BOARD OF COUNTY COMMISSIONERS, BROWARD COUNTY, FLORIDA

AGREEMENT SUMMARY

EXHIBIT 2

1. Other Contracting Party:

SOUTH FLORIDA COMMUNITY CARE NETWORK, LLC, D/B/A COMMUNITY CARE PLAN

2. Proposed Action:

☒ New Contract ☐ Amendment, Number ☐ Renewal ☐ Extension

3. Document Type (*select one*):

Group Health Insurance Coverage & Benefits

4. Purpose/Description:

Provides self-insured group health and pharmacy insurance benefits through a publicly owned narrow network comprised of Memorial Healthcare System, North Broward Hospital District, Holy Cross Hospital and Cleveland Clinic Florida-Weston to benefit-eligible employees, COBRA, Retirees, and covered dependents. Plan provides members with concierge care coordination level service and is based on a Total Cost of Care model.

5. Special Provisions (*select if applicable*):

☐ Living Wage Program
☐ Workforce Investment Pilot Program
☐ Federal DBE/ACDBE program
☐ CBE Program
☐ SBE Sheltered Market Program
☐ M/WBE Program
☐ In-Kind Match Required: $ _____ or _____ %
☐ Cash Match Required: $ _____ or _____ %

6.a. Effective Dates (*for new agreements only*):

Start : 01/01/2018

End: 12/31/2018

6.b. Effective Dates (*amendments only*):

☐ No Change
☐ End date has changed from _____ to _____.
☐ Term has from to .

7. Contract Administrator:

Name: Mary McDonald

Phone: 954-357-6044

8. Contract Type:

☐ Cost reimbursement ☐ Open-end
☒ Firm fixed price ☐ Time and materials
☐ Performance-based ☐ Other______

9.a. Contract Value (*new contracts*)

☐ Actual ☒ Estimated

Base amount	$1,716,000
Reimbursables	$0.00
Optional Services	$0.00
Total contract value	$1,716,000

9.b. Contract Value (*amendments only*)

☐ No change ☐ Actual ☐ Estimated

Original approved contract value	
Approved previous adjustments	
Value of this action	
Amended total contract value	

10. Payment Method

☐ Lump Sum Payment
☐ Milestone or Progress-Based
☒ Scheduled or Time-Based
☐ Other

11. Payment Terms

Active Employees – monthly Administration Fee based on enrollment and weekly claims reimbursement based on claims period.

COBRA and Retiree participants – monthly Administration Fee collected and paid by Third Party Administrator. Claims paid by County.

12. Cost Adjustment

☒ Not Applicable ☐ Fixed Percentage - __% ☐ Actual Cost
☐ CPI or other Index ☐ Fixed Amount - $_____ ☐ Other:

13. Equity Program Participation Summary

a. County established M/WBE, SBE, CDBE, CBE, DBE or ACDBE participation goal for this action or project: N/A

b. Contractor-committed M/WBE, SBE, CDBE, CBE, DBE or ACDBE participation goal planned for this action or project: N/A

c. M/WBE, SBE, CDBE, CBE, DBE or ACDBE participation to date: N/A

14. Renewal or Extension Terms:

THREE ONE-YEAR RENEWAL TERMS

15. Termination and Cancellation Provisions

For Cause: 30 DAYS WRITTEN NOTICE BY COUNTY

For Convenience: 30 DAYS WRITTEN NOTICE BY COUNTY

16. Deliverables, milestones or scope of this action:

Provides group health insurance benefits to benefit-eligible employees, COBRA participants, Retirees, and covered dependents.

17. List terms, considerations or deviations from standard county form.

Article 13 Indemnification: due to the different obligations and responsibilities of the parties in a self-insured relationship.