AGREEMENT

THIS AGREEMENT is made and entered into as of this ____ day of ______________, 2020, 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
261 N. University Drive
Plantation, Florida 33324

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 FY21-016 - Group Medical Benefits for School Board Employees, dated December 17, 2019 and amended by Addendum Number One dated December 17, 2019, Addendum Number Two dated December 19, 2019, Addendum Number Three dated December 20, 2019, Addendum Number Four dated February 6, 2020 and Addendum Number Five dated February 21, 2020 (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 March 9, 2020 (hereinafter referred to as "Proposal") which is incorporated by reference herein, in response to the RFP; and

WHEREAS, the SBBC and AETNA desire to memorialize the terms and conditions of this Agreement to include references to the Exhibit A - Administrative Service Agreement, Exhibit B - Administrative Service Fees, Exhibit C - Medical Network Guarantee Discount, Exhibit D – Pharmacy Service and Fee Schedule, Exhibit E - Performance Guarantees - Medical and Pharmacy, Exhibit F – Tri-County Provider Count, HIPAA Business Associate Agreement, 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, 2021** and conclude on **December 31, 2023**. 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 renewal 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 as part of this Agreement to include references to the Exhibit A - Administrative Service Agreement, Exhibit B - Administrative Service Fees, Exhibit C - Medical Network Guarantee Discount, Exhibit D – Pharmacy Service and Fee Schedule, Exhibit E - Performance Guarantees - Medical and Pharmacy, Exhibit F – Tri-County Provider Count, respectively attached as Exhibits A – F to this Agreement.

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

- **Wellness Coordinator**
  - Aetna agrees to fund an additional Full time/On-site Wellness Coordinator.
- **Custom Provider Network**
  - At SBBC's sole option during the term of the initial Agreement, SBBC may opt to replace or include the Kids Plans with a Custom Network, as more fully described in their Proposal.
- **Tri-County Provider Count**
  - Aetna has the following number of providers in the tri-county area, as outlined in Exhibit F.
- **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.

ARTICLE 2 – SPECIAL CONDITIONS cont'd

- **Value Added Services**
  - Aetna Advice and Feeling Better will be offered at no additional cost.

- **CVS Health Hub**
  - At SBBC's sole option, SBBC shall determine the co-pay for the CVS Health Hub visit.

- **Wellness Tracking**
  - At SBBC's sole discretion, SBBC can elect to add the Vitality Wellness Program during the term of the initial contract, at a cost of $1.57 for Employee Only and $1.77 for Employee plus Spouse or Domestic Partner.

- **National Advantage Plan (NAP)**
  - Aetna will receive 35% of the savings and will cap the savings at $100,000 per claim.

- **Interactive Health Station Kiosks**
  - Aetna agrees to provide and fund an additional four (4) additional Kiosks. The total annual allowance for the additional Kiosks will be $15,000 Additionally, Aetna will add and fund a CVS Over-the-Counter Kiosks, at no additional cost to SBBC.

- **Virtual Visit – Behavioral Health & Dermatology**
  - Additionally, Aetna agrees to provide Virtual Telehealth Services for Behavioral Health and Dermatology. Such services will be billed as a claim, at no additional fees.

- **V-Codes**
  - Aetna agrees to cover V-codes, as a covered benefit under the plan.

- **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.

- **Transparency Tool - Aetna Informed Rewards**
  - At SBBC's sole option, during the term of this contract SBBC may offer this service through Aetna as follows:
    - Years 1-3 at a cost of $1.50 per employee per month
    - Years 4-5 at a cost of $1.75 per employee per month

- **Data Exchange with 3rd Parties Vendors**
  - Aetna agrees to provide standard data reports and exchange of data at no cost to SBBC.

- **Audits**
  - Aetna agrees to provide an Audit Fund of $100,000 annually, to be used either for a Medical and/or Pharmacy Audit(s).

2.04 **In-Patient Hospitalization Review**. Aetna agrees to provide a report to SBBC of all inpatient admissions over 30 days. In addition, Aetna agrees to provide notification of large claimants over $300,000 to SBBC no later than 48 hours after escalation process review.

2.05 **Performance Guarantees**. Aetna agrees to the Performance Guarantees as outlined in Exhibit E.

2.06 **Cost of Services.** SBBC shall pay AETNA for services rendered under this Agreement, as outlined in Exhibits B and D 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 (COB), as part of the ASO fees and will not charge a percentage of COB savings.

2.07 **Ad-hoc Reporting**. Aetna agrees to provide Ad-hoc reports, as requested by SBBC at no charge.

2.08 **Fraud & Abuse**. Aetna agrees to provide quarterly fraud and abuse reporting and return 100% of recovered dollars to SBBC, at no charge to SBBC.

2.09 **Medical and Pharmacy Fee Credit**. Medical and Pharmacy fee credits as more fully described in the Proposal and Exhibit D.

