibility period.

Effective Dates

- A new employee becomes eligible for enrollment on the 1st of the month following the date of eligibility.
- No retro-active coverage will occur.

XIII. Medical Underwriting

The Corporation, in consultation with the Vendor Steering Committee, has established a single, standardized set of questionnaires for underwriting purposes.

Uniform Questionnaires for Small Groups

A uniform employer group questionnaire will screen an employer's eligibility for the small group pilot. Information requested on the employer group questionnaire will include the following:

- Employer legal name and contact information
- Type of organization
- Employer contribution to health care coverage
- Length of employer's waiting period for new hires
- Worker's compensation coverage
- Number of eligible employees
- Number of employees working outside of Florida
- Number of ineligible employees
- Number of excluded employees
- Number and names of formers employees on COBRA
- Current or previous health insurance coverage of the group

Employers reporting a group size of 10 to 50 will also complete an employer medical questionnaire. This on-line questionnaire seeks an employer's response to medical questions about the overall group. The information sought may include, but is not limited to, the following:

- Number of employees currently pregnant and their dues dates
- Previous employee hospitalizations
- Diagnosis or treatment of a variety of diagnoses within the previous five-year period

Employers reporting a group size of 4 to 9 will be asked to have employees complete the employee and family medical questionnaire. This on-line form seeks detailed medical information about each employee and eligible family members related to the following categories:

- Heart/Circulatory
- Eyes/Ears/Nose/Throat
- Immune
- Cancer/Tumors
- Neurological
- Arthritis
- Bones/Muscles/Joints

- Transplants
- Psychological
- Diabetes/Endocrine
- Reproductive
- Lung/Respiratory
- Intestinal
- Live/Kidney/Urinary

For all "yes" answers to a condition found under the above categories, employees are asked to provide detail information by identifying the family member, their diagnosis and treatment, date of onset, medication prescribed, etc. Additional questions about tobacco use, pregnancies, pending test results and other prescription medications are also posed.

The proposed questionnaires are found in Exhibit D in draft form. When finalized, the forms will be assigned a form number and will contain the appropriate fraud statement required for use in the State of Florida.

Small Group Underwriting

When submitting their completed questionnaires, small employers will indicate the vendors from which small group health insurance quotes are desired. Vendors selected by the employer will be notified that a group is requesting a quote and the group will be subject to the vendor's internal underwriting guidelines.

Quote Generation and Presentation

Vendors will respond with a small group quote within two weeks or less on average. The quote, when returned, may deviate from the vendor's base rate (1.0) by offering a rate deviation in compliance with the Florida Insurance Code (.90-1.15). Vendor quotes will be presented to the employer for consideration. The Corporation anticipates that eligible groups with nine or fewer participating employees will be table rates and groups with ten or more participating employees will be composite rated.

Vendors will honor the group rates quoted for a minimum of 90 days.

Questionnaire Filing

The Corporation will file the employer group questionnaire, the employer medical questionnaire, and the employee and family medical questionnaire, with the appropriate regulatory body. The Corporation proposes that, when filed, the form will be utilized by all vendors participating in the small group pilot.

XIV. THIRD PARTY ADMINISTRATION

The Corporation contracts with Xerox State Healthcare, LLC (Xerox), to provide third party administration services. The range of services provided by Xerox includes:

A. Web-Based Portal

In partnership with CHOICE Administrators (CHOICE), Xerox is establishing and will maintain a web-based choice portal. Xerox and CHOICE will design and deploy the web-based choice portal with a wide range of functions. The functions will include:

- Provide information to interested persons about available offerings and vendors
- Facilitate eligibility and enrollment of:
  - Employers
  - Employees of enrolled employers
  - Health insurance agents
- Allow comparison of benefit, plan and service options utilizing a standardized presentation of information

Information about each product and service available through the program will be made available through this interactive website. The presentation of plan and service options will allow comparison when reasonable comparisons exist. The purpose is to allow the interested groups, agents and individuals to search through plan and service offerings based on a variety of search criteria. The search criteria will permit the user to identify options available in their geographic area and may also organize the options using other criteria selected by the user.

B. Eligibility Determination

Xerox and CHOICE will accept registrations and validate eligibility of employers and health insurance agents. Forms for enrollment will be accepted through electronic means initially. Upon validation of eligibility, the information collected during the enrollment process will generate an account for the applicant employer or health insurance agent.

C. Employee Enrollment

Eligible employees of enrolled employers will complete the enrollment process when notified by their employer of commencement of the open enrollment period. Employees can complete the enrollment form

on-line, choose the plan option that best suits that employee's individual or family needs, and submit the enrollment form for approval by the employer.

D. Enrollment Management

Xerox and CHOICE will maintain a comprehensive, automated, enrollment management system and the capabilities described below:

- Correspondence generation
- Account history maintenance
- Late/delinquent payment notification
- Outgoing correspondence
- Transmittal of participant data to participating plans and service providers
- Provide verifications to vendors
- Transfer enrollment to another insurer or service provider when a vendor withdraws from the program or when the participant elects a new choice
- Changes in contact information
- Account update due to change in family composition
- Process returned mail and update address changes received from the U.S. Postal Service
- Continuing eligibility verification
- Renewal processing

E. Financial Services

The Administrator will calculate and facilitate the collection of participant and third party contributions toward the cost of multiple program offerings.

Xerox and CHOICE are responsible for maintaining all financial activity on employer and agent accounts and provide the following financial services:

- **Premium Calculation –** Based upon information collected as to participant choice and contribution amounts designated by the employer, CHOICE will calculate the amount of funds due from each source for each participant. The Administrator will make the details available to enrolled employers and aggregate the total amount due from the employer for the payroll frequency established by the employer.

- **Premium Collection -** Options for premium collection will include check and payment by credit card. Vendors are not responsible for credit card fees when credit card payments are made to the marketplace.

- **Remittance Processing -** Each week, CHOICE will generate detailed reports for remittance of premiums to participating vendors. Vendors will receive EDI 820 detailed premium distribution reports that will reflect premiums remitted by enrollee. Premiums will be remitted each Friday.

F. Customer Contact Center

Xerox provides customer service via a toll-free hotline, email, chat and regular U.S. mail service. The Statewide Customer Contact Center (Center) is located in Tallahassee, Florida and will:

- Provide access to account information
- Assist individual participants with managing available resources
- Respond to inquiries from employers, employees and agents
- Distribute materials that are unique to the program
- Provide general program information and answer inquiries about eligibility and enrollment
- Provide account payment and coverage verification
- Return calls left on voice mail
- Refer calls to participating agents as appropriate
- Return calls requiring additional research

Professional, accurate, courteous customer service is a high priority for the Corporation. Xerox is prepared to accurately and timely process all incoming correspondence, all outgoing correspondence, and all telephone or email inquiries related to application and enrollment in the marketplace.

The Center provides customer service days and hours of operation which are conducive to participant needs and include regular business hours on Monday through Friday, from 8:00 a.m. until 7:00 p.m. Eastern Standard Time, excluding approved holidays. The Center provides the option of a live call agent for all callers during these hours of operation.

The Center will manage customer communications in a professional, culture and language sensitive manner. At a minimum, the Center will make sufficient numbers of English and Spanish speaking staff during all hours of Center operations. The Administrator has the ability to communicate timely, accurately and efficiently with non-English speaking callers, and callers that are hearing impaired.

XV. MARKETING

Several sources of data have been identified that will be useful in designing and implementing marketing and outreach efforts to employers and potential participants. The Corporation proposes to establish partnerships with public and private agencies that may share information on businesses, professionals, Corporations, and contractors licensed by, doing business with, or associated with the partner agency.

The Corporation intends to develop targeted marketing and outreach efforts for the purpose of educating potential participant employers and their employees about the Florida Health Choices Program. Marketing materials may be designed and distributed based on a variety of elements including county of residence, zip code, type or status of professional license, business type, association membership, etc.

A comprehensive approach to establish awareness of the program will be developed. A Marketing and Outreach Committee of the FHC has been established and will begin meeting in the coming weeks. Vendor input and suggestions on developing the marketing approach are solicited.

Vendors offering products in the Marketplace will have the ability to co-market and promote the Marketplace subject to the approval of the Corporation.

XVI. VENDOR RESPONSIBILITIES

Participating vendors have the following responsibilities:

- Timely response to any request for small group quotes.
- Distribution of group contracts, certificates of coverage, identification cards and other enrollment materials unique to the participating vendor.
- Compliance with timely claims and complaint handling requirements established by the State of Florida.
- Adherence to the terms of the participation agreement.
- Payment of the vendor's commission schedule at the same rate inside and outside the Marketplace.
- Distribution of any notices required by the insurance code including termination notice and COBRA options when applicable. Florida's Insurance Marketplace does not administer COBRA.
- Compliance with bankruptcy requirements when an enrolled employer group files for bankruptcy.
- Participation in evaluation efforts that initially include the activities proposed in Exhibit I. Vendors may choose to voluntarily participate in evaluation deliverable 5 by providing vendor claim detail.

XVII. ENROLLMENT PROCESS OUTLINE

In this section, the Corporation outlines the steps employers, their agents and eligible employees will take to achieve enrollment in the marketplace and obtain small group coverage with a participating vendor.

