AGENDA REQUEST FORM

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

ITEM No.: EE-9.

MEETING DATE	2017-09-06 10:05 - School Board Operational Meeting
AGENDA ITEM	ITEMS
CATEGORY	EE. OFFICE OF STRATEGY & OPERATIONS
DEPARTMENT	Procurement & Warehousing Services

Special Order Request ○ Yes ◉ No

Time

Open Agenda ◉ Yes ○ No

TITLE:

Recommendation of $500,000 or Greater - 18-009V - Group Medical Insurance for School Board Employees

REQUESTED ACTION:

Approve the recommendation to award the above Request for Proposal (RFP). Contract Term: January 1, 2018 through December 31, 2020, 3 Years; User Department: Benefits & Employment Services; Award Amount: $36,000,000; Awarded Vendor(s): Aetna Life Insurance Company; Small/Minority/Women Business Enterprise Vendor(s): Various.

SUMMARY EXPLANATION AND BACKGROUND:

The School Board of Broward County, Florida, received five (5) proposals for RFP 18-009V - Group Medical Insurance for School Board Employees. Two (2) proposals from Healthcare Carriers and three (3) proposals from Pharmacy Benefit Managers for a pharmacy carve-out program. As a result of issuing this RFP, coupled with negotiations with Aetna Life Insurance Company, a projected savings of $15.2 million will be realized over the term of the initial contract period.
A copy of the RFP documents are available online at:
http://www.broward.k12.fl.us/supply/agenda/18-009V_GroupMedicalBenefitsSchoolBoardEmployees.pdf
This Agreement has been reviewed and approved as to form and legal content by the Office of the General Counsel.

SCHOOL BOARD GOALS:

○ **Goal 1: High Quality Instruction** ◉ **Goal 2: Continuous Improvement** ○ **Goal 3: Effective Communication**

FINANCIAL IMPACT:

There will be a financial impact to the School Board of approximately $12 million for Administrative Services Fees and approximately $224 million for claims for 2018. The funding source will come from the Fringe Benefits Clearing Account.

EXHIBITS: (List)

(1) Executive Summary (2) Agreement (3) Recommendation Tabulation

BOARD ACTION:

APPROVED

(For Official School Board Records Office Only)

SOURCE OF ADDITIONAL INFORMATION:

Name: Dr. Dildra M. Ogburn	Phone: 754-321-3100
Name: Mary C. Coker	Phone: 754-321-0501

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Approved In Open Board Meeting On: SEP 0 6 2017

By: Abby M. Freedman
School Board Chair

Senior Leader & Title

Maurice L. Woods - Chief Strategy & Operations Officer

Signature

Maurice Woods
8/24/2017, 5:11:31 PM

Electronic Signature

Form #4189 Revised 08/04//2017

RWR/ MLW/MCC/DMO:ch

EXECUTIVE SUMMARY

Recommendation of $500,000 or Greater
18-009V – Group Medical Insurance for School Board Employees

On August 16, 2016, the Board approved the one-year contract extension for Aetna Life Insurance Company (Aetna). The term of the Agreement is from January 1, 2017 through December 31, 2017.

A Medical Request for Proposal (RFP) was developed and subsequently reviewed in a public meeting on October 19, 2016, by the Superintendent's Insurance & Wellness Advisory Committee (SIWAC).

On December 2, 2016, the Procurement & Warehousing Services Department released RFP 18-009V – Group Medical Insurance for School Board Employees. Proposals were due on or before February 6, 2017, and were received from the following vendors:

Medical (with Integrated Pharmacy)	**PBM (Pharmacy Carve-Out)**
Aetna Life Insurance Company	BeneCard PBF
AvMed, Inc.	Express Scripts
	MedImpact Healthcare Systems, Inc.

On March 22, 2017, SIWAC met and evaluated the proposals, based on the following criteria: Experience and Qualifications, Scope of Services, Cost of Services, and Small/Minority/Women Business Enterprise (S/M/WBE). As a result of the Committee's evaluation and subsequent negotiations, the Committee voted to recommend the selection of **Aetna Life Insurance Company (Aetna)** to the Superintendent of Schools.

If approved by the School Board, the term of the initial agreement will be January 1, 2018 through December 31, 2020. The term of the contract may be extended for two (2) additional one-year periods.

OUTCOMES

As a result of issuing the Group Medical Insurance RFP and subsequent negotiations with Aetna, the following outcomes were achieved:

EMPLOYEE WELLNESS

- An additional $500,000; paid in two (2) installments within 2018 to be utilized for the establishment of Wellness Incentives for various Wellness Initiatives.

- **Apple Watch**
  - A total of $72,000 over the term of the Initial Contract period ($24,000 annually) will be provided for the purpose of providing an incentive for benefit eligible employees to purchase an Apple Watch, which will assist them with managing their health.

- **Wellness Coordinator**
  - A dedicated Aetna Wellness Coordinator will be provided to assist in the development, implementation, and management of the District's Wellness Initiatives.

- **Interactive Health Station Kiosks**
  - Three (3) Interactive Health Station Kiosks will be provided by Aetna to enable employees to check their basic health status, e.g., Blood Pressure, and will also allow the employee to communicate electronically with a healthcare professional.

PHARMACY

- **Retail Generic Discount Guarantees**
  - Retail Generic Discount Guarantee rates will be increased as follows:
  - 2018 – Average Wholesale Price (AWP) -76.5%
  - 2019 – Average Wholesale Price (AWP) - 77%
  - 2020 - Average Wholesale Price (AWP) - 77.5%

- **Prescription Drug Market Check**
  - Aetna agrees to a market check in 2019. If this market check yields at least 1.5% gross savings in the marketplace, Aetna agrees to improve the pricing guarantees at a minimum, to equal or better this savings amount in 2020 refer to Exhibit F for additional details.

- **Voluntary Maintenance Medications**
  - A 90-day retail refill will be available at CVS pharmacies, for maintenance medications, on a voluntary basis at the same copays as the mail order.

S/M/WBE

- Annual minority scholarship in the amount of $20,000 for the term of the Initial Contract period. If SBBC exercises years four (4) and five (5), Aetna will continue to fund $20,000 for each of those years.

- During the Initial Contract period, a total of $809,509 will be spent with minority vendors. If SBBC exercises years four (4) and five (5), Aetna agrees to spend $269,000 each year with minority vendors.

AGREEMENT

THIS AGREEMENT is made and entered into as of this 6th day of September, 2017, by and between

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
(hereinafter referred to as "SBBC"),
a body corporate and political subdivision of the State of Florida,
whose principal place of business is
600 Southeast Third Avenue, Fort Lauderdale, Florida 33301

and

Aetna Life Insurance Company
(hereinafter referred to as "AETNA"),
whose principal place of business is
1340 Concord Terrace
Sunrise, Florida 33323-2830

WHEREAS, SBBC is in need of certain products and services and has selected AETNA to provide such products and services; and

WHEREAS, SBBC issued a Request for Proposal, identified as RFP 18-009V - Group Medical Benefits for School Board Employees, dated December 2, 2016 and amended by Addendum Number One dated December 6, 2016, Addendum Number Two dated December 19, 2016 and Addendum Number Three dated December 23, 2016 (hereinafter referred to as "RFP") which is incorporated by reference herein, for the purpose of receiving proposals for Group Medical Benefits for School Board Employees; and

WHEREAS, AETNA is willing to provide such products and services to the SBBC; offered a proposal dated February 6, 2017 (hereinafter referred to as "Proposal") which is incorporated by reference herein, in response to RFP; and

WHEREAS, the SBBC and AETNA desire to memorialize the terms and conditions of this Agreement to include references to the Administrative Agreement, Standard Medical and Pharmacy Reports, Administrative Service Fees, Network Provider Discount, Claims Target, Pharmacy Definitions, Performance Guarantees - Medical and Pharmacy, respectively attached as Exhibits A – G to this Agreement.

NOW, THEREFORE, in consideration of the premises and of the mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties hereby agree as follows:

ARTICLE 1 – RECITALS

1.01 **Recitals.** The Parties agree that the foregoing recitals are true and correct and that such recitals are incorporated herein by reference.

ARTICLE 2 – SPECIAL CONDITIONS

2.01 **Term of Agreement.** Unless terminated earlier pursuant to Section 3.05 of this Agreement, the term of this Agreement shall commence on **January 1, 2018** and conclude on **December 31, 2020**. The term of the Agreement may by mutual agreement between SBBC and the Awardee, upon the Superintendent's Insurance & Wellness Advisory Committee's recommendation and Board approval be extended for two (2) additional one-year periods. If needed, upon SBBC's sole option after the initial or any one-year renewal option, an extension of 180 days beyond the expiration date of the renewal period at the same rates/fees as the previous twelve (12) months.

2.02 **Description of Goods or Services Provided**. AETNA shall provide the Administrative Services described in Exhibit A- Administrative Agreement, Exhibit B – Standard Medical and Pharmacy Reports, Exhibit C – Administrative Service Fees, Exhibit D – Network Provider Discount, Exhibit E – Claims Target, Exhibit F – Pharmacy Definitions, Guarantees and Performance Guarantees and Attachment G – Medical Performance Guarantees

2.03 **Benefits.** AETNA agrees to the following negotiated provisions:

- **Apple Watch**
  - AETNA agrees to fund a total of $72,000 over the term of the contract for the purpose of providing an incentive for benefit eligible employees to purchase an Apple Watch, which will assist them with managing their health and increasing member engagement. At SBBC's soles option, SBBC will determine criteria, incentive amount and launch date.
- **Wellness Coordinator**
  - AETNA agrees to provide SBBC with a dedicated Wellness Coordinator funded by AETNA in addition to other funding requirements, as outlined in the RFP. The location of the Wellness Coordinator to be determined by SBBC.
- **National Advantage Plan (NAP)** – SBBC agrees that for calendar year 2018, to include the NAP program for services that are provided by non-contracted facilities and non-contracted providers. In addition, on a quarterly basis, AETNA will provide SBBC, or its designee, mutually agreed upon data including but not limited to the claims dollars within these categories and the savings and fees that result from their participation in the NAP program. Annually, SBBC at its sole option, will opt in or opt out of the NAP program based on the prior year's reporting/savings.

- **Interactive Health Station Kiosks**
  - AETNA agrees to provide and fund three (3) Interactive Health Station Kiosks at a total annual cost of $14,800. Location of the Kiosks will be determined by SBBC.
- **Telehealth/Teledoc**
  - AETNA agrees to waive the twenty-cents per employee, per month fee.
- **Accountable Care Organization**
  - At the sole option of SBBC, as ACO's or other types of risk sharing arrangements are developed these will be presented to SBBC, including members potentially impacted and potential cost savings. SBBC, at its sole option will opt-in or opt-out for each such program.
- **Preauthorization/Step Therapy Formulary**
  - Any modifications within these programs will continue to be on an annual basis. Notification of changes must be at a minimum of 60 days in advance.
- **Wellness Initiatives**
  - AETNA agrees to fund an additional one-time $500,000 to be paid in two (2) installments within 2018 to be utilized for the establishment of incentives for Wellness Initiatives.
- **Retail Generic Discount Guarantee**
  - AETNA agrees to increase the Retail Generic Discount Guarantee rate as follows:
  - 2018 – Average Wholesale Price (AWP) -76.5%
  - 2019 – Average Wholesale Price (AWP) - 77%
  - 2020 - Average Wholesale Price (AWP) - 77.5%
- **Prescription Drug Market Check**
  - AETNA agrees to a market check in 2019. If this market check yields at least 1.5% gross savings in the marketplace, AETNA agrees to improve the pricing guarantees at a minimum, to equal or better this savings amount in 2020 refer to Exhibit F for additional details.
- **Specialty Medication**
  - AETNA agrees to allow SBBC's Benefits Consultant to review, provide and recommend changes and upon annual discussion and agreement implement changes, and amendments regarding criteria for specialty medication prior authorization protocols, based on industry norms.
- **Voluntary Maintenance Medications**
  - AETNA has included a 90-day retail fill, at CVS, for maintenance medications on a voluntary basis at the same copays as the mail order.

2.04 **M/WBE.** AETNA agrees to provide a scholarship in the amount of $20,000 per year for minority students. If SBBC exercises years four (4) and five (5) AETNA agrees to continue providing $20,000 for each of those years.

AETNA also agrees to spend $809,509 during the initial contract period, with identified minority vendors, as outlined in the RFP. If SBBC exercises years four (4) and five (5) AETNA agrees to spend $269,000 per each year towards minority vendors.

2.05 **Performance Guarantees**. AETNA agrees to place 20% of the annual Administrative Fees "at risk", for the Medical Performance Guarantees and additional $400,000 for the Pharmacy Performance Guarantees, outlined in Attachment R of the RFP.

2.06 **Claims Target/Network Guarantee/Discount Guarantee.** – AETNA agrees to increase the Network Guarantee to 70.01%, based the criteria, as outlined in Exhibits contained in this Agreement and the Medical Supplemental document contained in the RFP. Further, AETNA has placed a maximum of 40% At Risk for these guarantees.

2.07 **Cost of Services.** SBBC shall pay AETNA for services rendered under this Agreement, as outlined in Exhibit C contained in this Agreement. If SBBC exercises optional years four and five, AETNA further agrees not to exceed a 3% fee cap in said years. AETNA agrees to provide SBBC with 100 percent of SBBC rebates. AETNA agrees to provide the coordination of benefit services, as part of the ASO fees and will not charge a percentage of savings.

2.08 **Additional Documents.** SBBC and AETNA, desire to enter into an ASO (Exhibit "A") with AETNA. Exhibit A- Administrative Agreement, Exhibit B – Standard Medical and Pharmacy Reports, Exhibit C – Administrative Service Fees, Exhibit D – Network Provider Discount, Exhibit E – Claims Target, Exhibit F – Pharmacy Definitions, Guarantees and Performance Guarantees and Attachment G – Medical Performance Guarantees.

2.09 **Additional Options.** At SBBC sole option, SBBC may elect to offer the following benefits/products:

- Health Savings Accounts Administration
- Mandatory Mail Order for Maintenance Medications
- Transparency Tool

2.10 **Priority of Documents.** In the event of a conflict between documents, the following priority of documents shall govern.

First: The Agreement and its Exhibits A through G; then
Second: Addendum Number Three (dated, December 23, 2016); then
Third: Addendum Number Two (dated December 19, 2016); then
Fourth: Addendum Number One (dated December 6, 2016); then
Fifth: RFP 18-009V – "Group Medical Benefits for School Board Employees".

2.10.1 **Disputes.** In the event of any dispute or difference of opinion concerning the interpretation of the Agreement and any documents incorporated therein, the decision of SBBC shall be final and binding upon all parties.

2.11 **Inspection of AETNA Records by SBBC.** AETNA shall establish and maintain books, records and documents (including electronic storage media) sufficient to reflect all income and expenditures of funds provided by SBBC under this Agreement. All AETNA records,

regardless of the form in which they are kept, shall be open to inspection and subject to audit, inspection, examination, evaluation and/or reproduction, during normal working hours, by SBBC's agent or its authorized representative to permit SBBC to evaluate, analyze and verify the satisfactory performance of the terms and conditions of this Agreement and to evaluate, analyze and verify any and all invoices, billings, payments and/or claims submitted by AETNA or any of AETNA'S payees pursuant to this Agreement. AETNA Records subject to examination shall include, without limitation, those records necessary to evaluate and verify direct and indirect costs (including overhead allocations) as they may apply to costs associated with this Agreement. AETNA Records subject to this section shall include any and all documents pertinent to the evaluation, analysis, verification and reconciliation of any and all expenditures under this Agreement without regard to funding sources.

(a) AETNA Records Defined. For the purposes of this Agreement, the term "AETNA Records" shall include, without limitation, accounting records, payroll time sheets, cancelled payroll checks, W-2 forms, written policies and procedures, computer records, disks and software, videos, photographs, executed subcontracts, subcontract files (including proposals of successful and unsuccessful bidders), original estimates, estimating worksheets, correspondence, change order files (including sufficient supporting documentation and documentation covering negotiated settlements), and any other supporting documents that would substantiate, reconcile or refute any charges and/or expenditures related to this Agreement.

(b) Duration of Right to Inspect. For the purpose of such audits, inspections, examinations, evaluations and/or reproductions, SBBC's agent or authorized representative shall have access to *AETNA* Records from the effective date of this Agreement, for the duration of the term of this Agreement, and until the later of five (5) years after the termination of this Agreement or five (5) years after the date of final payment by SBBC to *AETNA* pursuant to this Agreement.

(c) Notice of Inspection. SBBC's agent or its authorized representative shall provide *AETNA* reasonable advance notice (not to exceed two (2) weeks) of any intended audit, inspection, examination, evaluation and or reproduction.

(d) Audit Site Conditions. SBBC's agent or its authorized representative shall have access to *the AETNA'S* facilities and to any and all records related to this Agreement, and shall be provided adequate and appropriate work space in order to exercise the rights permitted under this section.

(e) Failure to Permit Inspection. Failure by *AETNA* to permit audit, inspection, examination, evaluation and/or reproduction as permitted under this Section shall constitute grounds for termination of this Agreement by SBBC for cause and shall be grounds for the denial of some or all of any *AETNA* claims for payment by SBBC.