2.10 **Pharmacy**. Aetna agrees to the following negotiated items.

- **Pharmacy Paper Claims.**
  - Aetna agrees to waive any fees for Pharmacy paper claims.

- **Mac Listing.**
  - Agrees to provide the MAC list to SBBC on a quarterly basis.

2.11 **Rebate**. Aetna agrees that any earned rebates will continue to be paid out after the termination of this Agreement.

2.12 **Market Check.** Aetna agrees to a Pharmacy Market check as more fully described in Exhibit D to this Agreement.

2.13 **Pharmacy Discount Guarantees**. If a certain percentage off of average wholesale priced is missed, the entire difference will be paid to SBBC, as further outlined in Exhibit D.

2.14 **Medical Network Guarantee Discount Performance Guarantee**. Refer to Exhibit C for details of this Performance Guarantee.

2.15 **S/M/WBE.** AETNA agrees to provide a scholarship in the amount of $50,000 per year for minority students. If SBBC exercises years four (4) and five (5) AETNA agrees to continue providing $50,000 for each of those years.

AETNA further agrees to spend $1,653,600 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 $552,000 per each year towards minority vendors.

2.16 **Additional Documents.** SBBC and AETNA, desire to enter into an ASA - Exhibit A - Administrative Service Agreement, Exhibit B - Administrative Service Fees, Exhibit C - Medical Network Guarantee Discount, Exhibit D – Pharmacy Service and Fee Schedule, Exhibit, E - Performance Guarantees - Medical and Pharmacy, Exhibit F – Tri-County Provider Count, HIPAA Business Associate Agreement, Exhibit G, respectively attached as Exhibits A – G to this Agreement.

2.17 **Public Records Request of Redacted Data**. Upon a public records request for Aetna marked trade secret information, SBBC will notify Aetna timely and Aetna promptly will provide SBBC with a court order to protect such data being deemed trade secret. If Aetna wishes to protect data contained in this Agreement or any Exhibits attached hereto, then Aetna at its sole option, expense, and defense to protect such data from public domain is Aetna's full and sole responsibility. If Aetna does not obtain such court order in a timely fashion, then the Plan Sponsor may release the requested data to fulfill the public records request. Areas highlighted in yellow and in red font in this Agreement and Exhibits have been requested by Aetna to be marked as a trade secret.

2.18 **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 Five, dated, February 21, 2020; then
Third Addendum Number Four, dated, February 6, 2020; then
Fourth: Addendum Number Three, dated, December 20, 2019; then
Fifth: Addendum Number Two, dated, December 19, 2019; then
Sixth: Addendum Number One, dated, December 17, 2019; then
Seventh: RFP FY21-016 – "Group Medical Benefits for School Board Employees".

2.18.1 **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.

2.19 **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 workspace 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.

2.20 **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:	Director, Benefits & Employment Services 7770 W. Oakland Park Blvd. Sunrise, Florida 33351
To AETNA:	Gabrielle Dimitrakis, Account Manager, Florida Public & Labor 261 N. University Drive Plantation, Florida 33324
With a Copy to:	Cathy Aguirre, Market Head Public & Labor Segment 261 N. University Drive Plantation, Florida 33323

2.21 **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.

2.22 **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.

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

2.24 **HIPAA Compliance.** AETNA acknowledges that the Health Insurance Portability and Accountability Act ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act") (HIPAA and HITECH Act are collectively referred to herein as "HIPAA") protect the privacy of protected health information ("PHI") and may be applicable to student records in certain circumstances; and shall enter into SBBC's HIPAA Business Associate Agreement ("BAA") attached as **Exhibit G.** PHI may be used and disclosed only in compliance with HIPAA.

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.

ARTICLE 3 – GENERAL CONDITIONS cont'd

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.

ARTICLE 3 – SPECIAL CONDITIONS cont'd

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)

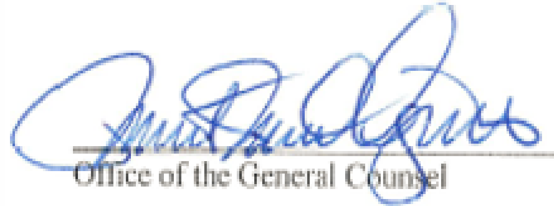
ATTEST:

____
Robert W. Runcie, Superintendent of Schools

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

By______________________________
Donna P. Korn, Chair

Approved as to Form and Legal Content:



FOR AETNA

(Corporate Seal)

AETNA LIFE INSURANCE COMPANY

ATTEST:

By ______________________
Catherine Aguirre, Market Head,
Public & Labor of Florida

______________________, 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 Florida

COUNTY OF Broward

The foregoing instrument was acknowledged before me this 24 day of August, 2020 by Catherine Aguirre 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

Ruth Zafra
Printed Name of Notary

(SEAL)

GG053923
Notary's Commission No.