The steps in the process include the following:

- Browse Plans
- Agent Enrollment
- Shop and Compare
- Get a Quote
- Registration and Set Up, Choose a Vendor
- Employee Shop, Compare, Enroll
- Group Eligibility Validated
- Coverage Begins

Browse Plans

- Anyone will be able to enter the marketplace by accessing a link provided at www.myfloridachoices.org or by visiting www.floridahealthchoices.com
- To browse, the agent, employer or individual selects the "Agent/Pathfinder" entryway and types in basic demographic information for an employer
- Vendors and plans available in the county will be displayed along with the basic rates. (1.0)
- Users can browse through informational links for tips on navigating the site, view frequently asked questions, watch a tutorial, and learn more

Agent Enrollment

To register and participate with the marketplace, agents complete a four-step process:

- At initial registration, the agent enters the Florida License Number issued by the Florida Department of Financial Services and the agent's last name
- At validation, the system compares the information entered to data on file with the Florida Department of Financial Services to confirm the license is in an active status with the State of Florida
- At verification, the agent data on file with the state is auto-populated into the registration record
- An email notification confirms the agent's active status in the marketplace
- After registration is complete, an agent may choose to explore an employer's options in the marketplace. The agent can use the window shopping option to determine vendors, plans and the basic rates available to the client employer. An interested shopper without an agent can also pick one by searching the agent listings.

Shop and Compare

Visitors to the web-based portal can shop and compare between vendors and their plan offerings. The web-based portal, based on criteria entered by the shopper, will present the options available in the shopper's geographic area and provides several options to search by.

During the soft start/small group pilot, the rates presented during the shop and compare activity are the base rates for each plan. In order to receive the actual rates for a given employer group, the agent or employer will be directed to the next step in the process which is obtaining a group quote.

Get a Group Quote

After browsing or upon completion of the shop and compare opportunity, the employer group questionnaire is completed by all employers and includes questions about employer eligibility. All employers complete this questionnaire and, depending on the size of the group, they will also complete either the employer medical questionnaire or ask employees to fill out the employee and family medical questionnaire on-line.

The group may request initial quotes from one, some or all vendors available in their area and initial quoting responses will typically be returned in two weeks or less for the employer's consideration.

Vendors will honor the initial quote provided for at least 90 days.

Registration and Set Up

After deciding to purchase through the Marketplace, the agent or employer can register as an applicant group at www.floridahealthchoices.com. During the registration process, employers will be asked to confirm plan year, enrollment dates, select an employer contribution, etc. When selecting the preferred vendor, the employer may also pick up to four plans offered by the chosen vendor that the employer will recommend to eligible employers.

When employer set up is complete a customized URL is enabled. Employers or their agent will provide the secure access to eligible employees and invite them to complete the enrollment process.

Employee Shop, Compare, Enroll

Once received, the employee uses the employer URL, and is prompted to enter basic demographic information. Upon doing so, up to four plans recommended by the employer and provided by the chosen vendor are displayed for consideration. The on-line calculator shows the total monthly premium, employer contribution, and the employee share of premium. Out of pocket costs are also estimated based upon information provided by the employee for each member of the family.

After choosing a plan, the employee completes the on-line enrollment form. The employer is then notified electronically that an employee application is pending and awaiting verification by the employer.

Group Eligibility Validated

The last step in the enrollment process is to validate that the employer group met all of the employer eligibility criteria. During group validation, the Third Party Administrator verifies the minimum 50% employer contribution requirement was met, reviews employee participation to ensure at least 70% of eligible employees completed enrollment and, after all of the above, verifies that the final group enrollment count is at least 4 but no more than 50.

Enrollment Transmission

Upon confirmation that the new group has passed the validation test, and after receipt of the applicable premium amount, enrollment detail for the new group will be transmitted to the vendor. Upon receipt of the new group detail, if the Vendor finds that the final group composition supports a revision to the initial rate quoted, a final quote may be submitted to the Marketplace provided such final rate is submitted to the Marketplace within five business days of the new group transmission to the Vendor.

Group and Member Number Assignments

The Corporation proposes to assign the group number and member number for each enrolled member prior to enrollment transmission. The vendor is asked to provide a range of member and group numbers to be used by the Corporation's third party administrator in making these assignments. This method of assignment will ensure that all systems reconcile enrollment efficiently and will allow for an improved customer service experience when the customer contact center works with an enrolled member.

Final Quotes

As is common practice today in Florida, group enrollment, when actual enrollment is finalized, may result in revision of the initial quote and submission of a final quote for a group. This may occur when the makeup of the group is different than originally proposed by the employer or agent. In the Marketplace, vendors are permitted to submit final quotes post new group enrollment when the change in the group composition would have resulted in a rate difference of five percent or more.

The Marketplace will notify the employer of the change in group quote and adjust employer invoices to reflect the final quote.

Once enrolled, the group's premium rate is good for a twelve month period regardless of any changes to the group composition or number of participating employees.

Coverage Begins

Upon confirmation that all eligibility requirements continue to be met after the group has completed the enrollment process, employers are invoiced for the first monthly premium and their payment is processed. The chosen vendor is notified of group enrollment and the plans chosen by eligible employees. Upon receipt of the new enrollment notice, the vendor issues the group contract, enrollment materials and identification cards. Coverage is effective on the first of a month.

XVIII. OTHER PROGRAM RULES

A. Open Enrollment Periods

- An eligible employee may enroll in health coverage during the employer's established 60-day open enrollment period.

- Participants are locked into their plan selection for one year unless a life event qualifies them to make a change in plan selection.

B. Special Enrollment Periods

- A qualifying life event will permit participants to change coverage during the plan year and will establish a special enrollment period for the qualified family or individual. (Proposed qualifying life events are listed in Exhibit C.)

- If the reported change causes a change in the monthly premium, the system will calculate the new rate based on the rate that was in effect for the group at the time the participant enrolled in the plan.

C. Timely Premium Payment

- Participating employers must agree to payroll deduction of employee contributions.

- Employers are required to make full payment of their invoice by the due date. Employees will not be billed directly.

- Employers that do not make timely payment are permitted a 30-day grace period without cancellation of the group. If the premiums remain unpaid, upon completion of the 30-day grace period, the group will be cancelled.

- If the employer makes the delinquent payment within 14 days of the cancellation effective date, the group will be reinstated at the prior group rate.

- If the employer seeks reinstatement more than 14 days after the cancellation effective date, the group can reapply, however, new plans and rates will apply.

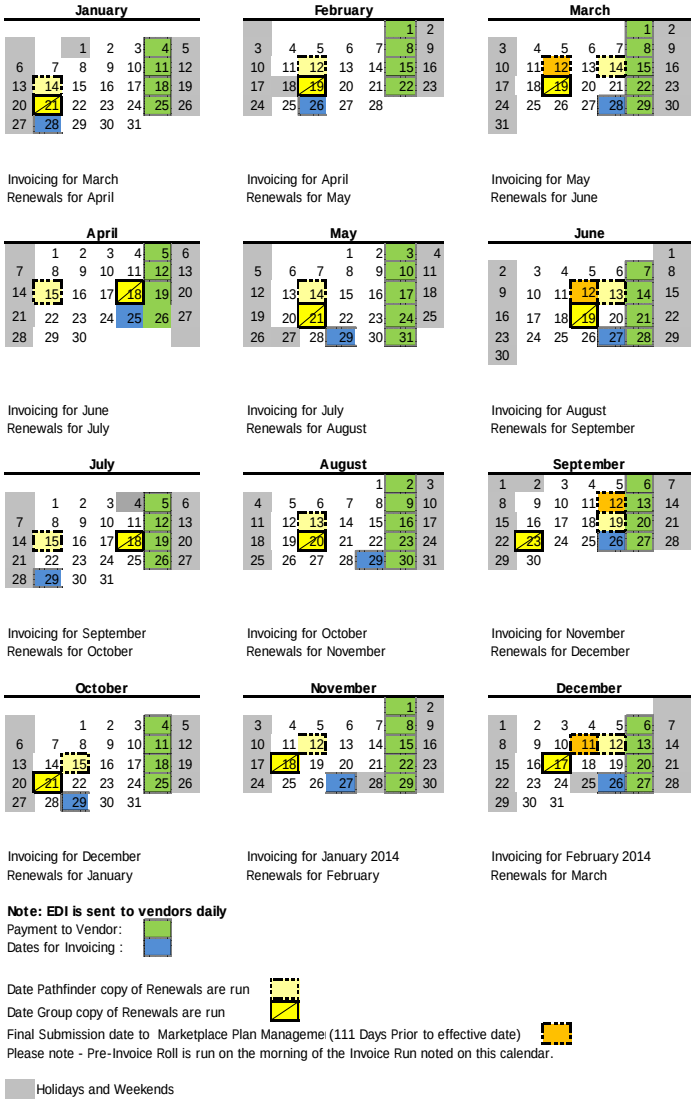
- Employees associated with an employer whose group coverage is cancelled will also be cancelled.

- Employer accounts that are paid after the due date for which a notice of insufficient funds is received will be assessed a $25.00 fee.