(f) Overcharges and Unauthorized Charges. If an audit conducted in accordance with this Section discloses overcharges or unauthorized charges to SBBC by *AETNA* in excess of two percent (2%) of the total billings under this Agreement, the actual cost of SBBC's audit shall be paid by *the AETNA*. If the audit discloses billings or charges to which *the AETNA*

is not contractually entitled, the *AETNA* shall pay said sum to SBBC within twenty (20) days of receipt of written demand under otherwise agreed to in writing by both parties.

(g) Inspection of Subcontractor's Records. *AETNA* shall require any and all subcontractors, insurance agents and material suppliers (hereafter referred to as "Payees") providing services or goods with regard to this Agreement to comply with the requirements of this section by insertion of such requirements in any written subcontract. Failure by *AETNA* to include such requirements in any subcontract shall constitute grounds for termination of this Agreement by SBBC for cause and shall be grounds for the exclusion of some or all of any Payee's costs from amounts payable by SBBC to *AETNA* pursuant to this Agreement and such excluded costs shall become the liability of *the AETNA*.

(h) Inspector General Audits. *AETNA* shall comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by the Florida Office of the Inspector General or by any other state or federal officials.

2.12 **Notice.** When any of the parties desire to give notice to the other, such notice must be in writing, sent by U.S. Mail, postage prepaid, addressed to the party for whom it is intended at the place last specified; the place for giving notice shall remain such until it is changed by written notice in compliance with the provisions of this paragraph. For the present, the Parties designate the following as the respective places for giving notice:

To SBBC:	Superintendent of Schools The School Board of Broward County, Florida 600 Southeast Third Avenue Fort Lauderdale, Florida 33301
With a Copy to:	Dr. Dildra Martin-Ogburn, Director Benefits & Employment Services 7770 W. Oakland Park Blvd. Sunrise, Florida 33051
To AETNA:	Chris Ciano, Market President 1340 Concord Terrace Sunrise, Florida 33323
With a Copy to:	Cathy Aguirre, Market Head Public & Labor Segment 1340 Concord Terrace Sunrise, Florida 33323

2.13 **BACKGROUND SCREENING.**

AETNA agrees to comply with all requirements of Sections 1012.32 and 1012.465, Florida Statutes, and all of its personnel who (1) are to be permitted access to school grounds when students are present, (2) will have direct contact with students, or (3) have access or control of school funds,

will successfully complete the background screening required by the referenced statutes and meet the standards established by the statutes. This background screening will be conducted by SBBC in advance of the AETNA or its personnel providing any services under the conditions described in the previous sentence. AETNA shall bear the cost of acquiring the background screening required by Section 1012.32, Florida Statutes, and any fee imposed by the Florida Department of Law Enforcement to maintain the fingerprints provided with respect to the AETNA and its personnel. The parties agree that the failure of AETNA to perform any of the duties described in this section shall constitute a material breach of this Agreement entitling SBBC to terminate immediately with no further responsibilities or duties to perform under this Agreement. To the extent permitted by law, AETNA agrees to indemnify and hold harmless SBBC, its officers and employees from any liability in the form of physical or mental injury, death or property damage resulting from AETNA'S failure to comply with the requirements of this Section or with Sections 1012.32 and 1012.465, Florida Statutes. Nothing herein shall be construed as a waiver by SBBC or AETNA of sovereign immunity or of any rights or limits to liability existing under Section 768.28, Florida Statutes.

2.14 **Insurance Requirements.**

(a) General Liability. Limits not less than $1,000,000 per occurrence for Bodily Injury/ Property Damage; $1,000,000 General Aggregate. Limits not less than $1,000,000 for Products/Completed Operations Aggregate.

(b) Worker's Compensation. Florida Statutory limits in accordance with Chapter 440; Employer's Liability limits not less than $100,000/$100,000/$500,000 (each accident/disease- each employee/disease-policy limit). Workers' Compensation Affidavit shall be required if less than four (4) employees and submit with Agreement.

(c) Professional Liability/Technical Errors & Omissions. Limits not less than $1,000,000 per occurrence covering services provided under this contract

(d) Auto Liability. Owned, Non-Owned and Hired Auto Liability with Bodily Injury and Property Damage limits of not less than $1,000,000 Combined Single Limit. If AETNA does not own any vehicles, hired and non-owned automobile liability coverage in the amount of $1,000,000 will be accepted. In addition, an affidavit signed by AETNA must be furnished to SBBC indicating the following: AETNA does not own any vehicles. In the event insured acquires any vehicles throughout the term of this agreement, insured agrees to provide proof of "Any Auto" coverage effective the date of acquisition.

(e) Acceptability of Insurance Carriers. The insurance policies shall be issued by companies qualified to do business in the State of Florida. The insurance companies must be rated at least A- VI by AM Best or Aa3 by Moody's Investor Service.

(f) Verification of Coverage. Proof of the required insurance must be furnished by an Awardee to SBBC Risk Management Department by Certificate of Insurance within 15 days of notification of award. All certificates (and any required documents) must be received and approved

by SBBC before any work commences to permit Awardee time to remedy any deficiencies. **FAX CERTIFICATES OF INSURANCE TO SBBC RISK MANAGEMENT AT 866-897-0424.**

(g) Required Conditions. Liability policies must contain the following provisions. In addition, the following wording must be included on the Certificate of Insurance: The School Board of Broward County, Florida, its members, officers, employees and agents are added as additional insured. All liability policies are primary of all other valid and collectable coverage maintained by The School Board of Broward County, Florida. (Certificate Holder: The School Board of Broward County, Florida, 600 Southeast Third Avenue, Fort Lauderdale, Florida 33301)

(h) Cancellation Of Insurance. AETNA's are prohibited from providing services under this contract with SBBC without the minimum required insurance coverage and must notify SBBC within two business days if required insurance is cancelled.

The School Board of Broward County, Florida reserves the right to review, reject or accept any required policies of insurance, including limits, coverage's or endorsements, herein throughout the term of this agreement.

2.15 **Payment Method.** AETNA agrees that SBBC will not pay convenience fees, surcharges, or any additional costs for payments made by electronic payment.

ARTICLE 3 – GENERAL CONDITIONS

3.01 **No Waiver of Sovereign Immunity.** Nothing herein is intended to serve as a waiver of sovereign immunity by any agency or political subdivision to which sovereign immunity may be applicable or of any rights or limits to liability existing under Section 768.28, Florida Statutes. This section shall survive the termination of all performance or obligations under this Agreement and shall be fully binding until such time as any proceeding brought on account of this Agreement is barred by any applicable statute of limitations.

3.02 **No Third Party Beneficiaries.** The parties expressly acknowledge that it is not their intent to create or confer any rights or obligations in or upon any third person or entity under this Agreement. None of the parties intend to directly or substantially benefit a third party by this Agreement. The parties agree that there are no third party beneficiaries to this Agreement and that no third party shall be entitled to assert a claim against any of the parties based upon this Agreement. Nothing herein shall be construed as consent by an agency or political subdivision of the State of Florida to be sued by third parties in any matter arising out of any contract.

3.03 **Independent Contractor.** The parties to this agreement shall at all times be acting in the capacity of independent contractors and not as an officer, employee or agent of one another. Neither party or its respective agents, employees, subcontractors or assignees shall represent to others that it has the authority to bind the other party unless specifically authorized in writing to do so. No right to SBBC retirement, leave benefits or any other benefits of SBBC employees shall exist as a result of the performance of any duties or responsibilities under this Agreement. SBBC shall not be responsible for social security, withholding taxes, contributions to

unemployment compensation funds or insurance for the other party or the other party's officers, employees, agents, subcontractors or assignees.

3.04 **Equal Opportunity Provision.** The parties agree that no person shall be subjected to discrimination because of age, race, color, disability, gender identity, gender expression marital status, national origin, religion, sex or sexual orientation in the performance of the parties' respective duties, responsibilities and obligations under this Agreement.

3.05 **Termination.** This Agreement may be canceled with or without cause by SBBC during the term hereof upon thirty (30) days written notice to the other parties of its desire to terminate this Agreement. SBBC shall have no liability for any property left on SBBC's property by any party to this Agreement after the termination of this Agreement. Any party contracting with SBBC under this Agreement agrees that any of its property placed upon SBBC's facilities pursuant to this Agreement shall be removed within ten (10) business days following the termination, conclusion or cancellation of this Agreement and that any such property remaining upon SBBC's facilities after that time shall be deemed to be abandoned, title to such property shall pass to SBBC, and SBBC may use or dispose of such property as SBBC deems fit and appropriate.

3.06 **Default.** The parties agree that, in the event that either party is in default of its obligations under this Agreement, the non-defaulting party shall provide to the defaulting party (30) days written notice to cure the default. However, in the event said default cannot be cured within said thirty (30) day period and the defaulting party is diligently attempting in good faith to cure same, the time period shall be reasonably extended to allow the defaulting party additional cure time. Upon the occurrence of a default that is not cured during the applicable cure period, this Agreement may be terminated by the non-defaulting party upon thirty (30) days' notice. This remedy is not intended to be exclusive of any other remedy, and each and every such remedy shall be cumulative and shall be in addition to every other remedy now or hereafter existing at law or in equity or by statute or otherwise. No single or partial exercise by any party of any right, power, or remedy hereunder shall preclude any other or future exercise thereof. Nothing in this section shall be construed to preclude termination for convenience pursuant to Section 3.06.

3.07 **Annual Appropriation.** The performance and obligations of SBBC under this Agreement shall be contingent upon an annual budgetary appropriation by its governing body. If SBBC does not allocate funds for the payment of services or products to be provided under this Agreement, this Agreement may be terminated by SBBC at the end of the period for which funds have been allocated. SBBC shall notify the other party at the earliest possible time before such termination. No penalty shall accrue to SBBC in the event this provision is exercised, and SBBC shall not be obligated or liable for any future payments due or any damages as a result of termination under this section.

3.08 **Excess Funds.** Any party receiving funds paid by SBBC under this Agreement agrees to promptly notify SBBC of any funds erroneously received from SBBC upon the discovery of such erroneous payment or overpayment. Any such excess funds shall be refunded to SBBC.

3.09 **Public Records**: The following provisions are required by Section 119.0701, Florida Statutes, and may not be amended. AETNA shall keep and maintain public records required by SBBC to perform the services required under this Agreement. Upon request from SBBC's custodian of public records, AETNA shall provide SBBC with a copy of any requested public records or to allow the requested public records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law. AETNA shall ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the Agreement's term and following completion of the Agreement if AETNA does not transfer the public records to SBBC. Upon completion of the Agreement, AETNA shall transfer, at no cost, to SBBC all public records in possess-ion of AETNA or keep and maintain public records required by SBBC to perform the services required under the Agreement. If AETNA transfer all public records to SBBC upon completion of the Agreement, AETNA shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If AETNA keeps and maintains public records upon completion of the Agreement, Insert Name shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to SBBC, upon request from SBBC's custodian of public records, in a format that is compatible with SBBC 's information technology systems.

3.10 **Student Records.** Notwithstanding any provision to the contrary within this Agreement, any party contracting with SBBC under this Agreement shall fully comply with the requirements of Sections 1002.22 and 1002.221, Florida Statutes; FERPA, and any other state or federal law or regulation regarding the confidentiality of student information and records. Each such party agrees, for itself, its officers, employees, agents, representatives, contractors or subcontractors, to fully indemnify and hold harmless SBBC and its officers and employees for any violation of this section, including, without limitation, defending SBBC and its officers and employees against any complaint, administrative or judicial proceeding, payment of any penalty imposed upon SBBC, or payment of any and all costs, damages, judgments or losses incurred by or imposed upon SBBC arising out of a breach of this covenant by the party, or an officer, employee, agent, representative, contractor, or sub-contractor of the party to the extent that the party or an officer, employee, agent, representative, contractor, or sub-contractor of the party shall either intentionally or negligently violate the provisions of this section or of Sections 1002.22 and/or 1002.221, Florida Statutes.

3.11 **Compliance with Laws.** Each party shall comply with all applicable federal state and local laws, SBBC policies codes, rules and regulations in performing its duties, responsibilities and obligations pursuant to this Agreement.

3.12 **Place of Performance.** All obligations of SBBC under the terms of this Agreement are reasonably susceptible of being performed in Broward County, Florida and shall be payable and performable in Broward County, Florida.

3.13 **Governing Law and Venue.** This Agreement shall be interpreted and construed in accordance with and governed by the laws of the State of Florida. Any controversies or legal problems arising out of this Agreement and any action involving the enforcement or

interpretation of any rights hereunder shall be submitted to the jurisdiction of the State courts of the Seventeenth Judicial Circuit of Broward County, Florida.

3.14 **Entirety of Agreement.** This document incorporates and includes all prior negotiations, correspondence, conversations, agreements and understandings applicable to the matters contained herein and the parties agree that there are no commitments, agreements or understandings concerning the subject matter of this Agreement that are not contained in this document. Accordingly, the parties agree that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written.

3.15 **Binding Effect.** This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

3.16 **Assignment.** Neither this Agreement nor any interest herein may be assigned, transferred or encumbered by any party without the prior written consent of the other party. There shall be no partial assignments of this Agreement including, without limitation, the partial assignment of any right to receive payments from SBBC.

3.17 **Incorporation by Reference.** **Exhibits A-G,** attached hereto and referenced herein shall be deemed to be incorporated into this Agreement by reference.

3.18 **Captions.** The captions, section designations, section numbers, article numbers, titles and headings appearing in this Agreement are inserted only as a matter of convenience, have no substantive meaning, and in no way define, limit, construe or describe the scope or intent of such articles or sections of this Agreement, nor in any way affect this Agreement and shall not be construed to create a conflict with the provisions of this Agreement.

3.19 **Severability.** In the event that any one or more of the sections, paragraphs, sentences, clauses or provisions contained in this Agreement is held by a court of competent jurisdiction to be invalid, illegal, unlawful, unenforceable or void in any respect, such shall not affect the remaining portions of this Agreement and the same shall remain in full force and effect as if such invalid, illegal, unlawful, unenforceable or void sections, paragraphs, sentences, clauses or provisions had never been included herein.

3.20 **Preparation of Agreement.** The parties acknowledge that they have sought and obtained whatever competent advice and counsel as was necessary for them to form a full and complete understanding of all rights and obligations herein and that the preparation of this Agreement has been their joint effort. The language agreed to herein expresses their mutual intent and the resulting document shall not, solely as a matter of judicial construction, be construed more severely against one of the parties than the other.

3.21 **Amendments.** No modification, amendment, or alteration in the terms or conditions contained herein shall be effective unless contained in a written document prepared with the same or similar formality as this Agreement and executed by each party hereto.

3.22 **Waiver.** The parties agree that each requirement, duty and obligation set forth herein is substantial and important to the formation of this Agreement and, therefore, is a material term hereof. Any party's failure to enforce any provision of this Agreement shall not be deemed a waiver of such provision or modification of this Agreement unless the waiver is in writing and

signed by the party waiving such provision. A written waiver shall only be effective as to the specific instance for which it is obtained and shall not be deemed a continuing or future waiver.

3.23 **Force Majeure.** Neither party shall be obligated to perform any duty, requirement or obligation under this Agreement if such performance is prevented by fire, hurricane, earthquake, explosion, wars, sabotage, accident, flood, acts of God, strikes, or other labor disputes, riot or civil commotions, or by reason of any other matter or condition beyond the control of either party, and which cannot be overcome by reasonable diligence and without unusual expense ("Force Majeure"). In no event shall a lack of funds on the part of either party be deemed Force Majeure.

3.24 **Survival.** All representations and warranties made herein, indemnification obligations, obligations to reimburse SBBC, obligations to maintain and allow inspection and audit of records and property, obligations to maintain the confidentiality of records, reporting requirements, and obligations to return public funds shall survive the termination of this Agreement.

3.25 **Contract Administration.** SBBC has delegated authority to the Superintendent of Schools or his/her designee to take any actions necessary to implement and administer this Agreement.

3.26 **Liability.** This section shall survive the termination of all performance or obligations under this Agreement and shall be fully binding until such time as any proceeding brought on account of this Agreement is barred by any applicable statute of limitations.

A. By SBBC: SBBC agrees to be fully responsible up to the limits of Section 768.28, Florida Statutes, for its acts of negligence, or its employees' acts of negligence when acting within the scope of their employment and agrees to be liable for any damages resulting from said negligence.

B. By AETNA: AETNA agrees to indemnify, hold harmless and defend SBBC, its agents, servants and employees from any and all claims, judgments, costs, and expenses including, but not limited to, reasonable attorney's fees, reasonable investigative and discovery costs, court costs and all other sums which SBBC, its agents, servants and employees may pay or become obligated to pay on account of any, all and every claim or demand, or assertion of liability, or any claim or action founded thereon, arising or alleged to have arisen out of the products, goods or services furnished by AETNA, its agents, servants or employees; the equipment of AETNA, its agents, servants or employees while such equipment is on premises owned or controlled by SBBC; or the negligence of AETNA or the negligence of AETNA'S agents when acting within the scope of their employment, whether such claims, judgments, costs and expenses be for damages, damage to property including SBBC's property, and injury or death of any person whether employed by AETNA, SBBC or otherwise.

3.27 **Authority.** Each person signing this Agreement on behalf of either party individually warrants that he or she has full legal power to execute this Agreement on behalf of the party for whom he or she is signing, and to bind and obligate such party with respect to all provisions contained in this Agreement.

IN WITNESS WHEREOF, the Parties hereto have made and executed this Agreement on the date first above written.

