



AGREEMENT SUMMARY

1. Other Contracting Party:

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

2. Proposed Action:

New Contract Amendment, Number 1 Renewal Extension

3. Document Type (select one):

Other Group Insurance Agreement

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

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

Start : _____
End: _____

6.b. Effective Dates (amendments only):

No Change
 End date has changed from 12/31/2018 to 12/31/2019.
 Term has from _____ to _____

7. Contract Administrator:

Name: David Kahn
Phone: 954-357-6005

8. Contract Type:

Cost reimbursement Open-end
 Firm fixed price Time and materials
 Performance-based Other _____

9.a. Contract Value (new contracts)

Table with 2 columns: Description, Value. Rows: Actual/Estimated, Base amount, Reimbursables, Optional Services, Total contract value.

9.b. Contract Value (amendments only)

Table with 2 columns: Description, Value. Rows: No change/Actual/Estimated, Original approved contract value (\$1,716,000), Approved previous adjustments, Value of this action (\$462,933), Amended total contract value (\$2,178,933).

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: None
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:

TWO 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.