D. Premium Management

- When enrollment is complete, the employer will be advised how much of the full premium is their responsibility and how much is their employee's.
- Billing to employers for their enrolled employees will be run monthly.
- Participating vendors will receive an EDI 820 and transmission of premium payments each Friday. See the calendar below:

SAMPLE- 2013 - Invoicing & Renewal Calendar



- Employers will be invoiced for the full premium for each of their active employees, aggregated into a single monthly invoice.

- The invoice detail will display the amount owed by the employee and the amount owed by the employer which, added together, will equal the total premium.

Employer groups may experience coverage changes during a month that affects the amount of premium that is owed. Employers may call the contact center to make any corrections and an adjustment will be reflected on the next invoice.

E. Methods of Payment

- Employers will have the option to pay by check, e-check, Automatic Clearing House (ACH) or credit card.

F. Premium Disbursement to Vendors

- The vendor disbursement process will be run every Thursday and premiums for groups that have paid 100% of the amount due will be transmitted to the vendor. An EDI 820 will provide detail to support the amount of premium paid by that group.

- The disbursement process will generate a Premium Distribution Report indicating what funds should be disbursed to each vendor. The Corporation or its Third Party Administrator will transmit funds to the vendor.

- Each month a reconciliation process will be performed to ensure enrollment records and financial transactions with vendors are accurate.

G. Premium Adjustments and Special Enrollment Periods

- Special enrollment periods for qualifying life events may result in changes in coverage during an enrollment month. With the exception of adding a dependent child due to birth, adoption or fostering, changes effective prior to the 15th of the month will result in premium adjustment for that month. Changes effective after the 15th of the month will result in premium adjustment effective the following month.

- Each month a reconciliation process will be performed to ensure enrollment records and financial transaction with vendors are accurate.

XIX. PROPOSED VENDOR PROCESSES

Florida Health Choices is committed to a successful partnership with interested vendors throughout implementation and during ongoing program administration. The vendor implementation delivery model is structured using best practices and industry standards for excellence within Florida's insurance marketplace.

The Corporation, working with Xerox and CHOICE, offer the following processes for consideration by interested vendors. Vendor comments and suggestions for improving upon the initial recommendations are desired.

A. Vendor Questionnaire

Completion of the vendor questionnaire by interested vendors will provide Xerox and its subcontractor, CHOICE Administrators, with some basic information about the vendor and will contribute to a smooth on-boarding process. The questionnaire is imbedded here for your review:

FHC Vendor Conference Questionn

B. Letter of Interest and Vendor Certification

Interested vendors are invited to submit a non-binding Letter of Interest. If choosing to submit a letter of interest for the soft start phase, please submit it no later than July 16, 2012 and direct it to the address info@myfloridachoices.org as noted in Designated Contacts. Letters of Interest received by the time and date indicated above will receive first consideration when the on-boarding process commences July 1. Letters of Interest submitted after this date may also be accepted. However, the on-boarding of plan detail may not commence on the schedule provided in this SOI.

With the Letter of Interest, please provide the formal name of the business, title, type of insurer, and business address. Include evidence of appropriate licensure and indicate the Florida file numbers issued by the Office of Insurance Regulation, Life and Health Product Review unit, for each of the small group plans the vendor proposes to offer during the Soft Start phase. (Dental plans are asked to submit equivalent information.) If the vendor proposes to offer a new plan, and an approved Florida file number has not yet been issued, please indicate the date on which the new plan was submitted for review to the Office of Insurance Regulation.

The Corporation will compare the vendor certification requirements and the information provided with the letter of interest. A determination that the vendor meets or does not meet the certification requirements will be made by the Corporation.

C. Non-Disclosure Agreement

Upon certification, the vendor will be provided with a Non-Disclosure Agreement (NDA). The agreement is intended to facilitate the on-boarding process and provide assurance to the vendor that no vendor plan detail or any other proprietary information of the vendor's will be shared or loaded to the live shop and compare web-based platform without specific approval by the parties. A draft NDA is found in Exhibit H.

D. Implementation Meetings

Upon notification by the Corporation that a vendor has been certified and has executed the Non-Disclosure Agreement, CHOICE will schedule and conduct an implementation meeting with the vendor. During the meeting, CHOICE will distribute instruction documentation and gather eligibility file requirements. CHOICE will also field technical questions about the data submission process and assist the vendor until data loads are checked for accuracy and approved by the vendor.

E. Submit Vendor Detail

1. Interested vendors are provided with a plan template. The template will be used to obtain the plan description/benefits, rates, rate rules (age, gender, location, etc.), eligibility rules (location), zip code tables, provider directory, billing rules, pre-existing exclusions and effective dates.

2. Once all plan detail and rates have been loaded and reviewed by the on-boarding quality team, the vendor will test and approve plan setup before it is released to production. The Corporation will also have access to review the plan information prior to it being released to production.

F. Marketplace Changes

1. Vendors may submit rate and benefit changes on a quarterly basis according to a calendar that will be established by the Corporation.

2. The Corporation will notify vendors of any planned changes to the Marketplace rules, requirements, or functionality prior to implementation of the change and with two quarter's advance notice whenever possible.

XX. PARTICIPATION AGREEMENT AND TERMS

The vendor will execute a participation agreement with the Corporation. The Corporation intends to develop a standard participation agreement for vendor consideration. At a minimum, vendors must agree:

- To ensure the availability of covered services and benefits to participating individuals for an enrollment year.
- To submit required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product or service offered through the program.
- To comply with grievance and other procedures established by the Corporation which are found in Exhibit G. The Corporation's grievance procedures will be applied to unique grievances related to the marketplace and are not intended to duplicate or replace the vendor's own grievance process or appeal methods established by the State of Florida.
- To participate in reporting and evaluation efforts with the understanding that the submission of vendor claims detail to the Corporation's evaluator is voluntary and at the discretion of the vendor.
- To a prohibition on refusal to sell any offered non-risk-bearing product to a participant who elects to buy it.
- To accept payment for enrolled participants from the Corporation.

The Corporation will assess all vendors a surcharge on products and services purchased through the marketplace. The maximum surcharge permissible in 408.910, F. S. is 2.5%. Therefore, the Corporation will remit a minimum of 97.5% of the premium or service amount collected.

Once collected, and based upon remittance reports generated, the Corporation will approve disbursement of the appropriate amount to the recipient vendors.

Vendors will benefit from the marketing efforts of the Corporation and from the activities conducted by its Third Party Administrator. Vendors are not responsible for any payments to the Corporation's Third Party Administrator.

A proposed Participation Agreement is provided as Exhibit F and vendor suggestions or comments on the draft agreement are encouraged.

XXI. SOLICITATION OF INTEREST

A. Comments and Questions

Please direct comments, questions or suggestions about this SOI to info@myfloridachoices.org as noted in the Designated Contact section.

B. Letters of Interest For Future Phases

Vendors that are not interested in offering products or services during the Soft Start/Small Group Pilot are encouraged to express interest in later phases. Vendors doing so will be notified when additional Solicitations of Interest are issued. To express interest in a future phase, please provide the formal name, title, type of insurer, and business address. Indicate the phase(s) during which the vendor is eligible to introduce offerings to the marketplace and the type of offering. Please direct your letter of interest for future phases to infor@myfloridachoices.org as noted in the Designated Contact Section.

XXII. GENERAL CONDITIONS

A. Corporation Furnished Property

No material, labor, or facilities will be furnished by the Corporation unless otherwise provided for in this SOI.

B. Special Note

The Corporation is a private, not-for-profit Corporation, and is not subject to the bid requirements of the State of Florida. The Corporation is not a state agency.

C. Excluded Organizations

The Corporation will not consider, directly or indirectly, any vendor that is debarred, suspended, ineligible or voluntarily excluded from doing business with any state or federal agency.

Otherwise eligible vendors may be excluded from participating in the marketplace for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the Corporation.

D. Performance Standards

The Corporation places a high priority on customer service including the timely and accurate handling of all vendor functions. Please know that the Corporation is committed to negotiation of reasonable standards of performance.

E. Announcements

To ensure the accuracy of any public communication, the content of any announcement, press release or statement issued by a vendor concerning acceptance to or withdrawal from the Corporation's marketplace must be submitted to, and approved by, the Corporation prior to release.

XVII. EXHIBITS

EXHIBIT A

Vendor Steering Committee

Representative	Vendor/Organization
Sherry R. Baker	Aetna
Joy Ryan	America's Health Insurance Plans
Nicholas M. Kavouklis, DMD	Argus Dental Plan
Javier Mendoza	AvMed Health Plans
V. Sheffield "Chip" Kenyon	Blue Cross Blue Shield of Florida
Joseph Rogers	Broward Health
Tom Glennon	Capital Health Plan
Holly Benson	Centene Corporation/Sunshine State Health Plan
Greg Mellowe	Florida C.H.A.I.N.
Vincent DiBenedetto	Consumer Health Alliance and Coverdell
Heather Grzych	Delta Dental
Josh Babyak	Dentalplans.com
Lourdes T. Rivas	DentaQuest
Michael W. Garner	Florida Association of Health Plans
David C. Schandel	Florida Health Care Plans
Les Beitsch	FSU School of Medicine
Tim Love	Humana
Scot Giambruno	Liberty Dental Plan of FL
Carlos Lacasa and Glen Feingold	MCNA Dental Plan
Alberto F. Arca	Preferred Medical Plan
Glenn Baker	United Healthcare of Florida
Darcy Gartner	Vista/Coventry

EXHIBIT B
Enrollment Periods

Enrollment Periods Applying to Risk-Bearing Products Only[1]				
Type	Duration	Allowable Activity	Established By	Reference
Initial Open Enrollment Period	60 days	Shop and Compare	Employer	408.910(7)(a) Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the Corporation.
				408.910(7)(b) Initial selection of products and services must be made by an individual participant within 60 days.
Annual Open Enrollment Period	60 days	Shop and Compare	Based on initial enrollment	408.910(7)(d) Changes in selected products and services may only be made during the annual enrollment period.
Change Period				
Special Open Enrollment Period	Up to 60 days	Add/Remove/Change as determined by the qualifying event	Board of Directors	Qualifying life events
Enrollment Period	12 month duration	Continuation in chosen offerings		408.910 (7)(c) 12 months unless the individual participant specifically agrees to a different period of coverage or service duration.
Non-Open Enrollment Period	Year-round	Enrollment in Flexible spending Account Services is Permitted		408.910 (7)(b) Initial selection of products and services must be made by an individual participant within 60 days after the date the individual employer qualified for participation. An individual who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual enrollment period.