FOR SBBC

(Corporate Seal)

ATTEST:

Robert W. Runcie, Superintendent of Schools

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

By
Abby M. Freedman, Chair

Approved as to Form and Legal Content:

08/21/17
Office of the General Counsel

FOR AETNA

(Corporate Seal)

AETNA LIFE INSURANCE COMPANY

ATTEST:

By _____
Christopher Ciano, Market President

_____
, Secretary

-or-

_____
Witness

_____
Witness

The Following Notarization is Required for Every Agreement Without Regard to Whether the Party Chose to Use a Secretary's Attestation or Two (2) Witnesses.

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me this 18th day of August, 2017 by **Christopher Ciano** of AETNA, on behalf of the corporation/agency.

He/She is personally known to me or produced _____ as identification and did/did not first take an oath.
Type of Identification

My Commission Expires:

_____
Signature – Notary Public

(SEAL)

RUTH ZAFRA
Notary Public - State of Florida
Commission # GG 053923
My Comm. Expires Dec 8, 2020

Ruth Zafra
Printed Name of Notary

GG 053923
Notary's Commission No.

EXHIBIT A
ADMINISTRATIVE SERVICES

This Administrative Services Exhibit A (this "Exhibit") is effective the 1ST day of January 2018, (the "Effective Date") by and among The School Board of Broward County, Florida ("Plan Sponsor") the Plan Sponsor of one or more self-funded employee health and welfare benefits plan(s), and Aetna Health Care of Florida, Inc. and Aetna Life Insurance Company ("Health Plan," "Administrative Services Provider," or "ASP)."

WHEREAS, Plan Sponsor has established the Plan to provide for the direct payment of covered health care benefits to Employees (as defined below) and their eligible dependents; and

WHEREAS, the Plan Sponsor desires ASP to provide and ASP desires to provide certain administrative services for the Plan, as more fully set forth in this Exhibit.

NOW, THEREFORE, intending to be legally bound hereby, the parties to this Exhibit agree as follows:

Definitions. The following terms, whether used in the singular or plural, shall have the meanings set forth below when used in this Exhibit.

1.1. "Beneficiary" means each person covered under the terms of the Plan, including an Employee and his or her dependents, as determined by Plan Sponsor in accordance with the Plan and this Exhibit.

1.2. "Covered Services" means those health care benefits for which Plan Sponsor is obligated to pay or indemnify pursuant to the Plan that are provided while this Exhibit is in effect and received by ASP while this Exhibit was in effect or during the Run-Out Period, as referenced in SPD.

1.3. "Employee" means Plan Sponsor's active and retired employees, over age dependents, COBRA participants, employees on approved Leave of Absence and Kids Plan subscribers.

1.4. "Network Provider" means a Provider who has: (i) met ASP's credentialing and recredentialing standards; (ii) contracted as an independent contractor directly or indirectly with ASP or through an affiliate; (iii) agreed to accept the rate or amount agreed to with ASP as payment in full for Covered Services provided to eligible Beneficiaries subject to applicable copayments, coinsurance and deductibles; and (iv) agreed to cooperate with ASP regarding Quality Improvement and Utilization Review procedures incident to the services.

1.5. "Non-Network Provider" means a Provider who has not contracted directly or indirectly with ASP, or through an affiliate, to provide Covered Services to eligible beneficiaries of Plan Sponsors of ASP.

1.6. "Plan" shall refer to the self-funded employee health and welfare benefits plan(s) sponsored by Plan Sponsor for which ASP provider the administrative services set forth in this Exhibit.

1.7. "Plan Administrator" is the person, committee or entity designated by Plan Sponsor to administer the Plan. The Plan Sponsor shall serve as Plan Administrator if no Plan Administrator has been formally designated by Plan Sponsor.

1.8. "Provider" means an individual or entity providing Covered Services who is a duly licensed physician or other health care professional, or a hospital or other facility or ancillary services provider properly licensed to provide Covered Services. Provider may refer to a Network Provider or Non-Network Provider, as applicable.

1.9. " Records" for purposes of an audit as described in Section 2.7 shall mean all claims and eligibility data and internal policies and procedures used for determining appropriate claims determinations.

1.10. "Run-Out Period" shall mean the three hundred sixty-five (365) day period following the day that this Exhibit terminates in accordance with the terms and conditions set forth herein with no charge to SBBC.

1.11. "Summary Plan Description/Plan Document" or "SPD" means the written description of the Plan and any amendment thereto as required by and in accordance with State and/or Federal legislation.

Duties of Plan Sponsor.

2.1 Plan Fiduciary Responsibility. Plan Sponsor understands and agrees that it and the Plan Sponsor shall be fully responsible for Plan design, and the terms of the Plan will determine how ASP pays the Covered Services provided under the Plan. Plan Sponsor will comply with all legal requirements applicable to the Plan and satisfy any and all reporting, notice, disclosure, and filing requirements imposed by applicable laws and regulations, including but not limited to: PPACA; the Internal Revenue Code; and HIPAA.

Plan Sponsor acknowledges that Plan compliance shall include, but not be limited to, the following:

2.1.1 Preparation and /or review of all required plan documentation, including, but not limited to, the Summary Plan Descriptions;

2.1.2. Advising Beneficiaries of their rights under any federal, state or local law, and the preparation and distribution of any notices, except for Certificates of Creditable Coverage, required to be distributed under such laws; and

2.1.3. Preparation distribution and filing of all reports required under any federal, state or local law.

2.2 Eligibility Information. The Plan Sponsor has established the eligibility requirements for participation of Beneficiaries in the Plan, which are described in the Plan document. Plan Sponsor will provide eligibility and other necessary Plan data to ASP in a format mutually agreed upon by the parties. During the term of Exhibit, Plan Sponsor shall notify ASP in writing at least ninety (90) days in advance of any change and ASP shall notify Plan Sponsor whether it can administer such change within thirty (30) days of such notice. The right to change eligibility requirement is reserved

solely to the discretion of the Plan Sponsor, provided such requirements are permitted by applicable law, rule and regulation. Provided further, ASP is not required to implement any changes unless Plan Sponsor notifies ASP of any changes within the required time period.

Notwithstanding any other term or condition in Exhibit, Plan Sponsor shall only add or terminate Beneficiaries in accordance with the eligibility requirements of the Plan and ASP shall not be required to pay claims for any persons who ASP reasonably determines do not qualify as Beneficiaries under the Plan.

2.3 Distribution of Information. The Plan Sponsor shall be responsible for coordinating the distribution to Beneficiaries all information and forms necessary for enrollment, continued eligibility and for Covered Services under the Plan within a reasonable period of time or as required by State and/or Federal law before coverage begins.

2.4 Discounts and Rebates. Plan Sponsor understands and warrants that it will disclose to Beneficiaries that Beneficiaries' coinsurance and other payments to Network Providers may be based on an approved rate schedule, but that such rates may not represent the compensation ultimately retained or received by Network Providers from ASP. Such compensation is determined on the basis of a particular Network Provider's agreement with ASP and may be an amount less than the approved rate. Further, Plan Sponsor understands and agrees that ASP may receive a retrospective discount or rebate from a Network Provider or vendor related to the volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by ASP and its affiliates. Plan Sponsor further understands and agrees that it shall not share in such retrospective volume-based discounts or rebates, except as otherwise stated in Exhibits of this Agreement.

2.5 Sufficient Funds. The Plan Sponsor shall be responsible for providing sufficient funds for the payment of Covered Services under the terms of the Plan, payment of Administrative Services Fees and any other amounts due to ASP, all as further described in this Exhibit. Plan Sponsor acknowledges that ASP has no obligation to use its own funds to pay for Covered Services provided under the Plan.

2.6 Control of Plan Assets. Plan Sponsor shall have absolute authority with respect to the control, management, investment, disposition and utilization of Plan assets solely as permitted in accordance with applicable State and Federal law, and ASP shall neither have nor be deemed to exercise any discretion, control or authority with respect to the disposition of Plan assets.

2.7 Independent Audit. ASP allows independent audits of relevant records and documentation by Plan Sponsor and their representatives, provided no audit interferes with ASP business operations or the confidential interests of our company or another party. ASP has assumed for the purpose of this Exhibit that an "audit" is defined as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations and shall be subject to a mutual agreement as to nature, scope, format, structure and cost. ASP works from established audit guidelines that are accepted in this industry.

In addition ASP will allow access to full Medical claims audit, at ASP expense, if significant performance issues are discovered within the independent audit.

ASP is providing Plan Sponsor with an annual allowance of $50,000 to be used for the Pharmacy review process and audit expenses. Payment will be made to third party vendor(s) upon receipt of invoices for the appropriate expenses. Any unused allowance monies at the end of each contract year will be forfeited. Any fees that exceed $50,000 annually will be the responsibility of Plan Sponsor.

Audits of Pharmacy Rebates

ASP allows Plan Sponsor to have a mutually agreed upon third party auditor to conduct a rebate audit. An audit of this type is subject to the appropriate confidentiality agreement and audit request forms be executed between the parties before the commencement of the audit. ASP will make every effort to provide your third party auditor with information sufficient to confirm the payments to you are accurate.

2.8.1 General

2.8.1.1 Generally. ASP agrees to execute Plan Sponsors Business Associate Agreement. Plan Sponsor duly-authorized representatives may be requested to execute a Non-Disclosure Agreement to conduct audits and audit all Records in accordance herewith. The selection of any audit representatives shall be made solely by Plan Sponsor. Plan Sponsor and its representatives shall have the right to make copies of any Records at its expense, subject to the confidentiality provisions set forth in this Section and after the removal of any patient identifiers. ASP shall provide reasonable workspace to Plan Sponsor representatives.

2.8.1.2 Limitations on Audits. All audits shall be initiated within two (2) years from the settlement dates of the claims being audited but in no event more than one (1) year after the termination of this Agreement. Notwithstanding the foregoing, the parties acknowledge and agree that any claim for overpayment shall only be made in accordance with the timeframes required under Florida law. For medical claims, audits will involve stratification of the claims population with claims being randomly selected from the total population of claims incurred and/or processed during the audit period. The total number of claims selected will not exceed two hundred fifty (250) claims in number and results will be extrapolated to the total population. Pharmacy claims audits will be conducted electronically or onsite and will involve a review of the entire population of claims.

2.8.1.3 Confidentiality with Respect to Audits. Plan Sponsor and its representatives shall utilize information learned directly through audits only for the purposes of Plan Sponsor's own Plan. Neither Plan Sponsor nor its representatives shall sell, give, or otherwise transmit information regarding ASP's business learned through audits to any other entity without the prior written consent of ASP. Plan Sponsor shall require that its audit representatives not release any information that would jeopardize ASP's responsibility to safeguard the confidentiality rights of Beneficiaries. Information released by Plan Sponsor auditors to Plan Sponsor shall be released only in an aggregated form which does not allow direct or indirect identification of any Beneficiary. This clause shall not limit ASP's obligation to notify Plan Sponsor of

potential or suspected fraud on the part of a Beneficiary except where prohibited by applicable law.

2.8.1.4 ASP's Support of Audits. ASP shall reasonably support all audits conducted by Plan Sponsor audit representatives under this Section (Audits) and shall exert its best efforts to furnish Plan Sponsor authorized representatives with access to all Records requested by its authorized representatives, including underlying provider, third party administrator, hospital and other like contracts, files and computer data ("Supporting Documentation"). ASP shall exert its best efforts to furnish such Supporting Documentation to Plan Sponsor within fifteen (15) calendar days after Plan Sponsor requests such Records in writing. Such Supporting Documentation shall not be used for any purpose other than the audit. Plan Sponsor and its representatives shall have the right to make copies of any Records at its expense, subject to the confidentiality provisions set forth in this Section (Confidentiality with Respect to Audits). ASP shall bear its internal expenses associated with a standard audit. In addition, ASP will allow access to full Medical claims audit, at ASP expense, if significant performance issues are discovered within the independent audit.

ASP is providing Plan Sponsor with an annual allowance of $50,000 to be used for the Pharmacy review process and audit expenses. Payment will be made to third party vendor(s) upon receipt of invoices for the appropriate expenses. Any unused allowance monies at the end of each contract year will be forfeited. Any fees that exceed $50,000 annually will be the responsibility of Plan Sponsor.

2.8.1.5 **AUDIT RIGHTS**

(A) General Guidelines - An "audit" is defined as performing a detailed review of health claim transactions for the purpose of assessing the accuracy of benefit determinations. Audits must be commenced within two (2) years following the period being audited. Audits must be performed at the location where Plan Sponsor's claims are processed.

Any requested payment from ASP resulting from the audit must be based upon documented findings, agreed to by both parties, and must be due to ASP's actions or inactions.

(B) Auditor Qualifications and Requirements – Plan Sponsor will utilize individuals to conduct audits on its behalf who are qualified by appropriate training and experience for such work, and will perform its review in accordance with published administrative safeguards or procedures and applicable law against unauthorized use or disclosure (in the audit report or otherwise) of any individually identifiable information. Plan Sponsor and such individuals will not make or retain any record of provider negotiated rates included in the audited transactions, or payment identifying information concerning treatment of drug or alcohol abuse, mental/nervous or HIV/AIDS or genetic markers, in connection with any audit. ASP reserves the right to refuse to allow an auditor to conduct an audit in the event ASP determines the auditor has a conflict of interest. Determination of the nature of a

conflict of interest shall be in the sole discretion of ASP. A conflict of interest includes (but is not limited to) a situation in which the audit agent (a) is employed by an entity which is a competitor of ASP; or (b) has terminated from ASP within the past 12 months; or (c) is affiliated with a vendor subcontracted by ASP to adjudicate claims. The audit firm in complying with state licensure requirements or professional standards with Auditing professional groups (e.g. American Institute of Certified Public Accountants) will meet ASP's standard for professionalism. If the audit firm is not licensed, or a member of a national professional group or if audit firm has a financial interest in audit findings or results, the audit agent will agree by signature to ASP's Code of Conduct in performing the audit.

(C) Audit Coordination - Plan Sponsor will provide reasonable advance notice of its intent to audit and will complete an Audit Request Form providing information reasonably requested by ASP. Further, Plan Sponsor or its representative will provide ASP at least four (4) weeks in advance of the desired audit date, with a complete and accurate listing of the transactions to be pulled for the audit, and with identification of the potential auditor. Notification requirements may exceed four weeks for unusual audit requests, including but not limited to audits involving large sample sizes (e.g., greater than 250 transactions). No audit may commence until the Audit Request Form is completed and executed by the Plan Sponsor, the auditor, and ASP.

(D) Identification of Audit Sample - The sample must be based on a statistical random sampling methodology (e.g., systematic random sampling, simple random sampling, stratified random sampling). ASP reserves the right to review and approve the sample size, the objectives of the audit and the sampling methodology proposed by the auditors.

(E) Closing Meeting - The auditors will provide their draft audit findings to ASP, in writing, and auditors shall discuss their draft audit findings with ASP at this stage of the audit process.

(F) Audit Reports - ASP will have a right to receive the final Audit Report. ASP shall have the right to include with the final Audit Report a supplementary statement containing supporting documentation and materials that ASP considers pertinent to the audit.

2.8.1.6 RECOVERY OF OVERPAYMENTS

The parties will cooperate fully to make reasonable efforts to recover overpayments of Plan benefits. If it is determined that any payment has been made by ASP to or on behalf of an ineligible person or if it is determined that more than the appropriate amount has been paid, ASP shall undertake good faith efforts to recover the erroneous payment. For the purpose of this provision, "good faith efforts" constitute ASP's outreach to the responsible party via letter, phone, email or other means to attempt to recover the payment at issue. If those efforts are unsuccessful in obtaining recovery, ASP may use an outside vendor, collection agency or attorney to pursue recovery unless the Plan Sponsor directs otherwise. With respect to contracted providers, ASP may withhold the applicable overpayment amount from subsequent payments to the provider to the extent permitted by law, contract,

and system capabilities. Except as stated in this section, ASP has no other obligation with respect to the recovery of overpayments.

Overpayment recoveries made through third party recovery vendors, collection agencies, or attorneys are credited to Plan Sponsor net of fees charged by ASP or those entities. If such recovery are due to ASP's overpayment, then no fees will be charged to Plan Sponsor.

Overpayments must be determined by direct proof of specific claims. Indirect or inferential methods of proof — such as statistical sampling, extrapolation of error rate to the population, etc. — may not be used to determine overpayments. In addition, application of software or other review processes that analyze claims in a manner different from the claim determination and payment procedures and standards used by ASP may not be used to determine overpayments.

Plan Sponsor may not seek collection, or use a third party to seek collection, of benefit payments or overpayments from contracted providers, since all such recoveries are subject to the terms and provisions of the providers' proprietary contracts with ASP. For the purpose of determining whether a provider has or has not been overpaid, Plan Sponsor agrees that the rates paid to contracting providers for covered services shall be governed by ASP's contracts with those providers, and shall be effective upon the loading of those contract rates into ASP's systems, but no later than three (3) months after the effective date of the providers' contracts.

Plan Sponsor may not seek collection, or use a third party to seek collection, of benefit payments or overpayments from parties other than contracted providers described above, until ASP has had a reasonable opportunity to recover the overpayments. ASP must confirm all overpayments before collection by a third party may commence. Plan Sponsor may be charged for additional ASP expenses incurred in overpayment confirmation.