[1] Limitation on open enrollment do not apply to flexible spending plans or any product offering individual participants a specific amount and types of health service and treatments at a contracted price. 408.910(7)(e)

EXHIBIT C
Qualifying Life Events

Event	Example	Action
Employee Events		
Employee gains dependent	Marriage	Add spouse
Employee gains dependent	Birth Adoption Fostering	Add dependent • If reported within 30 days of event, coverage retroactive to the event date with no retroactive premium. • If reported 31-60 days of the event, coverage is retroactive to the event date when any retroactive premium is paid
Employee loses dependent	Death Divorce Placed for adoption	Remove dependent
Employee becomes eligible	New hire Job status change	Add employee/family
Employee loses eligibility	Employment ends Job status change	Add independent
Employee loses eligibility in dependent plan	Dependent employment ends Divorce Dependent job status change	Add employee/family
Employee moves out of service area	Relocation by employer Residence address change	Remove employee/family
Eligible employee moves to new service area	Relocation by employer Residence address change	Add employee/family
Employee enrolls in public coverage	Enrolls in Medicare Enrolls in Medicaid/SCHIP	Remove employee/family
Eligible employee loses public coverage	Public coverage canceled due to ineligibility.	Add employee/family
Dependent enrolls in another plan	Enrolls in employer's plan	Remove dependent
Dependent loses eligibility in another plan	Dependent employment ends Job status change	Add dependent
Dependent become ineligible	Overage dependent	Remove dependent
Dependent moves out of service area	Out of service area college student	Remove dependent
Dependent moves to service area	Returning college student	Add dependent
Dependent enrolled in public coverage	Enrolls in Medicare Enrolls in Medicaid/SCHIP	Remove dependent
Eligible dependent loses public coverage	Public coverage canceled due to ineligibility.	Add dependent
Judgment, decree or order to add	Court order requiring coverage for employee's dependent	Add dependent
Judgment, decree or order to release	Court order releasing required coverage for employee's dependent	Remove dependent

EXHIBIT D

Draft Questionnaires


HC_forms_1_2Ver1F.
pdf

EXHIBIT E

Vendor Certification Criteria

Certification of Vendors Licensed by the Office of Insurance Regulation						
Vendor Type	**Vendor Sub-type**	**Licensing Reference**	**License Requirement**	**Issued By**	**Limitations**	**Verification = Certification**
Insurer		Chapter 624	Certificate of Authority	Office of Insurance Regulation		www.floir.com/companysearch
Health maintenance organization		Chapter 641	HMO Certificate of Authority	Office of Insurance Regulation	Geography	www.floir.com/companysearch
			Health Care Provider Certificate	Agency for Health Care Administration		www.floridahealthfinder.gov/HealthPlans
Prepaid limited health service organization	• Dental • Ambulance • Vision • Mental Health • Substance Abuse • Chiropractic • Podiatric • Pharmaceutical	Part I Chapter 636	Certificate of Authority	Office of Insurance Regulation		www.floir.com/companysearch
Discount medical plan		Part II Chapter 636	Certificate of Authority or Discount Medical Plan license	Office of Insurance Regulation		www.floir.com/companysearch
Prepaid health clinic		Part II Chapter 641	Certificate of Authority	Office of Insurance Regulation	Geography	www.floir.com/companysearch
			Health Care Provider Certificate	Agency for Health Care Administration		www.floridahealthfinder.gov/HealthPlans

Certification of Health Service Vendors						
Vendor Type	**Vendor Sub-type**	**Licensing Reference**	**License Requirement**	**Issued By**	**Limitations**	**Verification and Satisfactory Assessment = Certification**
Health care provider	• Hospitals and licensed health facilities • Health care clinics • Licensed health professionals • Pharmacies • Other licensed health care providers	Applicable state law		Appropriate Florida regulatory agency		• Verification of appropriate, active license at www.myflorida.com/ and verification of business entity at www.sunbiz.org • Assessment will vary depending on the vendor type and experience. Certification is at the absolute discretion of the Corporation. Assessment may include but is not limited to the following: If in business at least three years: Credit history for previous 3 years Absence of actions against licenses Performance bond required If in business less than 3 years: Principal background and experience Principal credit history Business plan Principal credit history Performance bond required And, if indicated Solvency review Actuarial review
Provider organization	• Service networks • Group practices • Professional associations • Other incorporated organizations of providers	Applicable state law		Appropriate Florida regulatory agency		
Corporate entities		Applicable state law		Appropriate Florida regulatory agency		

EXHIBIT F

FLORIDA HEALTH CHOICES, INC.

VENDOR PARTICIPATION AGREEMENT

This Agreement is entered into between Florida Health Choices, Inc. ("FHC"), a Florida not-for-profit corporation, pursuant to Chapter 617, Florida Statutes and [enter VENDOR's COMPLETE LEGAL name], [name of state and state type of business entity] VENDOR ("VENDOR") to participate in the Program and Marketplace as herein described.

WHEREAS, FHC administers a Program and Marketplace ("Program" and "Marketplace") as created by and governed under Section 408.910, F.S., and related state and federal laws, for health care insurance and related products and services; and

WHEREAS, Section 408.910 authorizes certain entities to participate in the Program and to sell certain approved Offerings in the Marketplace as a Participating Vendor if such entities meet the criteria set forth in Section 408.910, F.S., and if it complies with the procedures established by FHC; and

WHEREAS, VENDOR wishes to participate in the Program and sell Offerings through the Marketplace; and

WHEREAS, FHC certifies that VENDOR meets the criteria set forth in Section 408.910, F.S., and has complied with the procedures established by FHC to become a Participating Vendor; and

THEREFORE, in consideration of the mutual covenants and conditions hereinafter set forth, the parties agree as follows:

Section 1 Definitions

1-1 "Applicant" means those employers, individuals, vendors, and health insurance agents as set forth in Section 408.910, F.S.

1-2 "Calendar Quarter" means the three month periods ending on 3/31, 6/30, 9/30 and 12/31 of each calendar year.

1-3 "Corporation" means Florida Health Choices, Inc. ("FHC"), established under Section 408.910, F.S.

1-4 "Dependent" means a child, spouse, parent, or certain other relative to whom one contributes all or a major amount of necessary financial support.

1-5 "Enrollee Employer" means eligible employers that comply with the enrollment procedures established by the Corporation and elect to make their employees eligible through the Program.

1-6 "Florida Statutes" ("F.S.") means the Florida Statutes as amended from time to time by the Florida Legislature during the term of this Agreement.

1-7 "Health insurance agent" means an agent licensed under Part IV of Chapter 626, F.S.

1-8 "Insurance Products" are those products which are regulated by the Office of Insurance Regulation under the Florida Insurance Code.

1-9 "Insurer" means an entity licensed under Chapter 624, F.S., which offers an individual health insurance policy or group health insurance policy, a preferred provider organization as defined in Section 627.6471, F.S., an exclusive provider organization as defined in Section 627.6472, F.S., or a health maintenance organization licensed under part I of Chapter 641, F.S., or a prepaid limited health service organization licensed under Chapter 636, F.S.

1-10 "Marketplace" means the single, centralized market established by the Program that facilitates the purchase of Offerings made available in the marketplace.

1-11 "Non-risk-bearing" means not assuming the risk of loss.

1-12 "Offering" is a product or service made available for purchase through the Program and Marketplace, and may include insurance products regulated by the Office of Insurance Regulation or service contracts as defined in 1-18 herein.

1-13 "Offering Agreement" is a written agreement between FHC and the VENDOR that specifies the insurance product, services and other requirements unique to each Offering to be made by the VENDOR in the Marketplace.

1-14 "Office of Insurance Regulation" means the office within the Financial Services Commission pursuant to Section 20.121(a)1., F.S., which is responsible for all activities concerning entities licensed under the Florida Insurance Code.

1-15 "Participant individual" means an eligible individual who has enrolled in the Program.

1-16 "Participating agent" or "Buyer's Representative" is a health insurance agent who voluntarily participates in the Program by complying with the procedures established by FHC for participating agents.

1-17 "Program" means the program administered by FHC as created by and governed under Section 408.910, F.S., and related state and federal laws.