2.8.2. Specific Audit Areas

2.8.2.1 Performance Guarantee Audits. Plan Sponsor and/or its duly-authorized representatives shall have the right, upon forty-five (45) days' advance notice to ASP, to conduct performance guarantee with regards to reported metrics, financial accuracy and other areas as outlined in Exhibit G of this Agreement. Such audits are to be conducted during normal business hours of Records that are normally kept at ASP's Claims processing offices. ASP shall provide workspace to Plan Sponsor and/or duly-authorized representatives. The selection of any audit representatives shall be made solely by Plan Sponsor.

2.8.2.2 In-Depth Audits. If, based upon the results of the audits described in Section 2.8.2.1 (Performance Guarantee Audits), or ASP's internal audits, Plan Sponsor reasonably determines that more in-depth audits are required, ASP shall permit Plan Sponsor and/or its authorized representatives to perform such an in-depth audit. Plan Sponsor shall have sole discretion in selecting a representative to conduct an in-depth audit. In the event that the in-depth audit is requested because prior audits revealed that (1) ASP's performance falls below the financial or nine-eight and one half percentage points (98.5%) accuracy performance targets by at least one and one half percentage

points (1.5%) or below two and one half percentage points (2.5%) for procedural or combined accuracy for more than one quarter in a twelve (12)-month period, or (2) ASP has overpaid claims in dollar value by at least two and one quarter percent (2.25%) for the sample of claims audited by Plan Sponsor. ASP will make reasonable recovery efforts as set forth in Section 2.8.1.6 above. Such in-depth audits shall not occur more frequently than two (2) times in a calendar year, unless deficiencies identified during an in-depth audit are not promptly cured by ASP.

2.8.2.3 Pharmacy Audits. Within twelve months after the end of each Contract Year hereunder, Plan Sponsor, may audit ASP's records of Claims adjudicated during the prior Contract Year. ASP shall make available to Plan Sponsor's auditor, any and all financial records containing Plan Sponsor's information and such other records as reasonably necessary for auditor to confirm that the amounts paid by Plan Sponsor are the cost to ASP on the day the Covered Drug was dispensed. Plan Sponsor agrees to not use as its auditors, any person or entity which, in the sole discretion of ASP, is a competitor of ASP, a pharmaceutical manufacturer representative, or any other person or entity which has a conflict of interest with ASP. Plan Sponsor auditing representatives understand that ASP's contracts with pharmaceutical manufacturers, Participating Pharmacies, and other third parties may contain non-disclosure provisions, and hereby agrees to comply with such non-disclosure provisions. Plan Sponsor's auditor shall execute a conflicts of interest disclosure and confidentiality agreement with ASP prior to the audit. Audits shall only be made during normal business hours following thirty (30) days written notice, be conducted without undue interference to ASP's business activity, and in accordance with reasonable audit practices. Plan Sponsor's auditor may inspect ASP's contracts with Participating Pharmacies and pharmaceutical manufacturers at ASP's offices only, and no copies of such contracts may be removed from ASP's offices.

2.8.3. Result of Audits

2.8.3.1 Review of Audit Findings. After any audit is completed, a draft of the audit findings will be sent to ASP, in writing, ASP shall have the right to review a draft of the audit findings, discuss audit findings and provided written comments on those findings, within twenty (20) business days, or within such time period as is mutually agreed upon by the parties. ASP will have a right to receive the final Audit Report. ASP shall have the right to include with the final Audit Report a supplementary statement containing supporting documentation and materials that ASP considers pertinent to the audit.

2.8.3.2 Modifications to Payment System. ASP shall make the necessary modifications to its claims administration process in order to correct any specific deficient performance under this Agreement identified in the audits and to satisfy Plan Sponsor as to the implementation of such modifications, all at no additional charge to Plan Sponsor.

2.8.3.3. Recovery of Overpayments. The parties will cooperate fully to make reasonable efforts to recover overpayments of Plan benefits. If it is determined that any payment has been made by ASP to or on behalf of an ineligible person or if it is determined that more than the appropriate amount has been paid, ASP shall undertake good faith efforts to recover the erroneous payment. For the purpose of this provision, "good faith efforts" constitute ASP's outreach to the responsible party via letter, phone, email or other means to attempt to recover the payment at issue. If those efforts are unsuccessful in obtaining recovery, ASP may use an outside vendor, collection agency or attorney to pursue recovery unless the Plan Sponsor directs otherwise. With respect to contracted providers, ASP may withhold the applicable overpayment amount from subsequent payments to the provider to the extent permitted by law, contract, and system capabilities. Except as stated in this section, ASP has no other obligation with respect to the recovery of overpayments.

Overpayment recoveries made through third party recovery vendors, collection agencies, or attorneys are credited to Plan Sponsor net of fees charged by ASP or those entities. If such recovery are due to ASP's overpayment, then no fees will be charged to Plan Sponsor.

Overpayments must be determined by direct proof of specific claims. Indirect or inferential methods of proof — such as statistical sampling, extrapolation of error rate to the population, etc. — may not be used to determine overpayments. In addition, application of software or other review processes that analyze claims in a manner different from the claim determination and payment procedures and standards used by ASP may not be used to determine overpayments.

Plan Sponsor may not seek collection, or use a third party to seek collection, of benefit payments or overpayments from contracted providers, since all such recoveries are subject to the terms and provisions of the providers' proprietary contracts with ASP. For the purpose of determining whether a provider has or has not been overpaid, Plan Sponsor agrees that the rates paid to contracting providers for covered services shall be governed by ASP's contracts with those providers, and shall be effective upon the loading of those contract rates into ASP's systems, but no later than three (3) months after the effective date of the providers' contracts.

Plan Sponsor may not seek collection, or use a third party to seek collection, of benefit payments or overpayments from parties other than contracted providers described above, until ASP has had a reasonable opportunity to recover the overpayments. ASP must confirm all overpayments before collection by a third party may commence. Plan Sponsor may be charged for additional ASP expenses incurred in overpayment confirmation.

Duties of ASP.

3.1 **Administrative Services.** ASP shall perform the administrative services set forth in this Exhibit (the "Administrative Services") in accordance with the reasonable exercise of its business judgment and all applicable statutory and regulatory requirements. Plan Sponsor shall cooperate with ASP's performance of these administrative services. Plan Sponsor shall at all times retain ultimate control over the assets and operations of the Plan and final responsibility for the obligations of the Plan imposed by law, except as expressly delegated in this Exhibit .

ASP shall not be required to provide Administrative Services under this Exhibit, which relates to health care services provided to Beneficiaries prior to the Effective Date or after the termination date of the Agreement.

3.2 **Plan Documents**. Plan Sponsor is responsible for the design and development of the Covered Services. ASP will draft such initial documents as Plan Sponsor may request, such as the Summary of Benefits and Coverage, Summary Plan Description, Identification Cards, Enrollment Kits, and Covered Individual Reimbursement Forms. The Plan Sponsor shall notify ASP in writing of its approval of these documents or shall make any changes and provide final changes to ASP at least thirty (30) days prior to the Effective Date. If the Plan Sponsor makes material changes to such documents in a manner that may affect ASP's administration of the Plan, Plan Sponsor shall obtain ASP agreement to administer such changes, which agreement shall not be unreasonably withheld. Failure of the Plan Sponsor to object in writing to the documents provided by ASP within thirty (30) days of delivery of such documents will constitute Plan Sponsor's approval of the documents and the content of the documents.

Plan Sponsor understands and agrees that as of the date of this Agreement, material changes to the Plan, other than those required by law, may only be made at the Plan year renewal or upon sixty (60) days prior notice to Beneficiaries.

3.3 **Provider Contracting Services.** ASP shall arrange for the reasonable availability of Covered Services from Network Providers. Network Providers shall be contractually obligated to meet ASP's credentialing standards, including, but not limited to maintenance of licensure and malpractice insurance.

3.4 **Reports to Plan Sponsor.** ASP shall provide Plan Sponsor with such of ASP's standard reports as are listed in Exhibit B to this Agreement at the rates, if any, set forth in Exhibit C Any other reports and their costs shall be provided for a mutually-agreed price determined by the parties.

3.5 **Coverage Verification.** ASP shall develop and maintain Beneficiary and provider files to permit eligibility verification, rate and provider compensation computations, claims adjudication and efficient and timely response to inquiries from Beneficiaries and Providers. ASP may rely on information regarding the eligibility of Beneficiaries provided by Plan Sponsor. Notwithstanding anything herein to the contrary, Plan Sponsor shall be responsible for determining eligibility, or leave of absence for Beneficiaries which are active employees and their dependents ASP shall be responsible for billing overage dependents, COBRA, retiree and their Dependents and providing appropriate notices with respect to continuation of coverage following the occurrence of qualifying events under COBRA, if applicable.

3.6 **Telephone Access**. ASP shall establish and maintain adequate telephone lines and staff responsible for receiving and responding to inquiries and problems relating to Beneficiaries and services of providers to Beneficiaries under the Plan.

3.7 **Quality Improvement and Utilization Review**. ASP shall maintain systems and procedures necessary or appropriate for the operation of a reasonable and appropriate utilization review and quality improvement programs.

3.8 **Delegation of Claims Processing/Payment Services**. Plan Sponsor hereby delegates to ASP the responsibility and full discretionary authority for the interpretation of coverage of benefits (Covered Services) under the Plan in connection with ASP's adjudication of claims and administration of the appeal of claims denied, in whole or in part, as such reviews are required under applicable law, rules and regulations. ASP accepts such delegation. ASP shall interpret the language of the Plan in accordance with a uniform benefit coverage standard across localities, regions and state lines, regardless of the Beneficiary's geographic location. Any determination or interpretation made by ASP pursuant to this discretionary authority shall be given full force and effect and be binding on Plan Sponsor and Beneficiary, subject to the latter's legal rights. Nothing in Exhibit A is intended to create in ASP any fiduciary status other than in connection with the claims adjudication function delegated herein.

3.8.1. **Establishment of Plan Funding Account**. Benefit payments will be made by wire transfers to ASP, from Plan Sponsor, to bank account. ASP will advise of the amount to be charged for benefit payments and for agreed upon fees payable to ASP upon receipt of invoice on Tuesdays with payment due on or before Thursday (unless Plan Sponsor is closed). Plan Sponsor will notify their bank to initiate payment to be funded by the Plan Sponsor's general corporate account for transfer to the ASP account. The transfer will cover the total amount of Plan Sponsor's identified liabilities, as determined by ASP in compliance with and in a manner required to fulfill Plan Sponsor's obligation listed in Agreement.

3.8.2. **Claims Processing.** ASP will process all Clean Claims within thirty (30) days of receipt of such claim and will make a recommendation regarding denial or payment of each processed claim. Each week, ASP will prepare a report of all valid claims that have been processed for Covered Services provided to a Beneficiary under the terms of the Plan and recommended for payment. ASP will deliver the report to Plan Sponsor through a secure website, email or by facsimile. ASP will also prepare and deliver to Plan Sponsor each week a check register for the previous week that includes a listing of each check, payee name and payee amount that ASP recommends be issued based upon the report of processed claims and the total amount of monies that must be deposited into the CPA in order to cover the claims recommended for payment.

3.8.3. **Claims Payment.** ASP shall provide Plan Sponsor with a claims report on a weekly basis, on Tuesday with payment due on or before Thursday (unless SBBC is closed) of each week.

Plan benefit payments and related charges of any amount payable under the Plan shall be made by check drawn by Aetna payable through the Bank or by electronic funds transfer or other reasonable transfer method. Customer, by execution of the Services Agreement, expressly authorizes Aetna to issue and accept such checks on behalf of Customer for the purpose of payment of Plan benefits and other related charges.

Customer agrees to provide funds through its designated bank sufficient to satisfy all Plan benefits and related charges upon notice from Aetna or the Bank of the amount of payments made by Aetna. Customer agrees to instruct its bank to forward an amount in Federal funds equal to such liability by wire transfer or such other transfer method agreed upon between Customer and Aetna. As used herein "Plan benefits" means payments under the Plan, excluding any copayments, coinsurance or deductibles required by the Plan.

ASP shall advise Plan Sponsor of any disputed health care claims, (of which ASP is aware), by Beneficiaries over which litigation has been commenced or threatened or which is reasonably likely to result in litigation. In all such disputed or unresolved cases, the authority to resolve such claims is expressly retained by ASP and ASP expressly retains the authority to make the ultimate decision with regard to such claims. ASP also retains the authority to decide whether an investigation of any disputed claim is to be conducted and, if so, the extent of that investigation.

3.8.4. No Duty to Pay Claims from ASP Funds. Under no circumstances shall ASP be liable for the payment of claims, stop-loss premiums, or other monies owed to Provider (Network and Non-Network) and vendors of goods and services provided under the terms of the Plan, nor shall ASP be required to advance or use its own funds to make any such payments. Plan Sponsor shall be responsible for all expenses incident to the operation of the Plan, including but not limited to all risk of loss with regard to any mistake or error whatsoever in the verification of eligibility of Beneficiaries due to erroneous information supplied to ASP. ASP will not be considered the insurer, guarantor or underwriter of the liability of Plan Sponsor to provide benefits for Beneficiaries, and Plan Sponsor will have the sole responsibility and liability for payment of claims in accordance with the provisions of the Plan. ASP shall have no liability for underpayments or overpayments of claims made under the Plan. However, ASP shall make reasonable efforts to recover reimbursement for overpayments to Network Providers as allowable under the terms of its contracts with Network Providers and shall return such overpayments to Plan Sponsor upon receipt. Except to the extent required by applicable law, the defense of any legal action instituted on a claim for Covered Services under the Plan shall be solely an obligation of Plan Sponsor. ASP shall have no obligation with respect to any such claim, but shall cooperate with Plan Sponsor by furnishing such evidence as ASP has available in connection with the defense of any such action.

3.8.5. Failure to Fund. In the event that Plan Sponsor fails to fund the Plan Sponsor Account as set forth in this Exhibit, ASP shall immediately notify Plan Sponsor in writing (the "Failure to Fund Notice"). Plan Sponsor shall deposit into the Plan Sponsor Account the amount stated in the Failure to Fund Notice by the close of business on the business day following the business day of Plan Sponsor's receipt of the notice.

3.8.5.1. Termination of Exhibit A. In the event that Plan Sponsor fails upon three (3) or more notices to so fund the Plan Sponsor Account, ASP, in its sole discretion, may immediately terminate this Exhibit upon notice to Plan Sponsor.

3.8.5.2. Additional Payment Due to Failure to Fund. Plan Sponsor understands and agrees that if Plan Sponsor fails to fund the Plan Sponsor Account as required by this Exhibit, and such failure to fund causes claims for Covered Services provided to Beneficiaries to be paid later than required by law, regulation or an applicable Network Provider agreement, Plan Sponsor shall pay any additional amounts (whether interest, statutory penalties, or loss of contracted rate) required to be paid due to Plan Sponsor's failure to fund the Plan Sponsor Account and in the amount required under the applicable Network Provider agreement or by law or regulation.

3.9 **Subrogation/Recovery/Coordination of Benefits**. ASP shall administer a coordination of benefits, recovery and subrogation program on behalf of Plan Sponsor, subject to the approval of the Plan Sponsor and as outlined in SPD.

ASP, along with its affiliates, has contracted with a third party vendor (the "Recovery Vendor") to recover monies paid to Providers that should not have been paid to such Providers ("Ineligible Payments"). Ineligible Payments may occur for numerous reasons, including, but not limited to, late notice to ASP of an ineligible Covered Individual; a Covered Individual failing to provide correct coordination of benefits information to Plan Sponsor or ASP; or a Provider failing to disclose all information related to the service or item requested for payment under the Plan.

ASP, along with its affiliates, also has contracted with a third party vendor (the "Subrogation Vendor") to supervise ASP's Plan Sponsors' interests in litigation with third parties that may lead to a subrogation payment to ASP's Plan Sponsors, including Plan Sponsor. (The "Recovery Vendor" and "Subrogation Vendor" are hereinafter collectively referred to as the "Vendors" and individually as a "Vendor.")

ASP shall identify Ineligible Payments and potential subrogation matters that are appropriate to refer to the appropriate Vendor. The appropriate Vendor shall be paid a portion or percentage of any Ineligible Payment or subrogation amount that it recovers as payment for its services (a "Contingent Cost"). Contingent Costs shall be equal to the mutually agreed upon amount set forth in the contract between ASP and the applicable Vendor, the maximum of which is disclosed in Exhibit C of this Agreement.

ASP shall notify Plan Sponsor of amounts recovered by and paid to the Vendors. Plan Sponsor understands and agrees that Contingent Costs paid to the Vendors shall be deducted from amounts refunded to Plan Sponsor and ASP shall have no duty to pay such Contingent Costs or refund amounts equal to such Contingent Costs to Plan Sponsor. Further, Contingent Cost shall be paid by Plan Sponsor in addition to the Administrative Services Charge(s) and other charges described herein.

Notwithstanding the foregoing, neither ASP nor any Vendor shall act on behalf of Plan Sponsor in any way in the case of class action litigation. If requested by Plan Sponsor, ASP shall cooperate with Plan Sponsor by providing claims information reasonably necessary for

Plan Sponsor to pursue a claim in any class action litigation.

3.10 Government Program Reimbursement. Where the Beneficiary has also filed a claim or an appeal under any law applicable to benefit entitlement, such as worker's compensation, unemployment compensation, or disability, ASP will recommend appropriate action (such as holding such claim in a pending file), or shall turn the claim over to Plan Sponsor if the claim becomes involved in legal action or proceedings under such laws.