1-18 "Risk-bearing" means assuming the risk of insuring individuals without the protection of a reinsurance program under the Florida Insurance Code.

1-19 "Service contract" means a contract for products or services which are not regulated by the Office of Insurance Regulation, but are the type of product or service which VENDOR may legally provide and for which VENDOR has the capability to provide in the normal course of its business.

1-20 "Vendor" means a vendor as defined in Section 408.910, F.S., and certified by FHC as complying with the requirements and procedures set forth by FHC.

Section 2 Term and Termination of this Agreement

2-1 This Agreement is effective for one (1) year from the date of execution of this Agreement by FHC, and automatically renew from year to year unless terminated by FHC or VENDOR in accordance with Paragraph 2.2 of this Contact.

2-2 Termination of Agreement

2-2.1 Termination for Lack of Funding

This Agreement is subject to the continuation and approval of funding to FHC from state, federal and other sources. FHC shall have the absolute right, in its sole discretion, to terminate this Agreement if funding for the Program is to be changed or terminated such that this Agreement could not be sustained. FHC shall send VENDOR notice of termination and include a termination date of not less than thirty (30) calendar days from the date of the notice.

2-2.2 Termination for Lack of Payment

If FHC fails to make payments in accordance with the terms of this Agreement, VENDOR may terminate this Agreement and pursue the appropriate remedies for FHC's breach of its payment obligations. VENDOR must provide FHC at least thirty (30) calendar days written notice of any termination due to lack of payment and allow FHC an opportunity to correct the default prior to such termination.

2-2.3 Termination for Lack of Performance or Breach

The continuation of this Agreement is contingent upon the satisfactory performance of the VENDOR and corresponding evaluations by FHC. If VENDOR fails to make timely progress on the objectives of this Agreement or fails to meet the deliverables described under this Agreement in the time and manner prescribed, FHC reserves the right to

terminate this Agreement, or any part herein, at its discretion and such termination shall be effective at such times as is determined by FHC. In its sole discretion, FHC may allow VENDOR to cure any performance deficiencies prior to termination.

FHC further reserves the right to terminate this Agreement by written notice to the VENDOR for breach of any provision of the Agreement by the VENDOR, for the VENDOR's failure to perform satisfactorily any requirement of this Agreement, or for any defaults in performance of this Agreement, as determined in FHC's sole discretion.

Waiver of the failure to perform satisfactorily or of breach of any provision of this Agreement shall not be deemed to be a waiver of any other failure to perform or breach and shall not be construed to be a modification of the terms of this Agreement.

2-2.4 FHC may terminate this Agreement in the event of a Material Breach of any material term or condition hereof, if such breach is not cured to the reasonable satisfaction of the non-breaching party within ten (10) calendar days after the non-breaching party has given written notice thereof to the breaching party. In the event the VENDOR cannot perform the cure within ten (10) days after the receipt of notice from FHC, and FHC is satisfied, in its sole discretion, that the ability to cure is not the fault of the VENDOR, FHC may establish a timetable for cure and such decision by FHC shall be final. A "Material Breach" shall mean the failure to perform any of the duties, requirements, terms or conditions set forth herein, and shall mean a violation of any duty, responsibility of the VENDOR required under this Agreement, or any applicable state or federal laws or a rule or regulation.

It is expressly understood that evidence of VENDOR's refusal to substantially comply with this Agreement or such failure by VENDOR's subcontractors, assignees or affiliates performing under this Agreement shall constitute a Material Breach of this Agreement.

2-2.5 Termination upon Revision of Applicable Law

FHC and VENDOR agree if federal or state revisions of any applicable laws or regulations restrict FHC's ability to comply with the Agreement, make such compliance impracticable, frustrate the purpose of the Agreement or place the Agreement in conflict with FHC's ability to adhere to its statutory purpose, FHC may unilaterally terminate this Agreement. FHC shall send VENDOR notice of termination and include a termination date of not less than thirty (30) calendar days from the date of notice.

2-2.6 Termination upon Mutual Agreement

With mutual agreement of both parties, this Agreement, or any part herein, may be terminated on an agreed date prior to the end of the Contract without penalty to either party.

2-2.7 Either party may terminate this Agreement without cause by providing written notice to the other party at least thirty (30) days prior to the beginning of a Calendar Quarter. Such termination shall be effective at the end of the Calendar Quarter which the notice preceded.

Section 3 Payments

3-1 VENDOR agrees to accept payment directly from FHC for all premiums and/or fees of Enrollees or Participants of the Program who utilize the Offerings of VENDOR, as set forth in all executed Offering Agreements which are then in effect.

3-2 FHC will make payment to VENDOR bi-monthly on the 15th day of the month and the last day of the month in accordance with enrollment data and at the prices set forth in all executed Offering Agreements which are then in effect.

3-3 In the event VENDOR disagrees with or questions any amount paid by FHC, VENDOR agrees to communicate such disagreement to FHC in writing within thirty (30) calendar days of payment. Any disagreement or question about an amount that is not made within the 30-day period is waived. In the event VENDOR is entitled to a reimbursement regarding a timely claim, FHC will credit the reimbursement to the next payment due under 3-2 of this Agreement.

3-4 If VENDOR or FHC discovers that FHC has made payments in excess of the amounts due to VENDOR, such party shall notify the other party within thirty (30) days of such discovery, and VENDOR shall either refund the amount to FHC within thirty (30) days, or notify FHC that the amount should be deducted from the next payment due to VENDOR under 3-2 of this Agreement.

Section 4 Duties of VENDOR

4-1 Vendor Status

4-1.1 VENDOR agrees and acknowledges that its participation in the Program is voluntary.

4-1.2 VENDOR understands and agrees that it may not sell products that provide risk-bearing coverage unless VENDOR is authorized under a Certificate of Authority issued by the Office of Insurance Regulation under the provisions of the Florida Insurance Code.

4-1.3 Excluded Vendor: A vendor that is otherwise eligible to participate in the Program may be excluded from participating in the Program for engaging in deceptive or predatory practices, financial insolvency, for failure to comply with the terms of this Vendor Participation Agreement, any Product or Services Contract, or any of the standards or policies established by FHC; or for failure to comply with applicable laws and regulations pertaining to the Florida Insurance Code.

4-2 Deliverables

4-2.1 Offerings

VENDOR Offerings may be Insurance Products or Service Contracts, or both. VENDOR agrees that prior to sale of any Offering through the Program that VENDOR must submit to FHC the type of Offering, a complete description of the covered service and benefits, the provider network, any payment restrictions, the price, the frequency of rate or price changes, compliance with the insurance code, initial effective date, and any other pertinent details of such Offering in a form prescribed by FHC. Upon approval by FHC, VENDOR must execute an Offering Agreement with FHC which shall incorporate all the terms and conditions of this Vendor Participation Agreement, and which shall set forth all the details of the Offering in a form prescribed by the FHC.

4-2.2 Appointment of Agents

VENDOR agrees to appoint agents who participate with FHC and is responsible for their compensation. VENDOR may appoint additional participating agents.

4-2.3 Reporting

FHC may conduct a vendor performance review no more than annually, unless otherwise determined necessary by FHC. Standard statewide monitoring instruments outlining the performance standards, requirements and best practices, and the methodology (including source documents) to be used for each, shall be given to all VENDORS in advance of the monitoring activity.

4-2.4 Responsiveness to FHC

VENDOR agrees to be responsive to all inquiries of FHC, and shall respond orally or in writing within no less than five (5) business days of a FHC inquiry.

4-2.5 Grievance Procedures

VENDOR agrees to establish a method to accept and consider complaints or grievances received by the FHC or its Third Party Administrator when the complaint or grievance is most appropriately handled by the VENDOR.

4-3 Records Retention and Accessibility

4-3.1 VENDOR agrees to maintain books, records and documents in accordance with generally accepted accounting principles.

4-3.2 VENDOR shall have all records used or produced in the course of the performance of this Agreement available to FHC at all reasonable times for inspection, review, audit or copying, by any vendor contracted with FHC or any state or federal regulatory agency as authorized by law or FHC. Access to such records shall be during normal business hours and shall be either through on-site review of records or through the mail. These records shall be retained for a period of at least five (5) years following the term of this Agreement, except if an audit is in progress or audit findings are yet unresolved, in which case, records shall be kept until all tasks are completed.

4-3.3 VENDOR agrees to cooperate in any evaluative efforts conducted by FHC or an authorized subcontractor of FHC, or both during and for a period of at least five (5) years following the term of this Agreement. VENDOR participation in evaluation efforts that include the submission of VENDOR claim detail is voluntary at the discretion of the VENDOR. These efforts may include a post-Agreement audit.

4-3.4 VENDOR shall include all the requirements of this subsection in all approved subcontracts and assignments and VENDOR agrees to require subcontractors and assignees to meet these requirements.

4-4 Use of Subcontractors or Affiliates

VENDOR may contract with subcontractors or affiliates to deliver services under this Agreement provided that all such agreements between VENDOR and its subcontractors or affiliates to provide services under this Agreement shall be reduced to writing and shall be executed by both parties, and shall require that the subcontractor or affiliate fully comply with all terms and conditions of this Agreement between VENDOR and FHC..