3.11 Beneficiary Appeals/External Review. As part of its delegated duties under this Exhibit, ASP shall administer two levels of appeal under the Plan and have final authority on all disputed claims, subject to external review required under law. ASP shall administer a third level of appeal subject to external review process. Plan Sponsor shall cooperate with ASP and promptly respond to any requests for information.

4. Compensation of ASP.

4.1. Administrative Services Charge(s). In consideration of the administrative and other services to be provided hereunder, Plan Sponsor shall pay ASP those amounts (the "Administrative Services Charge(s)") set forth in Exhibit C of this Agreement. ASP shall provide a monthly invoice to Plan Sponsor in a format mutually agreed upon by the parties on or about the 15th of the month prior to the date the Administrative Services Charge(s) are due and shall notify Plan Sponsor that the invoice has been posted. The invoice shall contain an itemization of the Administrative Services Charge(s), including administrative charges, access charges, stop-loss premiums and other costs. Plan Sponsor acknowledges that these charges may include costs for services and products provided by third parties to Plan Sponsor. Plan Sponsor authorizes and directs ASP to pay any administrative costs to such third parties on behalf of Plan Sponsor.

Plan Sponsor shall pay the Administrative Services Charge(s) to ASP no later than thirty (30) days from the date of notification of posting of the monthly invoice. Payment can be made to ASP by Plan Sponsor by wire transfer, direct withdrawal or U.S. Mail. In the event that Plan Sponsor disputes any amount contained on a monthly invoice, Plan Sponsor must notify ASP as soon as reasonably practical. If ASP is in agreement with Plan Sponsor, any adjustments will be recognized on the invoice for the next month. At ASP's discretion, all amounts unpaid for more than thirty (30) days following the date of the invoice shall be subject to an interest charge at a monthly rate of the lesser of the maximum amount allowable by the law of the state in which Plan Sponsor is located or one and one-half percent (1.5%).

ASP shall provide Plan Sponsor with notice of changes to the Administrative Services Charge(s) at least two hundred seventy (270) days prior to the commencement of each Plan Year. If no agreement is reached on a new Administrative Services Charge(s) prior to the start of a new term of the Exhibit, this Exhibit shall terminate on the last day of the then current term. If the parties agree to a new Administrative Services Charge(s), this Exhibit shall be amended accordingly.

ASP shall meet such performance guarantees, set forth in Exhibit G.

4.2. Monthly Enrollment Adjustments. Monthly fees based on the number of Plan Sponsor's Employees enrolled in the Plan each month will be paid based upon the ASP's records of current enrollment in the Plan as of the first day of each month. Appropriate adjustments will be made for enrollment variances.

In the case of an Employee whose coverage is terminated and ASP is notified of said termination after the sixtieth (60th) day following the termination date, ASP will not provide to the Plan Sponsor any adjustment to the administrative charge for that Employee.

4.3. Changes of/Additional Administrative Service Charges.

4.3.1. The ASP will have the right to adjust all or a portion of the Administrative Services Charge(s) upon delivery of notice of such adjustment to Plan Sponsor forty-five (45) days prior to such adjustment if material changes are made to this Exhibit or any amendment to the Plan, which affects ASP's costs of services under this Exhibit.

4.3.2. The ASP may charge Plan Sponsor reasonable amounts for the reproduction or return of Plan records requested by Plan Sponsor or governmental agencies. Plan Sponsor shall reimburse, subject to Plan Sponsor approval, ASP for reasonable amounts charged by medical providers and others for information reasonably requested by ASP to perform its duties under this Exhibit.

4.3.3. Upon forty-five (45) days' notice to Plan Sponsor, ASP may adjust the Administrative Service Charge(s), if any change in law or regulations imposes duties or obligations on ASP greater than those specified by this Exhibit at the time of such change.

4.4. Additional Services. In the event that Plan Sponsor requests ASP to provide services other than those specified in Section 3 of this Exhibit, including, but not limited to, special research projects, reports, claims system changes to accommodate program changes, or other tasks to be specifically performed for and on behalf of Plan Sponsor, Plan Sponsor shall pay to ASP an additional charge to be mutually agreed upon by the parties in writing before the services are provided.

4.5. Exclusions. Expenses incurred by Plan Sponsor for the following services shall not be the responsibility of ASP: (i) expenses associated with meetings, communications and mailings to the Plan Sponsor, including its Board of Trustees or committees that do not pertain to the administration of the Plan; (ii) all insurance costs, including professional liability/malpractice, general liability coverage, which may be purchased for the Plan Sponsor; (iii) taxes or other government obligations of the Plan; (iv) the Plan Sponsor's annual financial audit and such other audits and financial statements required by state or federal law and cost associated with preparation of the Plan Sponsor's annual tax returns or other returns or reports for Plan; (v) costs of legal services for the Plan which arise in the normal course of the Plan's operations including ASP's provision of services for the Plan; (vi) license and filing costs and penalties and other costs associated with annual and other reports required to be filed by the Plan Sponsor by federal and state statutes and regulations;

(vii) expenses for independent legal, independent accounting and independent actuarial services of the Plan Sponsor; (viii) access fees for other network services purchased outside of this Exhibit; and (ix) all items expressly agreed upon by the parties and set forth in this Exhibit.

5. Termination.

5.1 **Run-Out Period.** In the event of termination of this Agreement, ASP shall continue to process claims during the Run-Out Period for health care services, equipment and supplies provided while this Agreement was in effect. Run-Out services are included for 12 months at no additional cost. On the first day following the end of the Run-Out Period, ASP shall forward any claims not yet fully processed to Plan Sponsor or to the person or entity to whom Plan Sponsor directs ASP to send such claims.

Notwithstanding the foregoing, if ASP has terminated this Agreement due to the breach of Plan Sponsor, including but not limited to, failure to fund the PFA, ASP shall have no obligation to continue to render any services during the Run-Out Period.

5.2 **Record Transfer.** Upon the termination of ASP's duties hereunder, it shall be the responsibility of the Plan Sponsor to arrange and pay all costs for the transfer to a successor of custody of any of Plan Sponsor's records in ASP's possession, excluding current data feeds provided to Plan Sponsor by ASP. ASP may, at its option, transfer such records in such form as it may desire, including computer tapes or disks. Information shall be presented in the form of ASP's then current standard file layouts at the time the data is requested, and it is the responsibility of the Plan Sponsor to convert such information into any other form required by the successor.

5.3 **Duties on Termination.** As of the effective termination date of this Exhibit, this Exhibit shall be considered of no further force of effect, provided, however, that each party shall remain liable for any obligations or liabilities arising from activities carried on by such party or its agents, servants, or employees during the period this Exhibit was in effect except those terms and conditions of the Exhibit expressly so noted shall survive termination of this Exhibit, including but not limited to post-termination services provided during the Run-Out Period.

6. Access to Books and Records.

6.1 Plan Sponsor Books and Records. Plan Sponsor agrees that ASP may have access to its books and records, on reasonable notice, and at reasonable times, during normal business hours, to verify the number of Beneficiaries reported by Plan Sponsor hereunder. This provision shall survive any termination of this Exhibit.

6.2 ASP Books and Records. ASP shall maintain books of accounts and supporting documents for its services hereunder in accordance with generally accepted accounting principles consistently applied, during the term of this Exhibit and for seven (7) years thereafter or, a

longer period, if required by applicable law. Any claims audit shall be conducted in accordance with Sections 2.07 and 2.08.

6.3 Proprietary Rights. Plan Sponsor acknowledges that ASP (including its affiliates) has developed and may develop in connection with this Exhibit, certain symbols, trademarks, service marks, designs, data, processes, systems, computer software, manuals, lists, programs, plans, procedures and information, including, but not limited to, utilization management and quality improvement plans and policies, all of which are proprietary information and trade secrets of ASP (collectively "Materials"). Such Materials are the property of ASP during the term hereof and thereafter. Plan Sponsor shall not use the Materials, except as expressly contemplated by this Exhibit, without the prior written consent of ASP, and shall cease any and all usage of the Materials immediately upon the termination of this Exhibit. In addition, ASP shall have the right to safeguard the secrecy of its systems and programs, and shall not be required to make such proprietary information available to Plan Sponsor or anyone else.

In the event of a breach or a threatened breach of this Section 6.3, the parties agree and acknowledge that the remedy at law for any breach or threatened breach shall be inadequate and ASP shall be entitled to an injunction restraining Plan Sponsor from committing or continuing to commit any such breach, without being required to post bond or other security and without having to prove the inadequacy of the available remedies at law. Nothing contained herein shall be construed as prohibiting ASP from pursuing any other remedies for such breach or threatened breach.

7. Relationships.

7.1 Relationships of the Parties. In the performance of the work, duties and obligations of the parties pursuant to this Exhibit, ASP shall at all times be acting and performing as an independent contractor with respect to Plan Sponsor. No relationship of employer and employee, or partners, agents, or joint ventures between ASP and Plan Sponsor is created by this Exhibit, and neither party may therefore make any claim against the other party for social security benefits, workers' compensation benefits, unemployment insurance benefits, vacation pay, sick leave or any other employee benefit of any kind. In addition, neither party shall have any power or authority to act for or on behalf of, or to bind the other except as herein expressly granted, and no other or greater power or authority shall be implied by the grant or denial of power or authority specifically mentioned herein.

7.2 **Relationship of ASP and Providers.** ASP has contracted with Network Providers as independent contractors to provide Covered Services. Network Providers and their employees and agents are not employees and agents of ASP and neither ASP nor any employee of ASP is an employee or agent of the Network Providers. ASP is not responsible and shall not be liable for any claims that may arise from the provision of Covered Services (or any other services outside the scope of this Exhibit) to Beneficiaries by Network Providers.

7.3 **Relationship of Providers and Beneficiaries**. Each Provider who is a Network Provider shall maintain the usual and customary Provider-patient relationship with Beneficiaries and shall be

solely responsible for medical treatment. The parties acknowledge and agree that any and all decisions rendered by ASP in its administration of this Exhibit, including, but not limited to, all decisions with respect to the determination of whether or not a service is a Covered Service, are made solely to determine if payment of benefits under the Plan is appropriate. The sole responsibility of Plan Sponsor in regard to a Network Provider's services is payment for Covered Services that are provided to Beneficiaries under the terms of the Plan, and nothing contained herein shall be construed as interfering with the Provider-patient relationship. Nothing herein shall require a Provider to commence or continue providing medical treatment to a Beneficiary. Further, nothing herein shall require a Beneficiary to commence or continue receiving medical treatment from a Provider.

7.4 **Fiduciary Status**. It is understood that ASP is not a named Plan fiduciary, Plan Administrator, or fiduciary of the Plan except as to the extent required by applicable law, and that, with respect to the provision of services by ASP under this Exhibit, ASP shall not assume any obligations of Plan Sponsor, the named Plan fiduciary or the Plan Administrator under the provisions of PPACA, COBRA, or any other applicable law except as expressly stated in this Exhibit. The Plan Sponsor has designated to ASP the authority to construe and interpret the terms and provisions of the Plan for purposes of making claims determinations, to decide disputes which may arise relative to a Beneficiary's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. ASP accepts this designation as Claims Final Fiduciary, to the extent herein described.

Dispute Resolution.

8.1. **Negotiation**. In the event there is any dispute arising out of this Exhibit, which is not resolved by or is not within the scope of any interim determination processes set forth in the Exhibit or which is not resolved by informal discussions between the parties, the parties will negotiate the dispute before proceeding to mediation. Either party may initiate negotiation by sending a written description of the dispute to the other party by certified or registered mail or hand delivery. This description shall explain the nature of the dispute in detail and set forth a proposed solution to the problem, including a specific time frame within which the parties must act. The party receiving the letter must respond in writing within ten (10) business days with a detailed explanation of its position and a response to the proposed solution. Within ten (10) business days of the initiating party receiving this response, principals of the party, who have authority to settle the dispute, must meet and discuss resolution of the dispute. The initiating party must initiate scheduling of this negotiation session.

8.2. **Litigation**. If a dispute arises out of this Exhibit which is not within the scope of any interim determination processes set forth in the Exhibit and which the parties cannot resolve through negotiation, the dispute will be litigated before a court of competent jurisdiction located in Broward County, Florida. In the event of litigation, each party shall be responsible at its own expense for defending itself in any action brought against it whether or not the other party hereto is also a defendant, arising out of activities engaged in pursuant to this Exhibit.

9. Miscellaneous.

9.1 **Non-assumption of Liabilities**. ASP shall not, by entering into and performing services in accordance with the terms of this Exhibit, become liable for any of the existing or future obligations, liabilities, or debts of Plan Sponsor, and ASP shall not, by providing claim processing or other services to Plan Sponsor assume or become liable for any of the obligations, debts, or liabilities of Plan Sponsor as otherwise provided herein.

Report Name	Frequency	Description
Accounting Report	Annually	Provides reporting on received payments, associated expenses and the resulting year end balance.
Ad hoc	Available upon request	Provides reporting on industry data and SBBC specific information .
Banking Reports	Monthly	Provides Fund Summary Report (FSR) of current month and a ytd control-suffix breakdownf of claims and the funding applied & Funds Request & Receipt Report (FRRR)that shows the daily wire transfer requests and receipts for a given month.
Case Management Reports	Quarterly	Provides Medical Management Activity Reports
Claims Report	Monthly	Provides Claim Detail Report of claim activity by line of coverage, along with detailed claim information for each employee as well as claim totals for employees and dependents by Medicare status.
Geo Access Report	Upon Request from SBBC	Access standard report
M/WBE Reports	Monthly	Provides reporting of M/WBE certified vendors that are utilized
Rx Standard Reporting Package	Monthly	Provides Rx analysis on top drugs by paid amount and by number of claims as well as analysis on formulary, retail, mail order and specialty drugs.
Utilization Reports	Monthly reports and real time access for analysis	Provides data analysis on topics such as key measures, components of medical trend, medical, high cost claimants, network savings and membership. Benchmark and normative data is also provided which compares data to allow SBBC to better gauge the performance of the plans.
National Advantage Plan	Quaterly Reports	Including but not limited to billed and allowed claims, negotiated savings, and fees by service category.

SELF-FUNDED MODEL – All Plans (HMOs, CDHP and Kid's Plans)
Proposed ASC Medical Fee with RX off-set. Includes Voluntary Maintenance Choice Pharmacy.

	2018	2019	2020
Expected Paid Claims (Medical Only)	$193,746,253	$214,961,467	$238,499,748
Expected Change in Claim Reserves (PEPM)	N/A	N/A	N/A
ASO Fees (PEPM) Option 1:	$34.50	$34.50	$34.50
Access Fees (PEPM)	Included.	Included.	Included.
Utilization Review/Medical Management Fees	Included.	Included.	Included.
PBM Interface Fees (PEPM)	Currently Integrated.	Currently Integrated.	Currently Integrated.
Disease Management/Wellness Fees (PEPM)	Included.	Included.	Included.
Disease Management			
Lifestyle Management			
Behavioral Health/Substance Abuse Fees (PEPM)	Included.	Included.	Included.
Cobra Administrative Fees (PEPM)	Included.	Included.	Included.
HIPAA Administrative Fees (PEPM)	Included.	Included.	Included.
DUR Fees (PEPM)	Included.	Included	Included.
Claim Fiduciary Fees (PEPM)	Included.	Included.	Included.
Credentialing	Included.	Included.	Included.
Quality Assurance	Included.	Included.	Included.
Claims Administration	Included.	Included.	Included.
Customer Service	Included.	Included.	Included.
Grievance/Appeals Administration	Included.	Included.	Included.
Coordination of Benefits	Included.	Included.	Included.
Subrogation Services	30%	30%	30%
Telehealth Services (PEPM/PPPM)	Waived	Waived	Waived
Standard Reporting	Included.	Included.	Included.
Ad hoc Reporting	50 hours of Ad-hoc reporting is	50 hours of Ad-hoc reporting is	50 hours of Ad-hoc reporting is

	2018	2019	2020
	included.	included.	included.
Interface with Other Carve-out Vendors	Charge varies and it based on what is carved out.	Charge varies and it based on what is carved out.	Charge varies and it based on what is carved out.
Conversion Plan	N/A	N/A	N/A
Run-Out Fees	Included.	Included.	Included.
Other Fees (PEPM)	N/A	N/A	N/A
Total Administrative Fees	$34.50	$34.50	$34.50

* * Telehealth / Teladoc has a $3.00 per consultation fee.

** H.S.A. Account. To add an H.S.A. account to the CDHP, the cost is $2.95 per account per month.

1. Are you willing to provide rate guarantees/rate caps for years four and five? Yes☒ No ☐ If yes, describe the rate guarantees/ rate caps you are proposing.

Years 4 & 5, not to exceed a 3% fee increase.

2. Describe what products and services are included in your disease management fees.

Disease management programs are included in our proposal. Please refer to attachment A1 Medical Questionnaire for a complete description of our DM programs.

3. Identify any other fees or costs that are not stated above, that would be included in your pricing. Include the amount of fee(s), cost(s), purpose for fee(s)/cost(s) and how the fee(s)/cost(s) is billed to SBBC. Also include any capitated claim expenses.

No capitations are included.

4. Identify all fees, savings programs, percentages of savings, etc. and if these are fixed for 36 months.

- 30% of savings for subrogation and 35% of savings for our National Advantage Program (NAP). SBBC agrees that for calendar year 2018, to include the NAP program for services that are provided by non-contracted facilities and non-contracted providers. In addition, on a quarterly basis, AETNA will provide SBBC, or its designee, mutually agreed upon data including but not limited to the claims dollars within these categories and the savings and fees that result from their participation in the NAP program. Annually, SBBC at its sole option, will opt in or opt out of the NAP program based on the prior year's reporting/savings.

5. Is there a difference in the stated ASO fees for sole carrier versus dual carrier? Yes☒ No☐ If yes, provide both sole carrier and dual carrier fees.

Our proposal is for a sole carrier option, if SBBC wishes to offer multiple carriers, the fee will need to be reviewed & discussed.

6. Describe how you develop your administrative pricing for self-funded accounts.

Administrative fees are developed based on our core administrative cost, including group specific requirements.

- What do administrative costs (including network charges) represent?

Network charges are not broken out from our administrative fees.

- As a percent of claims?

N/A

- As a capitated dollar amount per employee?

No capitations are included.

Medical Discount Guarantee

Product	Illustrative Inpatient Hospital Discount [1]	Illustrative Outpatient Hospital Discount [1]	Illustrative Physician/Other Discount [1][3]	Illustrative Composite Target Discount [2]
Overall	69.30%	74.00%	61.80%	70.01%

(1) These discounts are illustrative only as they have been weighted by the distribution of employees by network from the current census file.

(2) This composite target is illustrative only. The final guaranteed target will depend on the actual enrollment by network and claim service mix known at the end of the guarantee period. For purposes of this illustration, the service mix of network billed eligible claims prior to discount is based on network level assumed utilization of hospital inpatient, hospital outpatient, and physician/other.

(3) Our non-facility discounts exclude the impact of claims where the provider bills at a level within 3% the contracted rates, along with some situations where the contract allows us to pay the lesser of the billed amount or the contracted rate.

Product	Network ID	State	Network Name	Rating Area ID	Rating Area	Employees Within	Hospital Inpatient	Hospital Outpatient	Physician/ Other
CPII	1549	FL	MHMO Brevard County,	70	FL Volusia	2	69.30%	74.00%	61.80%
CPII	1549	FL	MHMO Brevard County,	79	FL Brevard	5	69.30%	74.00%	61.80%
CPII	1659	MS	Gulfport, MS	27003	MS - Gulfport	1	69.30%	74.00%	61.80%
CPII	1797	TN	Chattanooga, TN	47005	TN - Chattanooga	3	69.30%	74.00%	61.80%
CPII	1830	FL	MHMO Jacksonville, FL	2399	Leon (FL08)	2	69.30%	74.00%	61.80%
CPII	1830	FL	MHMO Jacksonville, FL	72	FL Jacksonville	3	69.30%	74.00%	61.80%
CPII	1832	FL	MHMO Ocala, FL (HMO)	73	Alachua/Marion	5	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	2223	GA01 - Cherokee	2	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	2226	GA01 - Cobb	3	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	2228	GA01 - Dekalb	2	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	2234	GA01 - Gwinnett	1	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	3215	Fannin (GA01)	1	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	3218	Habersham (GA01)	1	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	3226	Towns (GA01)	2	69.30%	74.00%	61.80%
CPII	1957	GA	MHMO Atlanta, GA	3229	White (GA01)	1	69.30%	74.00%	61.80%
CPII	1967	NC	Charlotte, NC	2292	Caldwell	1	69.30%	74.00%	61.80%
CPII	1980	PA	Pittsburgh, PA HMO	948	Clarion	1	69.30%	74.00%	61.80%
CPII	2156	FL	MHMO South Florida	1096	Miami/Dade	25	69.30%	74.00%	61.80%
CPII	2156	FL	MHMO South Florida	2259	FL - Treasure Coast	4	69.30%	74.00%	61.80%
CPII	2156	FL	MHMO South Florida	2493	Broward (FL04)	547	69.30%	74.00%	61.80%
CPII	2156	FL	MHMO South Florida	800	South Florida	34	69.30%	74.00%	61.80%
CPII	227	FL	MHMO TampaBay/St.	2058	Tampa 3 (Polk/Pasco)	2	69.30%	74.00%	61.80%
CPII	227	FL	MHMO TampaBay/St.	2059	Tampa 2 (South)	1	69.30%	74.00%	61.80%
CPII	2399	ME	Maine	1022	Maine - Cumberland	2	69.30%	74.00%	61.80%
CPII	2530	FL	Florida Panhandle MC	11005	FL - Pensacola	4	69.30%	74.00%	61.80%
CPII	26	HI	Hawaii, PPO - MDX Hawaii	61051	HI - Hawaii	1	69.30%	74.00%	61.80%
CPII	2722	WI	Central WI PPO	56010	WI - Wausau	1	69.30%	74.00%	61.80%
CPII	1974	NH	New Hampshire	2299	New Hampshire	1	69.30%	74.00%	61.80%
CPII	9166	NC	MHMO Mountain NC	3134	Ashe Avery Watauga (NC05)	2	69.30%	74.00%	61.80%
CPII	9166	NC	MHMO Mountain NC	3140	Cherokee Swain (NC05)	1	69.30%	74.00%	61.80%
CPII	9166	NC	MHMO Mountain NC	3142	Buncombe Jackson (NC05)	1	69.30%	74.00%	61.80%
CPII	1973	MA	Massachusetts	733	MA Massachusetts -	1	69.30%	74.00%	61.80%
CPII	1973	MA	Massachusetts	993	MA Massachusetts -	2	69.30%	74.00%	61.80%
CPII	3765	GA	Georgia - Macon	2207	GA02 - Bibb	1	69.30%	74.00%	61.80%
CPII	1965	MD	Maryland, Northern	708	MD Baltimore Metro - North	1	69.30%	74.00%	61.80%
CPII	1965	MD	Maryland, Northern	709	MD Eastern/Southern	1	69.30%	74.00%	61.80%
CPII	1989	VA	Virginia, Northern	2688	Fairfax (VA01)	1	69.30%	74.00%	61.80%
CPII	1962	CT	Connecticut HMO	895	CT Hartford County	2	69.30%	74.00%	61.80%
CPII	3920	NC	MHMO Coastal Carolina	2531	Brunswick (NC06)	1	69.30%	74.00%	61.80%
CPII	3920	NC	MHMO Coastal Carolina	2554	New Hanover (NC06)	1	69.30%	74.00%	61.80%
CPII	8192	GA	Georgia - South Georgia	3279	Lowndes (GA06)	1	69.30%	74.00%	61.80%
CPII	404	TN	Nashville	2585	Maury (TN01)	1	69.30%	74.00%	61.80%
CPII	396	FL	PalmB/Martin/St. Lucie	64826	FL - Indian River	5	69.30%	74.00%	61.80%

Medical Discount Guarantee

Product	Illustrative Inpatient Hospital Discount [1]	Illustrative Outpatient Hospital Discount [1]	Illustrative Physician/Other Discount [1][3]	Illustrative Composite Target Discount [2]
Overall	69.30%	74.00%	61.80%	70.01%

(1) These discounts are illustrative only as they have been weighted by the distribution of employees by network from the current census file.

(2) This composite target is illustrative only. The final guaranteed target will depend on the actual enrollment by network and claim service mix known at the end of the guarantee period. For purposes of this illustration, the service mix of network billed eligible claims prior to discount is based on network level assumed utilization of hospital inpatient, hospital outpatient, and physician/other.

(3) Our non-facility discounts exclude the impact of claims where the provider bills at a level within 3% the contracted rates, along with some situations where the contract allows us to pay the lesser of the billed amount or the contracted rate.

Product	Network ID	State	Network Name	Rating Area ID	Rating Area	Employees Within	Hospital Inpatient	Hospital Outpatient	Physician/ Other
CPII	397	FL	Miami-Dade/Broward, FL	11020	FL - Monroe Cnty	1	69.30%	74.00%	61.80%
CPII	1954	KY	Louisville	815	Louisville	1	69.30%	74.00%	61.80%
CPII	4426	SC	South Carolina HMO	2911	Dorchester (SC01)	1	69.30%	74.00%	61.80%
CPII	4426	SC	South Carolina HMO	2914	Fairfield (SC01)	1	69.30%	74.00%	61.80%
CPII	4426	SC	South Carolina HMO	2917	Greenville (SC01)	3	69.30%	74.00%	61.80%
CPII	4426	SC	South Carolina HMO	2921	Jasper (SC01)	1	69.30%	74.00%	61.80%
CPII	445	FL	MHMO Ft. Myers, FL	2216	FL03 - Collier	3	69.30%	74.00%	61.80%
CPII	445	FL	MHMO Ft. Myers, FL	2297	Highlands	3	69.30%	74.00%	61.80%
CPII	445	FL	MHMO Ft. Myers, FL	84	FL Fort Myers	2	69.30%	74.00%	61.80%
CPII	1352	FL	MHMO Orlando (HMO)	78	FL Orlando	5	69.30%	74.00%	61.80%
CPII	449	FL	Orlando, FL	11004	FL - Orlando	5	69.30%	74.00%	61.80%
CPII	1988	SC	York/Lancaster, SC HMO	2924	Lancaster (SC03)	1	69.30%	74.00%	61.80%
CPII	483	NY	Up State New York	67496	NY - Albany	2	69.30%	74.00%	61.80%
CPII	1952	TX	San Antonio	2498	San Antonio (TX02)	1	69.30%	74.00%	61.80%
CPII	1968	NC	Raleigh/Durham, NC	1002	NC Raleigh - Wake	2	69.30%	74.00%	61.80%
CPII	1968	NC	Raleigh/Durham, NC	865	NC Raleigh - Durham	1	69.30%	74.00%	61.80%
CPII	3767	GA	Georgia - Augusta	2201	GA03 - Richmond	1	69.30%	74.00%	61.80%
CPII	3766	GA	Georgia - Savannah	2219	GA04 - Bryan	1	69.30%	74.00%	61.80%
CPII	3766	GA	Georgia - Savannah	2239	GA04 - Long	1	69.30%	74.00%	61.80%
CPII	3766	GA	Georgia - Savannah	2338	Camden	2	69.30%	74.00%	61.80%
CPII	667	TN	Tri-Cities, TN	47009	TN - Tri-cities	1	69.30%	74.00%	61.80%
CPII	8645	LA	MHMO	2959	Ouachita (LA02)	1	69.30%	74.00%	61.80%
OA-AS	1975	NJ	New Jersey, Southern	717	New Jersey-Burlington	1	69.30%	74.00%	61.80%
OA-AS	1965	MD	Maryland, Northern	709	MD Eastern/Southern	2	69.30%	74.00%	61.80%
OA-AS	1961	NJ	New Jersey, Northern	917	New Jersey-Ocean County	1	69.30%	74.00%	61.80%
OA-AS	1961	NJ	New Jersey, Northern	921	New Jersey-Union	1	69.30%	74.00%	61.80%
OA-AS	1982	PA	Berks County, PA	968	Monroe	2	69.30%	74.00%	61.80%
OA-AS	1960	NY	New York HMO	718	NY New York (GN01)	6	69.30%	74.00%	61.80%
OA-AS	1549	FL	MHMO Brevard County,	70	FL Volusia	9	69.30%	74.00%	61.80%
OA-AS	1549	FL	MHMO Brevard County,	79	FL Brevard	6	69.30%	74.00%	61.80%
OA-AS	1785	NY	Up State New York	67496	NY - Albany	1	69.30%	74.00%	61.80%
OA-AS	1785	NY	Up State New York	67523	NY - Rochester	3	69.30%	74.00%	61.80%
OA-AS	1830	FL	MHMO Jacksonville, FL	2399	Leon (FL08)	8	69.30%	74.00%	61.80%
OA-AS	1830	FL	MHMO Jacksonville, FL	72	FL Jacksonville	6	69.30%	74.00%	61.80%
OA-AS	1832	FL	MHMO Ocala, FL (HMO)	73	Alachua/Marion	12	69.30%	74.00%	61.80%
OA-AS	1955	DC	District of Columbia	702	Washington DC	2	69.30%	74.00%	61.80%
OA-AS	1957	GA	MHMO Atlanta, GA	2226	GA01 - Cobb	1	69.30%	74.00%	61.80%
OA-AS	1957	GA	MHMO Atlanta, GA	2234	GA01 - Gwinnett	1	69.30%	74.00%	61.80%
OA-AS	1957	GA	MHMO Atlanta, GA	3227	Union (GA01)	1	69.30%	74.00%	61.80%
OA-AS	1979	PA	Southeastern PA HMO	947	Chester	1	69.30%	74.00%	61.80%
OA-AS	1979	PA	Southeastern PA HMO	973	Philadelphia	1	69.30%	74.00%	61.80%
OA-AS	1995	NV	Las Vegas, NV	739	Las Vegas	1	69.30%	74.00%	61.80%
OA-AS	3536	KS	MHMO Kansas City,	2666	Kansas City (KS01)	1	69.30%	74.00%	61.80%

Medical Discount Guarantee

Product	Illustrative Inpatient Hospital Discount [1]	Illustrative Outpatient Hospital Discount [1]	Illustrative Physician/Other Discount [1][3]	Illustrative Composite Target Discount [2]
Overall	69.30%	74.00%	61.80%	70.01%

(1) These discounts are illustrative only as they have been weighted by the distribution of employees by network from the current census file.

(2) This composite target is illustrative only. The final guaranteed target will depend on the actual enrollment by network and claim service mix known at the end of the guarantee period. For purposes of this illustration, the service mix of network billed eligible claims prior to discount is based on network level assumed utilization of hospital inpatient, hospital outpatient, and physician/other.

(3) Our non-facility discounts exclude the impact of claims where the provider bills at a level within 3% the contracted rates, along with some situations where the contract allows us to pay the lesser of the billed amount or the contracted rate.

Product	Network ID	State	Network Name	Rating Area ID	Rating Area	Employees Within	Hospital Inpatient	Hospital Outpatient	Physician/ Other
OA-AS	1980	PA	Pittsburgh, PA HMO	721	Allegheny	1	69.30%	74.00%	61.80%
OA-AS	1980	PA	Pittsburgh, PA HMO	944	Butler	1	69.30%	74.00%	61.80%
OA-AS	1983	PA	Western PA	954	Erie	1	69.30%	74.00%	61.80%
OA-AS	2156	FL	MHMO South Florida	1096	Miami/Dade	1423	69.30%	74.00%	61.80%
OA-AS	2156	FL	MHMO South Florida	2259	FL - Treasure Coast	62	69.30%	74.00%	61.80%
OA-AS	2156	FL	MHMO South Florida	2493	Broward (FL04)	25300	69.30%	74.00%	61.80%
OA-AS	2156	FL	MHMO South Florida	800	South Florida	1101	69.30%	74.00%	61.80%
OA-AS	227	FL	MHMO TampaBay/St.	2058	Tampa 3 (Polk/Pasco)	4	69.30%	74.00%	61.80%
OA-AS	227	FL	MHMO TampaBay/St.	2059	Tampa 2 (South)	3	69.30%	74.00%	61.80%
OA-AS	227	FL	MHMO TampaBay/St.	2060	Tampa 1 (Central)	7	69.30%	74.00%	61.80%
OA-AS	227	FL	MHMO TampaBay/St.	2347	Citrus (FL03)	1	69.30%	74.00%	61.80%
OA-AS	1352	FL	MHMO Orlando (HMO)	78	FL Orlando	15	69.30%	74.00%	61.80%
OA-AS	2284	FL	Orlando, FL	11004	FL - Orlando	2	69.30%	74.00%	61.80%
OA-AS	2285	FL	Miami-Dade/Broward, FL	11020	FL - Monroe Cnty	6	69.30%	74.00%	61.80%
OA-AS	2286	FL	PalmB/Martin/St.Lucie, FL	64773	FL - Tampa	2	69.30%	74.00%	61.80%
OA-AS	2286	FL	PalmB/Martin/St.Lucie, FL	64826	FL - Indian River	2	69.30%	74.00%	61.80%
OA-AS	2347	TN	Chattanooga, TN	47005	TN - Chattanooga	1	69.30%	74.00%	61.80%
OA-AS	2521	FL	Gainesville EPO	64769	FL -Gainesville	4	69.30%	74.00%	61.80%
OA-AS	2531	FL	Florida Panhandle EC	11005	FL - Pensacola	1	69.30%	74.00%	61.80%
OA-AS	1970	NC	MHMO Triad NC	2545	Guilford (NC04)	1	69.30%	74.00%	61.80%
OA-AS	3196	FL	Tallahassee FL EC	64768	FL -Tallahassee	1	69.30%	74.00%	61.80%
OA-AS	3196	FL	Tallahassee FL EC	64779	FL - Other Florida	2	69.30%	74.00%	61.80%
OA-AS	9166	NC	MHMO Mountain NC	3145	Macon (NC05)	1	69.30%	74.00%	61.80%
OA-AS	3288	MI	Northern MI Cofinity EC	67183	MI - Upper Peninsula	1	69.30%	74.00%	61.80%
OA-AS	8192	GA	Georgia - South Georgia	3278	Lee (GA06)	2	69.30%	74.00%	61.80%
OA-AS	407	TX	Dallas/Ft. Worth	2494	Dallas Collin/Denton (TX01)	1	69.30%	74.00%	61.80%
OA-AS	445	FL	MHMO Ft. Myers, FL	2216	FL03 - Collier	6	69.30%	74.00%	61.80%
OA-AS	445	FL	MHMO Ft. Myers, FL	2297	Highlands	7	69.30%	74.00%	61.80%
OA-AS	445	FL	MHMO Ft. Myers, FL	84	FL Fort Myers	7	69.30%	74.00%	61.80%
OA-AS	4631	MI	Eastern MI Aetna EC	25004	MI - Detroit	2	69.30%	74.00%	61.80%
OA-AS	4634	MI	Cent West MI Aetna EC	67182	MI - Central/West	1	69.30%	74.00%	61.80%
OA-AS	4637	MI	North MI Aetna EC	67180	MI - Northern	1	69.30%	74.00%	61.80%
OA-AS	223	TX	Houston	2515	West Harris County (TX03)	1	69.30%	74.00%	61.80%
OA-AS	1968	NC	Raleigh/Durham, NC	1002	NC Raleigh - Wake	1	69.30%	74.00%	61.80%
OA-AS	1968	NC	Raleigh/Durham, NC	865	NC Raleigh - Durham	1	69.30%	74.00%	61.80%
OA-AS	221	IL	Chicago	2501	Cook/DuPage (IL02)	2	69.30%	74.00%	61.80%
OA-AS	1962	CT	Connecticut HMO	895	CT Hartford County	1	69.30%	74.00%	61.80%
OA-AS	7413	TN	Upper Cumberland	67686	TN - Upper Cumberland	1	69.30%	74.00%	61.80%

Illustrative Inpatient Hospital Discount [1]	Illustrative Outpatient Hospital Discount [1]	Illustrative Physician/Other Discount [1]	Illustrative Composite Target Discount [2]
69.3%	74.0%	61.8%	70.01%

Example of the Reimbursement Calculation to SBBC

Actual composite savings percentage: [3]	Reimbursement as a % of fees	Reimbursement on a PEPM basis	Annual $ Reimbursement
69.0%	0.0%	$0.00	$0
68.0%	3.0%	$0.72	$249,039
67.0%	6.0%	$1.44	$498,077
66.0%	9.0%	$2.16	$747,116
65.0%	12.0%	$2.89	$996,155
64.0%	15.0%	$3.61	$1,245,194
63.0%	18.0%	$4.33	$1,494,232
62.3%	20.0%	$4.81	$1,660,258

[1] These discounts are illustrative only as they have been weighted by the distribution of employees by network from the current census file.