4-5 Indemnification

VENDOR shall indemnify, defend and hold FHC, its officers, directors, agents and employees harmless from all claims, losses, suits, judgments or damages, including court costs and attorneys' fees, arising out of:

A. Negligence, intentional torts or breach of contract by VENDOR; or

B. Any failure of VENDOR, its officers, employees to observe the requirements of applicable Florida or federal law, regardless of whether FHC knew or should have known of such failure.

4-6 Insurance

VENDOR shall not commit any work in connection with this Agreement until it has obtained all types and levels of insurance required and approved by FHC. Such coverage may include but is not limited to workers' compensation, general liability, professional liability, fire insurance, and property insurance depending upon the types of services being provided and shall be attached as Attachment F to this Agreement. VENDOR shall, upon the request of FHC, provide FHC proof of coverage of insurance by a Certificate of Insurance. FHC shall be provided proof of coverage of insurance by a Certificate of Insurance within five (5) business days of such request. Failure to provide proof of coverage when requested may result in the Agreement being terminated.

FHC shall be exempt from and in no way liable for any sums of money that may represent a deductible, copay, or other cost sharing mechanisms in any insurance policy. FHC shall also be exempt from and in no way liable for any premiums paid on any insurance policy pursuant to this Agreement. The payment of such a deductible, copay, other cost sharing mechanisms, or premiums shall be the sole responsibility of VENDOR and/or subcontractor holding such insurance.

Section 5 General Terms and Conditions

5-1 Amendment

This Agreement may be amended by mutual written consent of the parties at any time. This Agreement shall automatically be amended to the extent necessary from time to time to comply with state or federal laws upon notice by FHC to VENDOR to that effect.

5-2 Attachments

Attachments A through F are incorporated into this Agreement by reference. For any conflict between these Attachments and this Agreement, the Attachment shall control.

5-3 Attorneys' Fees

In the event of any legal action, dispute, litigation or other proceeding with relation to this Agreement, the prevailing party shall be entitled to recover reasonable attorneys' fees and costs incurred, whether or not suit is filed, and if filed, at both trial and appellate levels. Legal actions are defined to include administrative proceedings.

5-4 Bankruptcy

VENDOR shall give FHC notice of the intent to petition for bankruptcy or reorganization or arrangement at the time of the filing and immediately provide a copy of such filing to FHC. FHC shall have thirty (30) calendar days to elect continuation or termination of this Agreement.

5-5 Change of Controlling Interest

FHC shall have the absolute right to elect to continue or terminate this Agreement, at its sole discretion, in the event of a change in the ownership or controlling interest of VENDOR. VENDOR shall give FHC notice of regulatory agency approval, if applicable, prior to any transfer or change in control of documentation of the change of regulatory agency approval is inapplicable. FHC shall have thirty (30) calendar days after receipt of such notice to elect continuation or termination of this Agreement.

5-6 Confidentiality

Certain information held by the Corporation is deemed to be "proprietary confidential business information" or is otherwise exempt from the Florida Public Records Act pursuant to Section 408.910, F.S. VENDOR shall treat all proprietary confidential business information, particularly personal or identifying information relating to Applicants, Enrollees, and FHC client or customers lists, that is obtained through its performance under this Agreement, as confidential information to the extent confidential treatment is provided under state and federal laws.

VENDOR shall not use any information obtained in any manner except as necessary for the proper discharge of its obligations and to secure its rights under this Agreement. Such information shall not be divulged without written consent of FHC, the Applicant or the Enrollee. This provision does not prohibit the disclosure of information in summary, statistical or other form which does not identify particular individuals or entities.

VENDOR and FHC mutually agree to maintain the integrity of all proprietary information to the extent provided under the law. All proprietary information of VENDOR will be so designated. Neither party will disclose or allow others to disclose proprietary information as determined by law by any means to any person without prior written approval of the other party. This requirement does not extend to routine reports and other disclosures necessary for efficient management of the Program.

VENDOR understands that FHC is subject to the Florida Public Records Act, Section 119.07, F.S., and therefore all such information may be considered a public record and open to inspection. Thus, unless otherwise confidential or exempted by law, VENDOR shall allow public access to all documents, papers, letters, electronic correspondence or other material subject to the

provisions of Chapter 119, F.S., and made or received by VENDOR in conjunction with this Agreement. However, VENDOR agrees to advise FHC prior to the release of any such information.

5-7 Conflicts of Interest

5-7.1 Conflicts of Interest

VENDOR confirms that to the best of its knowledge, the responsibilities and duties assumed pursuant to this Agreement are not in conflict with any other interest to which VENDOR is obligated or from which VENDOR benefits. Further, VENDOR agrees to inform FHC immediately after becoming aware of any conflicts of interest which it may have with the interests of FHC, as set forth in this Agreement and which may occur in the future.

Within ten (10) days of Agreement execution, VENDOR shall submit a disclosure form identifying any relationships, financial or otherwise with any FHC Board Member, or any employee of FHC.

5-7.2 Gift Prohibitions

In accordance with FHC Corporate Policies, VENDOR affirms its understanding that FHC Board Members and FHC Employees are prohibited from accepting any gifts, including but not limited to, any meal, service or item of value even de minimus from those entities that conduct or seek to conduct business with FHC.

5-7.3 Non-Solicitation

A. VENDOR recognizes and acknowledges that as a result of this Agreement VENDOR will come into contact with employees of FHC and that these employees have received considerable training by FHC. VENDOR agrees not to solicit, recruit or hire any individual who is employed by FHC during the term of this Agreement.

B. VENDOR agrees that it will not intentionally solicit FHC Enrolled Employers or Participant Individuals for products or services which are similar to or which compete with Offerings in the Marketplace, nor shall VENDOR intentionally attempt to encourage Enrolled Employers or Participant Individuals to un-enroll in the Program. This section does not apply to general marketing efforts undertaken by the VENDOR that are directed toward a broad audience.

C. The prohibitions in this Paragraph 5-7.3 shall be in effect for both the term of this Agreement and for the twelve (12) months immediately following its termination.

5-8 Force Majeure

Neither party shall be responsible for delays of failure in performance of its obligations under this Agreement resulting from acts beyond the control of the party. Such acts shall include, but are not limited to, blackouts, riots, acts of war, terrorism, epidemics, government regulations or statutory amendments adopted following the date of execution of this Agreement, fire, communication line failure, computer hardware failure, computer executive software failure, power failure or shortage, fuel shortages, hurricanes or other natural disasters.

5-9 Governing Law; Venue

This Agreement shall be governed by applicable state and federal laws and regulations as such may be amended during the term of the Agreement, whether or not expressly included or referenced in this Agreement. Any legal action with respect to the provisions of this Agreement shall be brought in state court in Leon County, Florida.

VENDOR agrees to comply with the following provisions as such may from time to time be amended during the term of this Agreement:

A. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq., which prohibits discrimination on the basis of race, color or national origin.

B. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap.

C. Title XI of the Education Amendments of 1972, as amended 29, U.S.C. 601 et seq., which prohibits discrimination on the basis of sex.

D. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age.

E. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9848, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.

F. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires accommodation for persons with disabilities.

G. Section 274A (e) of the Immigration and Nationalization Act. FHC shall consider the employment by any VENDOR of unauthorized aliens a violation of this Act.

H. OMB Circular A-102, A-87, 45 CFR-92, and Attachment A of this Agreement which identifies procurement procedures which conform to applicable federal law and regulations with regard to debarment, suspension, ineligibility, and involuntary exclusion of contracts and subcontracts. Covered transactions include procurement contracts for services equal to or in excess of one hundred thousand dollars ($100,000.00) and all non-procurement transactions.

I. The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended from time to time ("HIPAA").

J. All applicable state and federal laws and regulations governing FHC.

K. All regulations, guidelines and standards as are now or may be lawfully adopted under the above statutes.

VENDOR agrees that compliance with this paragraph 5-9 constitutes a condition of VENDOR's continued participation in the Program through this Agreement and such compliance is binding upon VENDOR, its successors, transferees and assignees for the period during which services are provided. It is expressly understood that evidence of VENDOR's refusal or failure to substantially comply with this section or such failure by VENDOR in performing under this Agreement shall constitute a breach and renders this Agreement subject to unilateral cancellation by FHC.

5-10 Independent Contractor

The relationship of VENDOR to FHC shall be solely that of an independent contractor. The parties acknowledge and agree that neither party has the authority to make any representation, warranty or binding commitment on behalf of the other party, except as expressly provided in this Agreement or as otherwise agreed to in writing by the parties, and nothing contained in this Agreement shall be deemed or construed to (i) create a partnership or joint venture between the parties or any affiliate, employee or agent of a party; or (ii) constitute any party or any employee or agent of a party as an employee or agent of the other party.

5-11 Name and Address of Payee

Unless otherwise specified in an Offering Agreement, the name and address of the official payee to whom any payment shall be made:

For VENDOR:
Name
Address
Phone/fax
Email

5-12 Notice and Contact

All notices required under this section shall be in writing and may be delivered by certified mail with return receipt requested, by facsimile with proof of receipt, by electronic mail with proof of receipt or in person with proof of delivery.

Notice required or permitted under this Agreement shall be directed as follows:

For FHC:

Administrative Services Manager
Florida Health Choices, Inc.
200 W. College Avenue, Suite 203
Tallahassee, FL 32301
850-222-0933 (Phone)
850-222-8222 (Fax)

For VENDOR:

Name
Address
Phone/fax
Email

In the event that different contact persons are designated by either party after execution of this Agreement, notice of the name and address of the new contact shall be sent to the other party and be attached to the originals of this Agreement.

5-13 Severability

If any of the provisions of this Agreement are held to be inoperative by a court of competent jurisdiction, such a provision shall be severed from the remaining provisions of this Agreement which shall remain in full force and effect.

5-14 Survival

The provisions of the following sections: Records Retention and Accessibility; Attorneys' Fees; Confidentiality; Conflicts of Interest; Non-Solicitation and Governing Law; and Venue shall survive any termination of this Agreement.

5-15 Entire Understanding

This Agreement with all Attachments incorporated by reference embodies the entire understanding of the parties relating to the subject matter of this Agreement, and supersedes all other agreements, negotiations, understandings, or representations, verbal or written, between the parties relative to the subject matter hereof.

(TWO (2) SIGNATURE PAGES FOLLOW)

REMAINDER OF THIS PAGE LEFT INTENTIONALLY BLANK

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their undersigned officials as duly authorized. This Agreement shall be effective upon execution by FHC.

FOR VENDOR:

_____

NAME:_____

TITLE:_____

DATE SIGNED:_____

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20__,

by _____, as _____ on behalf of

_____. He/She is personally known to me or has produced _____

as identification.

_____
Signature
Notary Public – State of Florida

_____
Print, Type or Stamp Name of Notary Public

My Commission Expires: _____

WITNESS #1 SIGNATURE _____

WITNESS #1 PRINT NAME _____

WITNESS #2 SIGNATURE _____

WITNESS #2 PRINT NAME _____

FOR FLORIDA HEALTH CHOICES, INC.:

_____

NAME: Rose M. Naff
TITLE: Chief Executive Officer

DATE SIGNED: _____

STATE OF FLORIDA

COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 20__, by Rose M. Naff, as Chief Executive Officer on behalf of Florida Health Choices, Inc. She is personally known to me or has produced _____ as identification.

_____
Signature
Notary Public – State of Florida

_____
Print, Type or Stamp Name of Notary Public
My Commission Expires:_____

WITNESS #1 SIGNATURE _____

WITNESS #1 PRINT NAME _____

WITNESS #2 SIGNATURE _____

WITNESS #2 PRINT NAME _____

Reviewed by:

_____ Date:____/_____/20___
Wilbur E. Brewton
Fla Bar Number: 110408

ATTACHMENT A

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY and VOLUNTARY EXCLUSION CONTRACTS AND SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

A. Each VENDOR whose contract\subcontract equals or exceeds twenty five thousand dollars ($25,000) in federal monies must sign this certification prior to execution of each contract\subcontract. Additionally, entities which audit federal programs must also sign, regardless of the contract amount. Florida Health Choices, Inc., chooses not to contract with these types of entities if they are debarred or suspended by the federal government.

B. This certification is a material representation of fact upon which reliance is placed when this contract\subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the federal government may pursue available remedies, including suspension and/or debarment.

C. VENDOR shall provide immediate written notice to the contract manager at any time VENDOR learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

D. The terms “debarred,” “suspended,” “ineligible,” “person,” “principal,” and “voluntarily excluded,” as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.

E. VENDOR agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the federal government.

F. VENDOR further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract whose payment will equal or exceed twenty five thousand dollars ($25,000) in federal monies, to submit a signed copy of this certification.

G. Florida Health Choices, Inc., may rely upon a certification of VENDOR that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting\subcontracting unless it knows that the certification is erroneous.

H. This signed certification must be kept in the contract manager’s file. Subcontractors’ certifications must be kept at the VENDOR’s business location.

CERTIFICATION

VENDOR certifies, by signing this certification, that neither VENDOR nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal agency.

Where VENDOR is unable to certify to any of the statements in this certification, VENDOR shall attach an explanation to this certification.

_____ _____

Signature (Above) Date of Signature

Name and Title of Authorized Signatory: Name of VENDOR and Business Address:

ATTACHMENT B

CERTIFICATION REGARDING LOBBYING

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE CONTRACTS

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

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative Contract and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative Contract.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress or an employee of a member of congress in connection with this federal contract, grant, loan or cooperative Contract, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants and contracts under grants, loans and cooperative Contracts) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than ten thousand dollars ($10,000.00) and not more than one hundred thousand dollars ($100,000.00) for each such failure.

_____ _____

Signature (Above) Date of Signature

Name and Title of Authorized Signatory:

Name of VENDOR and Business Address:

ATTACHMENT C

REGARDING HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 COMPLIANCE: CERTIFICATION

CERTIFICATION

VENDOR certifies, by signing this certification, that:

1. VENDOR is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, as amended from time to time ("HIPAA"), and is in compliance with HIPAA.

2. VENDOR will, in accordance with HIPAA, appropriately safeguard the individually identifiable health information which is personal health information ("PHI") and/or electronic protected health information ("EPHI") received or exchanged under the terms of this Vendor Participation Agreement in accordance with HIPAA.

3. VENDOR will notify Florida Health Choices, Inc. in writing within fifteen (15) days in the event that VENDOR no longer qualifies as a Covered Entity, or is not in compliance with HIPAA.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction.

_____ _____

Signature (Above) Date of Signature

Name and Title of Authorized Signatory:_____

Name of VENDOR:_____

Business Address of VENDOR:_____

ATTACHMENT D
DISCLOSURE FORM

VENDOR NAME: _____

The following are relationships, business and personal, that may create a conflict of interest that VENDOR is hereby disclosing:

Type of Relationship (Business, Personal)	Name of Organization or Individual	Status of Organization or Individual (Current VENDOR, Applicant, Enrollee, etc.)	Term of Relationship

By my signature, I certify that the information contained in this report and any attachments to this document are true representations. INSURER understands that if any information is found to be false, that the Agreement between FHC and VENDOR may be terminated at FHC's sole discretion.

Submitted By: Date of Submission:

_____ _____

(Signature Above)

Name: _____ Title:_____

ATTACHMENT F

Insurance Coverage

Without limiting any of VENDOR's obligations or liabilities hereunder, VENDOR further agrees to procure and maintain at VENDOR's sole cost and expense the following insurance on an occurrence basis:

(1) Commercial General Liability Insurance, including but not limited to products and completed operations and contractual liability coverage, for bodily injury, death, and property damage with limits of liability of not less than $1,000,000 for each occurrence and $2,000,000 in the aggregate; and

(2) Automobile Liability, covering all owned, non-owned, and hired vehicles with a combined limit of at least $500,000 per person and $1,000,000 per occurrence for bodily injury and $1,000,000 per occurrence for property damage; and

(3) VENDOR shall provide Workers' Compensation benefits to its employees as required by and in compliance with Florida law; and

(4) Professional Liability Insurance in the amount of $10,000,000.

FHC shall be an additional Insured on VENDOR's policies of insurance specified in above Paragraphs (1), (2) and (4).

EXHIBIT G

100.30 Program Complaints/Grievances

Responsible Personnel Administrator, Staff, Board of Directors

Policy Statement
Florida Health Choices, Inc. shall set procedures, guidelines and timeframes for the review of any applicant or participant complaint or grievance. The policy shall include a four-tiered escalation process to ensure all program participants are provided an equitable and transparent opportunity to resolve their complaints and/or grievances. The intent is to address and resolve all customer issues at the earliest opportunity within the organization in an expeditious manner.

Definition of Terms:

Administrator is defined as the third-party administrator contracted to operate the health insurance marketplace.

Complaint is defined as dissatisfaction with the service or an outcome a customer has received. Complaints will be resolved the same business day when possible. Resolution shall not exceed 15 days.

Escalation is defined as a process which allows customers to elevate their issue(s) from one tier to the next at the customer's discretion.

Grievance is defined as dissatisfaction with the resolution a customer has received in response to a complaint. Any party who is dissatisfied by the resolution of their initial complaint is eligible to submit a grievance. Grievances will be addressed and resolved in accordance with the timeframes associated with the respective reviewing entity.

Participant is defined as anyone who does business with the marketplace and includes Employers, Employees, Individuals, Buyer's Representatives and Vendors.

Definition of Resolution Teams:

The **Contact Center** and the **Resolution Team** are part of the Administrator's customer support operation and represent the first tier in the resolution process. They are responsible for reviewing all customer complaints and issue a resolution.

The Administrator's **Grievance Team** supports the second tier in the grievance process**.** Participants who are dissatisfied with the complaint resolution provided by the Contact Center are eligible to lodge a formal grievance with the Grievance Team. In most cases, the Grievance Team is responsible for customer contact and coordination between other organizational entities.

The **Executive Team** supports the third tier in issue resolution. The Executive Team is comprised of the Chief Executive Office and the Administrative Services Director of Florida Health Choices. Participants who are dissatisfied with a decision made by the Grievance Team are eligible to escalate their grievance to the Executive Team. Members of the Vendor and Agent Steering committees, as well as other parties, may support the Executive Team when designated by the Chief Executive Officer.