[2] This composite target is illustrative only. The final guaranteed target will depend on the actual enrollment by network and claim service mix known at the end of the guarantee period. For purposes of this illustration, the service mix of network billed eligible claims prior to discount is based on network level assumed utilization of hospital inpatient, hospital outpatient, and physician/other.

[3] This chart represents the reimbursement amount should the actual achieved discounts be less than guaranteed.

Guaranteed Discount	70.01%
Corridor	1.0%
Payout starts at	69.01%
Achieved Discount	68.01%
Payout percentage	3.0%
Annual Fee x payout %	$249,039

We are pleased to offer a Medical Claim Target Guarantee that supports our commitment to you and your employees. When you offer the right plan design, incentives and strong medical management programs to your members, it can directly affect medical trend.

We guarantee your net effective trend for the 12-month guarantee period from January 1, 2018 through December 31 2018, and paid through June 30, 2018. Your active employees are included in this guarantee. You'll find an example of the calculation for the guarantee period below. Dollar amounts are shown for clarifying purposes only.

Year 1 (January 1, 2018 through December 31, 2018)

Proposed Aetna enrollment of 27,341 employees in CPII.		
Projection for the guarantee period 01/01/2018 thru 12/31/2018.		**Factor**
Base Year Medical Incurred Claim (per member per year)		$4,949
Net Effective Trend	X	1.1095
2018 Projected Claim Target (per member per year)	=	$5,491

Outlined below are the definitions of the items in the table(s) above.

Base year medical incurred claim

The base year medical incurred claims for Year 1 are for the period January 1, 2018 through December 31, 2018 and paid through June 30, 2018.

To ensure that we are comparing the base year and the projection year on the same basis, we adjust base year claims for:

- Changes in demographics and geography

The medical management and integration savings factor accounts for the decrease in medical costs due to:

- Our clinical and cost management programs (relative to your current vendors and programs)

Trend Factor

Your trend factor is guaranteed at the time of quotation.

Penalty Reconciliation

We compare the guaranteed net effective trend to the actual trend result to determine whether we meet the performance guarantee. Based on that outcome, we make any fee adjustments based on the table below.

Actual Claims PMPY vs. Projected Claims PMPY	Fee Adjustment	Maximum Guarantee Period Adjustment
> 101%	3.0% fee reduction to the per-employee, per-month fee for each full 1.0% of difference of actual claims above target claims plus the corridor	20%
<= 101%	No Adjustment	N/A

Aggregate Maximum

The maximum guarantee for the combination of Medical Claim Target Guarantee, Medical Discount Guarantee and Service Performance Guarantee adjustment is 40 percent of actual collected administrative service fees for the applicable guarantee period. Administrative service fees exclude commissions, implementation/communication/wellness allowances and any charges for services performed which are not included on the monthly administrative service fee bill.

Conditions for the guarantee

We reserve the right to revise or remove the guarantee if any of the following conditions are not met.

- Accurate Information: We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the net effective trend.

- Full Replacement: We are the full replacement vendor for medical, pharmacy & behavioral health.

- Large Claims: Claims per member per year paid in excess of $100,000are excluded from the total incurred claims of both the base year and the guarantee period.

- Involuntary Terminations: We do not include employees whose continuation in Aetna's benefit options stems from an involuntary termination occurring after the effective date in this guarantee.

- In-Network Utilization: Your Aetna medical plans maintain a minimum in-network claim dollar utilization of 90% during the guarantee period.

- Out of network reimbursement: The National Advantage Plan will be included for the guarantee period. If SBBC elects to not offer the NAP Program, the claims target guarantee may be amended to reflect the impact to the overall discount, by not offering NAP.

- Pharmacy Claims: Pharmacy and Specialty Pharmacy claims are excluded.

- Subrogation: Our subrogation services through a third-party vendor are included.

- Other Included Guarantees: We cannot offer this guarantee with Aggregate Stop Loss coverage.

Benefit plan conditions for the guarantee

We reserve the right to revise or remove the guarantee if any of the following benefit plan conditions are not met.

Your plan design includes:

- Steerage from emergency room to urgent care facilities and/or walk in clinics
- Steerage from hospital based services to free standing facilities
- Steerage to more cost effective radiology providers through our Enhanced Clinical Review program

You include the following Medical Management Programs:

- Aetna Health Connections℠ disease management
- MedQuery®
- Medical Psychiatric Case Management Program
- Online Disease Management
- Personal Health Record

Pharmacy Discounts & Fees

Pricing Arrangement	Traditional
Network	Aetna National Network
Employees	27,341

RETAIL			
	01/01/2018	01/01/2019	01/01/2020
Brand Discount	AWP - 16.50%	AWP - 16.60%	AWP - 16.70%
Generic Discount	AWP - 76.50%	AWP - 77.00%	AWP - 77.50%
Dispensing Fee	$0.95 per script	$0.95 per script	$0.95 per script

MAIL ORDER PHARMACY/MAINTENANCE CHOICE			
Mail Benefit Type	Voluntary Maintenance Choice		
	01/01/2018	01/01/2019	01/01/2020
Brand Discount	AWP - 24.00%	AWP - 24.00%	AWP - 24.00%
Generic Discount	AWP - 80.00%	AWP - 80.00%	AWP - 80.00%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

AETNA SPECIALTY PHARMACY			
Network	Exclusive Specialty Network		
Price List	Not Applicable		
	01/01/2018	01/01/2019	01/01/2020
Discount	AWP - 16.50%	AWP - 16.50%	AWP - 16.50%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

GENERIC DISPENSING RATE (GDR) GUARANTEE			
	01/01/2018	01/01/2019	01/01/2020
Retail GDR	85.00%	85.50%	86.00%
Mail GDR	77.00%	77.50%	78.00%
Annual Maximum	$400,000	$400,000	$400,000

CLINICAL PROGRAM FEES			
	01/01/2018	01/01/2019	01/01/2020
Rx Check	Included	Included	Included

ALLOWANCES			
	01/01/2018	01/01/2019	01/01/2020
Total Allowances	$50,000	$50,000	$50,000

Rebates

REBATES			
Formulary	Aetna Value		
Rebate Terms	Plan sponsor will receive the following minimum rebates:		
	01/01/2018	01/01/2019	01/01/2020
Retail	Greater of 100% or $72.00 Per Brand Script	Greater of 100% or $73.25 Per Brand Script	Greater of 100% or $82.25 Per Brand Script
Mail Order/Maintenance Choice	Greater of 100% or $158.75 Per Brand Script	Greater of 100% or $168.50 Per Brand Script	Greater of 100% or $191.50 Per Brand Script
Retail Specialty and Aetna Specialty Pharmacy	Greater of 100% or $803.25 Per Brand Script	Greater of 100% or $909.50 Per Brand Script	Greater of 100% or $1,025.75 Per Brand Script

Terms & Conditions

The pricing and services set forth herein are subject to the following Terms & Conditions:

- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Prescriptions dispensed by a Participating Retail Pharmacy shall be processed at the lower of the pharmacy's submitted Usual & Customary Retail Price, MAC (where applicable) plus a Dispensing Fee or discounted AWP cost, plus a Dispensing Fee.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
    - Discount and Dispensing Fee guarantees are measured individually and reconciled in the aggregate; surpluses in one or more component guarantees may be used to offset shortages in other component guarantees. If Aetna allows modifications to the reconciliation during the term of this Agreement to any customer in the Southeast Region, SBBC, at its sole discretion will be provided the opportunity to modify said guarantees.
    - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within one hundred eighty (180) days following the guarantee period.
    - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant copay and include zero balance due claims.
    - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein: compound drug claims, direct Plan Participant reimbursement/ out-of-network claims, over-the-counter products, and vaccines.
    - Retail pricing guarantees exclude claims that reflect the Usual & Customary Retail Price.
    - Prescriptions dispensed by Aetna Specialty Pharmacy are included in the Aetna Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are included in the Retail Brand Discount guarantees listed above.
    - Aetna has assumed 0% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
- Limited Distribution Specialty Products are excluded from the pricing terms contained herein.
- Pricing and terms in this proposal assume the Customer has elected the Aetna Value formulary or any new formulary mutually agreed upon.
    - Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within one hundred eighty (180) days following the end of the Plan year; a surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees. If Aetna allows modifications to reconciliation during the term of this Agreement to any customer in the Southeast Region,

SBBC, at its sole SBBC at its sole discretion will be provided the opportunity to modify said guarantees.

- Exclusive Specialty Products network means that Plan Participants are required to use the Aetna Specialty Pharmacy on the first fill.
- Retail and Mail Order GDR rates by Plan year will be calculated as total retail Generic Drug claims excluding dispense as written ("DAW") claims divided by total retail claims excluding DAW, and total mail Generic claims excluding DAW claims divided by total mail claims excluding DAW. A penalty, if applicable, will be calculated as the difference in the Brand Drug cost versus Generic Drug cost after Discount and Dispense Fee times the actual claim volume. Separate calculations will be performed for retail and mail, and for each Plan year. Reconciliation will be calculated annually within 180 days of the end of each of the guarantee periods. For the purposes of this guarantee, any penalty will be calculated based on the aggregate results across all retail and mail order categories.

Allowances

Allowances will be available as of the Effective Date of the pharmacy services schedule. Aetna will pay related expenses directly to a third party vendor once the Customer sends the invoice(s) outlining the expenses incurred to Aetna. Invoices must be submitted before the end of each Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of each Plan year will be forfeited.

Audit/Rx Review Process Allowance

Aetna is including a general allowance up to $50,000 annually. The Customer can use this allowance for Audit/Rx Review Process expenses.

Market Check

On an annual basis commencing (18) months after the effective date, Customer may, at its expense, engage a nationally-recognized consultant in the PBM market pricing industry reasonably agreeable to Aetna ("Consultant") to compare the aggregate value of the pricing terms of this Agreement with the aggregate value of the prevailing pricing terms offered to Similar Employers (the "Market Check"). The parties agree that the Market Check shall be based on the entirety of mail and retail pricing for Brand Drugs and Generic Drugs, pricing for Specialty Products, administrative fees and Rebates. Actual form, format and content of information to be provided to Aetna by Consultant for purposes of the Market Check will be mutually agreed in advance and subject to a confidentiality agreement. The term Similar Employers means those employers with (i) an equivalent range of services ("Full Service PBM Customers") and (ii) equal or lesser mail order penetration, generic dispensing rate, overall claim volume and enrolled members and (iii) similar formulary content, coverage parameters and utilization patterns which impacts overall rebate performance.

The term Full Service PBM Customers means customers which purchase (i) pharmacy management coverage on an individual basis, excluding coalitions and (ii) a similar bundle of PBM services including but not limited to retail network management, claims processing, rebate contracting and management, mail order and specialty pharmacy fulfilment, formulary development and management, and pharmacy clinical programs with a similar set of plan design incentives and features to support similar results with respect to generic dispensing rate, mail order and captive specialty pharmacy fulfilment utilization, and formulary compliance.

In order to conduct the Market Check as accurately as possible, Consultant shall take into consideration any unique circumstances which may vary among Customer and the Similar Employers such as geographic distribution of members, utilized pharmacies and mix of drugs. In the event such circumstances require Consultant to make any adjustments, Aetna shall be entitled to review such adjustments before the results of the Market Check are shared with Customer. A response will be provided within 30 days following receipt of a complete Market Check review submission. Finally, the Market Check shall reflect the average aggregate value of the pricing terms offered to a minimum of three (3) Similar Employers. Should the Market Check indicate an average aggregate value providing greater than 1.5% gross cost savings to Customer, Aetna agrees to accept the Market Check and negotiate new pricing terms with Customer.

If Customer and Aetna mutually agree to new pricing terms, the Agreement shall be amended accordingly effective as of the first day of the next Contract Year (January 1, 2020) provided that customer provides written approval for financial changes within 30 days after the after Customer and Aetna have mutually agreed to new pricing terms and Aetna receives 60 days to implement the financial changes. If Customer and Aetna fail to agree to new pricing terms, Customer may terminate the agreement upon at least 90 days prior written notice to Aetna.

Additional Disclosures

The Customer acknowledges that the Retail Discounts and Dispensing Fees contained in this Agreement reflect a Traditional or Lock-In pricing arrangement. Traditional or Lock-In Pricing means that the amount charged to the Customer and Plan Participants for retail network claims may differ from the amount paid to Participating Retail Pharmacy and/or Aetna's PBM subcontractor and Aetna retains the difference, in addition to any other fees or charges agreed upon by Aetna and Customer, as compensation for the pharmacy benefit management services provided to the Customer.

Aetna reserves the right to make appropriate changes to these price points if any event materially impacts Aetna's net income derived under this Agreement. Such events include (i) the termination or material modification of any material manufacturer Rebate contract, (ii) any significant changes in the composition of Aetna's pharmacy network or in Aetna's pharmacy network contract compensation rates with its pharmacy network subcontractor, CVS Health, (iii) a change in government laws or regulations, (iv) AWP is discontinued or modified in whole or in part.

Aetna reserves the right to modify its products, services, and fees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or

fees (assessments) applied to self-funded benefit Plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the Plan sponsor. The pharmacy pricing contained herein does not include any such Plan sponsor liability.

Rebate Payment Terms

Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

Rebates will be distributed on a quarterly basis via ACH based on the schedule shown below. Rebate allocations will be made within 180 days from the end of each calendar quarter, with payments issued to customers in the month following allocation.

- Rebates related to the first quarter will be paid in September of the current year
- Rebates related to the second quarter will be paid in December of the current year
- Rebates related to the third quarter will be paid in March of the following year
- Rebates related to the fourth quarter will be paid in June of the following year

Aetna receives other payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates and which are paid separately to Aetna or designated third parties (e.g., mailing vendors, printers). These payments are to reimburse Aetna for the cost of various educational programs. These programs are designed to reinforce Aetna's goals of maintaining access to quality, affordable health care for Plan Participants and the Customer. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. Aetna may also receive payments from Prescription Drug manufacturers and other organizations that are not Prescription Drug Formulary Rebates as compensation for (i) bona fide services it performs, such as the analysis or provision of aggregated information regarding utilization of health care services and the administration of therapy or disease management programs and (ii) drug therapies that underperform pursuant to value-based contracting arrangements. Consequently, these other payments are not considered Rebates, and are not included in the Rebates provided to the Customer, if any, under this agreement.

If this Agreement is terminated by Aetna for the Customer's failure to meet its obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall be entitled to deduct deferred administrative fees or other plan expenses from any future rebate payments due to the Customer following the termination date.

Formulary Management

Aetna offers several versions of formulary options ("Formulary") for Customer to consider and adopt as Customer's Formulary. The formulary options made available to Customer will be determined and

communicated by Aetna prior to the implementation date. Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Customer the right to use one of its Formulary options during the term of the Agreement solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan. Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors. Customer agrees that any proposed additions and/or deletions to the Formulary will be adopted by Customer as a matter of Customer's plan design, and that Customer has the right to not implement any such addition or deletion, which such election shall be considered a Customer change to the Formulary. Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

Other Payments

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with plan sponsors, including without limitation, Customer.