The **Grievance Committee** supports the fourth and final tier in the complaint/grievance process. The Grievance Committee is appointed by the Board of Directors and is comprised of members of the board who will serve on a rotating basis. Program participants who are dissatisfied with a decision made by the Executive Team are eligible to escalate their grievance to the Grievance Committee.

Tracking/Reporting

The Administrator shall maintain a **log** of all customer complaints and grievances and shall provide monthly reports to the Executive Team to provide an overview of all complaints and grievances, and to communicate ongoing customer service performance criteria.

The log shall consist of:

- Consumer's Name
- Siebel Case #
- Date complaint was received
- Summary of the complaint
- Date complaint was reviewed by FHC
- Resolution as it pertains to the complaint
- Date Consumer was sent communication on complaint resolution
- Link to communication sent to consumer regarding FHC review of their complaint
- Date grievance was received
- Summary of the grievance
- Date grievance was reviewed by FHC
- Body which reviewed and acted upon the grievance (Tier 2, 3, or 4)
- Decision as it pertains to the grievance
- Date Consumer was sent communication on decision
- Link to communication sent to consumer regarding FHC review of their grievance

Procedures

Tier 1 –Complaint

To make a complaint, a customer may call or submit a complaint in writing to the Contact Center. A customer service representative will record all relevant information and document the case. When noting a verbal complaint dictated during a call, the representative will offer to read back the caller's complaint to ensure accuracy.

All complaints, either written or verbal, will be logged.

The complaint information will be routed to the Resolution Team for review. The customer will be contacted by a Resolution Team member and informed of the resolution for their complaint. The Resolution Team member shall inform the customer of the next step in the grievance process.

Complaints will be resolved the same business day when possible and shall not exceed 15 days.

Tier 2 –Grievance

Customers who are dissatisfied with the resolution provided by the Resolution Team are eligible to file a formal grievance.

When noting a verbal grievance, the representative will offer to read back the caller's grievance to insure accuracy. Upon receipt, grievances will be routed to the Grievance Team for review. The Grievance Team shall issue a formal decision and may confirm, reverse or amend the complaint resolution issued by the Resolution Team.

The customer will be contacted by the Grievance Team and informed of the decision.

The Grievance Team shall maintain a log of all grievances.

Grievances will be resolved the same business day when possible and shall not exceed 15 days.

Tier 3 – Executive Review

Customers who are dissatisfied with a decision rendered by the Resolution Team and the Grievance Team may escalate their grievance to the Executive Team.

Upon receipt, grievances will be routed to the Executive Team for review. The Executive Team may conduct further research into the matter, review other documentation and/or make contact with the grievant. The Executive Team shall issue a decision and may confirm, reverse or amend the decision issued by the Grievance Team.

The Executive Team shall inform the Grievance Team of their decision. The Grievance Team shall be responsible to communicate the Executive Team's decision to the grievant.

The Grievance Team, on behalf of the Executive Team, shall maintain a log of all grievances addressed by the Executive Team.

Complaints subject to Executive Team review will be resolved the same business day when possible and shall not exceed 15 days.

Tier 4 – Board Review

Customers dissatisfied with a decision rendered by the Resolution Team, Grievance Team, and Executive Team, may escalate their grievance to the Grievance Committee.

Upon receipt, grievances will be routed to the Grievance Committee for review. A meeting of the Grievance Committee will be convened within 45 days and the grievant may attend the meeting in person or by phone. The Grievance Committee may conduct further research into the matter, review other documentation and/or make contact with the grievant in coordination with the Executive Team and the Grievance Team. The Grievance Committee shall issue a decision and may confirm, reverse or amend the decision issued by the Executive Team.

The Grievance Committee shall inform the Grievance Team and the Executive Team of their decision. The Grievance Team shall be responsible for communicating the Grievance Committee's decision to the customer.

The Grievance Team, on behalf of the Grievance Committee, shall maintain a log of all grievances addressed by the Grievance Committee.

The Grievance Committee shall provide a written decision to the grievant, the Executive Team, and to the Administrator within 15 days of the Grievance committee meeting.

EXHIBIT H

NON-DISCLOSURE AND CONFIDENTIALITY AGREEMENT

This non-disclosure and confidentiality agreement is entered into by and between Florida Health Choices, Inc. (FHC), and _____(Vendor) this _____ day of _____, 2012.

It is agreed by and between the parties that Vendor will provide live plan data (the "Data") in reference to the provision of healthcare coverage, the purpose of which is to be utilized to test the system being prepared pursuant to a contract dated May 25, 2012, by and between Xerox State Healthcare, LLC and FHC.

The parties agree that this Data will not be released to any parties, is considered a trade secret, and is confidential and proprietary business information. Data will not be sold to the general public or offered for sale to the general public at any time; or disclosed to any third party without express written consent of the parties to this Agreement.

FOR FHC:

FLORIDA HEALTH CHOICES, INC.:

_____

NAME: Rose M. Naff, Chief Executive Officer

FOR VENDOR:

_____

NAME:

EXHIBIT I

Florida Health Choices
Proposed Deliverables

Institute for Child Health Policy
University of Florida
May 6, 2012

Deliverable 1 (2012): Data Warehouse: The Institute for Child Health Policy (ICHP) proposes to conduct an evaluation of Florida Health Choices, Inc. that focuses on clients' experiences with the application and enrollment process, access to care, and quality of care. As outlined in the original proposal, ICHP will create the databases and build the data warehouse for Florida Health Choices. This work will comprise the first deliverable and will be achieved through intake of the enrollment and claims/encounter, and pharmacy data.

Deliverable 1 Timeline: Creation of Data Warehouse infrastructure will begin in July, 2012. Data will be accepted into the Warehouse beginning January, 2013.

Deliverable 2 (2012): Focus Groups with Insurance Agents: The insurance industry in Florida holds an annual conference in the summer months, which provides a central location and enhances convenience for insurance agents to participate in focus groups. The purpose of the focus groups is to meet with insurance agents in small group settings to better understand their attitudes toward and any barriers related to participating with Florida Health Choices. The participants also will be asked about strategies to enhance collaboration with Florida Health Choices. ICHP will work with Florida Health Choices to identify potential focus group participants among the insurance agents and issue invitations. All focus group sessions will be transcribed, themes analyzed, and a report issued to Florida Health Choices.

Deliverable 2 Timeline: Focus Group Report, October 2012.

Deliverable 3 (2013): Enrollment and Health Status Reports: The initial reports will focus on enrollment patterns and enrollee health status. An enrollment report will be created monthly with quarterly and annual summaries describing the characteristics of the enrollees using the variables in the enrollment file. These variables include sociodemographic, employment information, and months enrolled, among others. ICHP will use geocoding to geocode members at the census tract level.

When six months of data are available (and allowing for a three month claims lag), ICHP will use the Clinical Risk Groups or another classification system to categorize the enrollees' health status. The enrollees' health status will be compared to those of adults enrolled in Medicaid and to those insured by other payers using available state and

national datasets. Information about the health status of the enrollees is critical for ongoing program planning related to care management and health care expenditures.

Deliverable 3 Timeline: Enrollment reports will be produced beginning in February, 2013. The first health status reports will be produced in September 2013 (6 months of claims with a 3 month lag).

Deliverable 4: Analysis of Participating Employers: Using information from Florida Health Choices and enrollment files about participating employers, ICHP will prepare a report characterizing the types of employers (type of business, business size, location, and other information that can be obtained from publicly available reports). ICHP will compare businesses who participate to those who do not using publicly available information. In addition, ICHP will identify a random sample of participating and non-participating businesses and invite them to participate in online, written, or telephone surveys about their reasons for participating or not. The sample size will be determined once the number of participating businesses is known.

Deliverables 4 Timeline: January through April 2013.

Deliverable 5: Quality of Care, Potentially Preventable Events, and Health Care Use Reports (2013 and 2014): It will take at least 15 months to have sufficient health care claims and encounter data to conduct analyses related to health care use and quality of care (12 months of data plus a 3 month lag). Therefore deliverables related to heath care use and quality will be provided during Project Year 2. Once there is 15 months of claims/encounter and pharmacy data and sufficient numbers of enrollees who meet the criteria for various quality of care measures, ICHP will calculate HEDIS® measures (non-Hybrid) and also use the 3M Health Information System (HIS) software to calculate potentially preventable admissions, readmissions, and emergency room visits. ICHP will also calculate overall health care use and expenditure patterns. All potentially preventable event and health care use information will be risk-adjusted for enrollee health status.

In addition, ICHP will calculate HEDIS measures using the administrative data. The measures will include both primary care (Adult Access to Primary Care Providers, Cervical Cancer Screening, Breast Cancer Screening and others) and chronic care (Comprehensive Diabetes Care, Management of Cardiovascular Disease, Appropriate Use of Asthma Medication, and others). Measures or components of measures that rely on medical record review will only be conducted as funds are available through other grant sources. Examples of measures relying on medical record review (hybrid measures) include: HbA1c levels, LDL-C levels, Controlling High Blood Pressure). These reports will be produced annually.

Deliverables 5 Timeline: Initial health care use and potentially preventable events reports will be calculated when 6 months of data with a 3 month lag are available. This will be approximately in September 2013. HEDIS measures require one year of data with a three month lag. Therefore reports on the quality of care using HEDIS measures will not be available until May 2014.