Aetna's PBM subcontractor may also receive network transmission fees from its network pharmacies for services it provides for them. These amounts are not considered Rebates and are not shared with plan sponsors. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees.

Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or Aetna's PBM subcontractor, and instead are received by Aetna in connection with network contracting, provider education and other activities Aetna conducts across its book of business. Customer further agrees that the amounts described above belong exclusively to Aetna or Aetna's PBM subcontractor, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or Aetna's PBM subcontractor.

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Payments or rebates from drug manufacturers that compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

Pharmacy Audit Rights and Limitations

Customer is entitled to one annual Rebate audit, subject to the audit terms and conditions outlined in the pharmacy services schedule.

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the pharmacy services schedule.

Pharmacy audits shall be conducted at the Customer's own expense unless otherwise agreed to between the Customer and Aetna.

Limited Distribution Specialty Products

Certain Specialty Products may not be available at Aetna Specialty Pharmacy (ASRx) due to restricted or limited distribution requirements. These Specialty Products are referred to as Limited Distribution Specialty Products. Aetna has contracted with other network pharmacies to dispense Limited Distribution Specialty Products which are excluded from the pricing and terms contained in this Agreement. A copy of the current list of Limited Distribution Specialty Products may be obtained from Aetna upon request.

Exhibit G
Medical Performance Standards and Guarantees

Performance Standards Guarantees	Current Amount of Liquidated Damages	Yes, Can Comply
Claim Timeliness/Accuracy		
The employees of SBBC must have their healthcare claims processed and paid accurately within 30 calendar days. (Monthly)	$500 per occurrence	Yes, Can Comply
Procedural Accuracy - must have 99% all claims processed with no financial errors.	$500 per occurrence	Yes, Can Comply
Dollar Accuracy - must have 99% of all claims processed accurately.	$500 per occurrence	Yes, Can Comply
Claim Inquiries/Complaints		
All claims, written claim inquiries or complaints, and other contacts with the Awardees by the Benefits Department, the Payroll Unit, or SBBC employees and their covered dependents must have a written response within 20 calendar days of receipt by the Awardee.	$500 per item for each day beyond as outlined.	Yes, Can Comply
Telephone Responsiveness		
Average response time of 30 seconds or better. (Monthly)	$5,000/month	Yes, Can Comply
Abandonment rate of 5% or less. (Monthly)	$5,000/month	Yes, Can Comply
Network / Administration		
Awardee must agree that significant provider attrition during the course of this Agreement will constitute grounds for termination of this Agreement at the sole option of the School Board. Should the total number of voluntary and involuntary terminations by providers listed in the Provider Directory submitted with the Proposal exceed 20 percent of the total number of providers listed in that directory, the School Board, at its option, may terminate this Agreement with 60 days notice to the Awardee.	2/10 of 1 percent of annual premium for every percentage of provider turnover exceeding ten percent annually.	Yes, Can Comply
Administration		
Any time an SBBC employee or covered dependent receives a letter from a provider threatening legal action, referral to a collection agency, or other negative account which could jeopardize the employee or dependent's credit standing because of the Awardee's delay or failure in paying claims, the Awardee shall respond, in writing, directly to the letter writer, employee or covered dependent, and SBBC with an explanation of the claim status within ten (10) calendar days of receipt of notification by the Awardee.	$500 per item for each day beyond as outlined.	Yes, Can Comply

Exhibit G
Medical Performance Standards and Guarantees

Performance Standards Guarantees	Current Amount of Liquidated Damages	Yes, Can Comply
ID Cards - within three weeks following the date SBBC submits the enrollment data to the Awardee, ID cards must be delivered to the member's home address. An additional four calendar days will be added for total mailing time.	$25 per card for each day beyond three weeks.	Yes, Can Comply
Awardee must notify SBBC in writing at least 60 days prior to deletion of any drug in their formulary (not including FDA deletions). SBBC would request that employees are given a 60 to 90 grace period for the transition.	$1,000 per calendar day for each day less than 60 days.	Yes, Can Comply
Proposer agrees to liquidated damages for employee satisfaction ratings below 85% .	$1,500 for each percentage point below 85%.	Yes, Can Comply
The M/WBE's office will require a 30-day written notice for substitution of an M/WBE vendor.	$100 per calendar day for the first 30 days and $1,000 per calendar day thereafter until notifications received.	Yes, Can Comply
Performance penalties will be capped at 7% of ASO fees.	7% of ASO fees	Yes, Can Comply

General Performance Guarantee Provisions

Aetna Life Insurance Company (ALIC) provides benefits administration and other services for the self-funded pharmacy plans. The services set forth in this document will be provided by ALIC (hereinafter "Aetna").

Performance Objectives

Aetna believes that measuring the activities described below are important indicators of how well we service The School Board of Broward County, Florida (SBBC). We are confident that pharmacy administration services provided to SBBC will meet their high standards of performance. To reinforce SBBC's confidence in Aetna's ability to administer their program, we are offering guarantees in the following areas:

Performance Guarantee Category	Minimum Standard	Proposed Penalty
Claim Administration		
• Claim Processing Accuracy	99.0%	$45,000
• Financial Accuracy	99.0%	$45,000
• Formulary Drug Deletions	We will notify SBBC in writing at least 60 days prior to deletion of any drug in their formulary (not including FDA deletions)	$40,000
• Claim Inquiries/Complaints	Refer to Medical	Refer to Medical
• Legal Action/Collection Agency	Refer to Medical	Refer to Medical
• ID Cards	Refer to Medical	Refer to Medical
• M/WBE Office	Refer to Medical	Refer to Medical
Retail Claim Administration		
• Turnaround Time – Paper Claims	97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt	$45,000
Mail Order Claim Administration		
• Turnaround Time – Clean Claims	98.0% within an average of 2 business days of receipt	$45,000
• Turnaround Time – Claims Requiring Intervention	95.0% within an average of 5 business days of receipt	$45,000
• Mail Order Dispensing Accuracy	99.5%	$45,000
Member Services		
• Average Speed of Answer	30 seconds or less	$45,000
• Abandonment Rate	3.0%	$45,000
• Member Satisfaction	Refer to Medical	Refer to Medical
Total		**$400,000**

Guarantee Period

The guarantees described herein will be effective for a period of 12 months and will run from **January 1, 2018 through December 31, 2018** (hereinafter "guarantee period").

The performance guarantees shown below will apply to the self-funded Aetna Pharmacy Management plans administered under the Administrative Services Only Agreement ("Services Agreement"). These guarantees do not apply to non-Aetna benefits or networks.

Aggregate Maximum

In total, Aetna agrees to place **$400,000** at risk through the Performance Guarantees outlined in this document. Our offer assumes **27,341** employee lives. Aetna reserves the right to revisit the guarantees if there is a change in enrollment of more than 15%.

Termination Provisions

Termination of the guarantee obligations shall become effective upon written notice by Aetna in the event of the occurrence of (i), (ii) or (iii) below:

i. a material change in the plan initiated by SBBC or by legislative action that impacts the claim adjudication process, member service functions, pharmacy network management or rebates;
ii. failure of SBBC to meet its obligations to remit administrative service fees or fund the SBBC bank account as stipulated in the General Conditions Addendum of the Services Agreement;
iii. failure of SBBC to meet their administrative responsibilities (e.g., a submission of incorrect or incomplete eligibility information).

No guarantees shall apply for a guarantee period during which the Services Agreement is terminated by SBBC or by Aetna.

Penalty Reconciliation and Refund Process

At the end of each guarantee period, Aetna will compile the Performance Guarantees results. If necessary, Aetna will provide a refund to SBBC for any penalties incurred.

Claim Administration

Claim Processing Accuracy Guarantee

Guarantee: Aetna will guarantee that the claim processing accuracy rate for all retail, mail order and directly submitted paper claims will be 99.0% or better.

Definition: The number of retail claims, mail order claims and directly submitted paper claims adjudicated by PBM that do not contain a material adjudication error as revealed through sample claim audit. Claim Processing Accuracy is measured as the number of claims processed in accordance with the plan set-up parameters divided by the total number of claims audited.

Penalty and Measurement Criteria: A penalty of $11,250 will apply for each 0.25% that the actual claim processing accuracy rate for all retail, mail order and directly submitted paper claims falls below 99.0%. There will be a maximum penalty of **$45,000**. Guarantee results will be measured based on an audit (audit will be paid for by SBBC).

Financial Accuracy Guarantee

Guarantee: Aetna will guarantee that the financial accuracy rate for all retail claims, mail order claims and directly submitted paper claims will be 99.0% or better.

Definition: The absolute dollar amount of retail claims, mail order claims and directly submitted paper claims adjudicated by PBM that do not contain a material adjudication error as revealed through sample claim audit divided by the absolute dollar amount of all such claims adjudicated by PBM.

Penalty and Measurement Criteria: A penalty of $11,250 will apply for each 0.25% that the actual financial accuracy rate for all retail claims, mail order claims and directly submitted paper claims falls below 99.0%. There will be a maximum penalty of **$45,000**. Guarantee results will be measured based on an audit (audit will be paid for by SBBC).

Formulary Drug Deletions

Guarantee: Aetna must notify SBBC in writing at least 60 days prior to deletion of any drug in their formulary (not including FDA deletions). SBBC would request that employees are given a 60 to 90 grace period for the transition.

Penalty and Measurement Criteria: A one-time penalty of **$40,000** will apply if Aetna does not notify SBBC in writing at least 60 days prior to deletion of any drug in their formulary

(not including FDA deletions). Aetna's records will be used to determine if the terms of this guarantee have been met.

Retail Claim Administration

Turnaround Time – Paper Claims Guarantee

Guarantee: Aetna will guarantee that the claim payment processing turnaround time for all retail pharmacy claims submitted on paper will be 97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt.

Definition: Total percentage of claims processed is measured as the number of claims processed within specified number of days divided by the total number of claims audited. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $11,250 will apply for each 0.25% that the actual turnaround time for reimbursement of paper claims submitted falls below the guaranteed level of 97.0% within a weighted average of 5 business days of receipt and 99.5% within a weighted average of 10 business days of receipt. There will be a maximum penalty of **$45,000**. Guarantee results will be measured based on Aetna's book of business.

Mail Order Claim Administration

Turnaround Time - Clean Claims Guarantee

Guarantee: Aetna guarantees that at least 98.0% of all mail order claims not requiring intervention will be dispensed and shipped within an average of 2 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, not requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $22,500 will apply for each full day that the average turnaround time of 98.0% of all mail order claims not requiring intervention

exceeds an average of 2 business days. There will be a maximum penalty of **$45,000**. Guarantee results will be measured based on Aetna's book of business.

Turnaround Time – Claims Requiring Intervention Guarantee

Guarantee: Aetna guarantees that at least 95.0% of all mail order claims requiring intervention will be dispensed and shipped within an average of 5 business days of receipt.

Definition: For the respective guarantee period, turnaround time for claims, requiring intervention is determined by assessing the average time, in business days, that it takes prescriptions to be processed and shipped from the Aetna Rx Home Delivery pharmacy. This guarantee may not apply and a penalty may not be paid, if results are not achieved due to severe weather events which directly or indirectly impact performance during the guarantee period.

Penalty and Measurement Criteria: A penalty of $22,500 will apply for each full day that the average turnaround time of 95.0% of all mail order claims requiring intervention exceeds an average of 5 business days. There will be a maximum penalty of **$45,000**. Guarantee results will be measured based on Aetna's book of business.

Mail Order Dispensing Accuracy Guarantee

- Correct drug dispensed to correct member
- Correct drug, strength, dosage form
- Correct instructions provided to the member for use

Guarantee: Aetna guarantees that at least 99.5% of all mail order prescriptions will be dispensed correctly for drug, strength, form, instructions, and patient.

Definition: For the respective guarantee period, total dispensing accuracy is measured as the number of prescriptions with no errors divided by the total number of prescriptions dispensed.

Penalty and Measurement Criteria: A penalty of $11,250 will apply for each 0.1% that the actual percentage of all mail order prescription dispensing accuracy falls below the target of 99.5%. There will be a maximum penalty of **$45,000**. Guarantee results will be measured based on Aetna's book of business.

Member Services

The School Board of Broward County, Florida
Procurement & Warehousing Services

ITB / RFP No.:	18-009V	Tentative Board Meeting Date*:	SEPTEMBER 6, 2017
Description:	GROUP MEDICAL BENEFITS FOR SCHOOL BOARD EMPLOYEES	Notified: 381	Downloaded: 38
		ITB / RFP Rec'd: 5	No. Bids: 0
For:	BENEFITS & EMPLOYMENT SERVICES	ITB / RFP Opening:	FEBRUARY 6, 2017
Fund:	FRINGE BENEFITS CLEARING ACCOUNT	Advertised Date:	DECEMBER 2, 2016

POSTING OF ITB / RFP RECOMMENDATION/TABULATION: ITB / RFP Recommendations and Tabulations will be posted in the Procurement & Warehousing Services and www.Demandstar.com on **MARCH 27, 2017 @ 3:00 pm** and will remain posted for 72 hours. Any person who is adversely affected by the decision or intended decision shall file a notice of protest, in writing, within 72 hours after the posting of the notice of decision or intended decision. The formal written protest shall be filed within ten (10) days after the date the notice of protest is filed. Failure to file a notice of protest or failure to file a formal written protest shall constitute a waiver of proceedings under this chapter. Section 120.57(3)(b), Florida Statutes, states that "The formal written protest shall state with particularity the facts and law upon which the protest is based." Saturdays, Sundays, state holidays and days during which the District is closed shall be excluded in the computation of the 72-hour time period provided. Filings shall be at the office of the Director of Procurement & Warehousing Services, 7720 West Oakland Park Boulevard, Suite 323, Sunrise, Florida 33351. Any person who files an action protesting an intended decision shall post with the School Board, at the time of filing the formal written protest, a bond, payable to The School Board of Broward County, Florida, (SBBC), in an amount equal to one percent (1%) of the estimated value of the contract. Failure to post the bond required by SBBC Policy 3320, Part VIII, Purchasing Policies, Section N, within the time allowed for filing a bond shall constitute a waiver of the right to protest.

(*) The Cone of Silence, as stated in the ITB / RFP, is in effect until this ITB / RFP is approved by SBBC. The Board meeting date stated above is tentative. Confirm with the Purchasing Agent of record for the actual date the Cone of Silence has concluded.

RECOMMENDATION TABULATION

BASED UPON THE RECOMMENDATION OF THE SUPERINTENDENT'S INSURANCE & WELLNESS ADVISORY COMMITTEE (SWIAC), IT IS RECOMMENDED THAT THE FOLLOWING LISTED PROPOSER BE RECOMMENDED FOR AWARD FOR GROUP MEDICAL BENEFITS FOR SCHOOL BOARD EMPLOYEES.

M/WBE ADVISOR: LAVINIA FREEMAN, M/WBE SPECIALIST III

AETNA LIFE INSURANCE COMPANY

CONTRACT PERIOD: JANUARY 1, 2018 THROUGH DECEMBER 31, 2020.

By: _____ (Purchasing Agent) Date: 3/23/17

The School Board of Broward County, Florida, prohibits any policy or procedure which results in discrimination on the basis of age, color, disability, gender expression, national origin, marital status, race, religion, sex or sexual orientation. Individuals who wish to file a discrimination complaint, may call the Executive Director, Benefits & EEO Compliance at 754-321-2150 or Teletype Machine (TTY) at 754-321-2158.

Individuals with disabilities requesting accommodations under the Americans with Disabilities Act (ADA) may call the Equal Educational Opportunities (EEO) at 754-321-2150 or Teletype Machine (TTY) at 754-321-2158.

SCORING SHEET

Group Medical Benefits for School Board Employees RFP 18-009V	Max Points	Glynda Linton	Shawn Mass	Erum Motiwala	Craig Nichols	Harold "Chip" Osbor	Donna Sacco	Pete Tingom	Jack Vesey	Joseph Zeppetella	*Average Score*
Section D2: Supplier Diversity & Outreach Program (Employment Diversity Statistics)	2										
Aetna Life Insurance Company		1	2	2	1	2	2	2	2	2	*1.78*
AvMed, Inc.		2	2	2	1	2	2	2	2	2	*1.89*
Section D3: Supplier Diversity & Outreach Program (Involvement in Minority Community)	2										
Aetna Life Insurance Company		2	2	2	2	2	2	0	2	2	*1.78*
AvMed, Inc.		0	0	0	0	0	0	1	0	0	*0.11*
TOTAL SCORE	100										
Aetna Life Insurance Company - Option 1		80	90	95	85	88	74	86	84	87	*85.4*
Aetna Life Insurance Company - Option 3		87	91	97	88	88	78	88	86	90	*88.0*
AvMed, Inc.		83	71	77	62	76	64	82	77	72	*73.8*

Signature: _____ Date: _____

Section D2: Supplier Diversity & Outreach Program (Employment Diversity Statistics)	2										
Benecard Services, Inc. d/b/a BeneCard PBF		0	2	2	1	2	2	0	0	1	*1.11*
Section D3: Supplier Diversity & Outreach Program (Involvement in Minority Community)	2										
Benecard Services, Inc. d/b/a BeneCard PBF		0	0	0	0	0	0	0	0	0	*0*
TOTAL SCORE	100										
Benecard Services, Inc. d/b/a BeneCard PBF		88	68	82	67	57	55	75	60	66	*68.7*

Signature: _____ Date: _____