EXHIBIT A
ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement Exhibit A (this "Exhibit") is effective the 1ST day of January 2021, (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 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:

1. 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 and is the Director, Benefits & Employment Services.

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) calendar 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.

2. 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. Plan Administrator will prepare draft documents for Plan Sponsor to approve.

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 outlined by SBBC. During the term of Exhibit, Plan Sponsor shall notify ASP in writing at least ninety (90) calendar days in advance of any change and ASP shall notify Plan Sponsor whether it can administer such change within thirty (30) calendar 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, copayments 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, Target Medical and/or Pharmacy claims audits, at ASP expense, if significant performance issues are discovered within the independent audit.

ASP is providing Plan Sponsor with an annual allowance of $100,000 to be used for the Medical and/or Pharmacy review process and audit expenses. Payment will be made to third party vendor(s) directly from ASP to the 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 $100,000 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. ASP will make every effort to provide your third-party auditor with information sufficient to confirm the payments to you are accurate. ASP may elect to request data within the Audit be marked as trade secret, if such is requested than the provisions as outlined in the Agreement will be followed.

2.8.1 General

2.8.1.1 Generally. ASP agrees to execute Plan Sponsor's Business Associate Agreement. 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 ASP request to maintain records as trade secret set forth in this Section and after the removal of any patient identifiers. ASP shall provide reasonable workspace to Plan Sponsor representatives. ASP may elect to request data within the Audit be marked as trade secret, if such is requested than the provisions as outlined in the Agreement will be followed.

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. Nothing in this clause shall limit the Plan Sponsor's obligation with regard to any public records request.

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") no matter where SBBC data is housed, 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, but no later than 45 calendar days. 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 ASP request to maintain records as trade secret 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 $100,000 to be used for the Medical and/or Pharmacy review process and audit expenses. Payment will be made directly from ASP to the 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 $100,000 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 and as described in the scope document.

(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 mutually agreeable 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 will 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) calendar days' advance notice to ASP, to conduct performance guarantee with regards to reported metrics, financial accuracy and other areas as outlined in Exhibit E 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. Audits shall only be made during normal business hours following thirty (30) calendar 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 mutually agreeable 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 will 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.

3. 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) calendar 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.

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) calendar 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 the RFP Response to this Agreement at the rates, if any, set forth in Exhibit B. 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 this Exhibit 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) calendar 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 Plan Sponsor 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 ASP payable through the Bank or by electronic

funds transfer or other reasonable transfer method. Plan Sponsor, by execution of the Agreement, expressly authorizes ASP to issue and accept such checks on behalf of Plan Sponsor for the purpose of payment of Plan benefits and other related charges. Plan Sponsor agrees to provide funds through its designated bank sufficient to satisfy all Plan benefits and related charges upon notice from ASP or the Bank of the amount of payments made by ASP. Plan Sponsor 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 Plan Sponsor and ASP. 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, that directly impact SBBC (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, 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. 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 the response to the RFP and Exhibit B 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.

4. **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.

4.1. 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 B 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, 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) calendar 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) calendar 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 meet such performance guarantees, set forth in Exhibit E including at a minimum annual reporting.

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) calendar 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) calendar 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 or Benefits Outsource, Inc, 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 Section

2.7 and 2.8.

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. If SBBC - In the event of a breach or a threatened breach of this Section 6.3 by SBBC, 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.

If a public records request - In the event of a breach or a threatened breach of this Section 6.3 due to a public records request, 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 precluding Plan Sponsor from complying with the public records request, 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. In the event of a **Public Records Request of Redacted Data**. Upon a public records request for ASP's marked trade secret information, SBBC will notify ASP timely and ASP promptly will provide SBBC with a court order to protect such data being deemed trade secret. If ASP wishes to protect data contained in this Agreement or any Exhibits attached hereto, then ASP at its sole option, expense, and defense to protect such data from public domain is ASP's full and sole responsibility. If ASP does not obtain such court order in a timely fashion, then the Plan Sponsor may release the requested data to fulfill the public records request. Areas highlighted in yellow and in red font in this Agreement and Exhibits have been requested by ASP to be marked as a trade secret.

7.0 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.

8. Miscellaneous.

8.1 **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.

FINANCIAL RESPONSE FORMS – SELF-FUNDED MODELS
Managed Care/HMO Models

SBBC is requesting a 36-month flat rate guarantee for the ASO fees, as outlined below, for each self-funded option. The Proposer shall state its proposed prices for providing all services as stated in the RFP. Note that fees in the initial Calendar Year (2021) shall be quoted on a Mature basis, i.e., fees/premiums are inclusive of run-out administration. Fees shall be quoted for 2021, 2022 and 2023. If the fee for one of the listed services is included in the fee for another service (e.g. if the utilization Management fee is included in the ASO fee), the enter "included" in the cell for that fee.

	2021	**2022**	**2023**
Expected Paid Claims	$177,351,127 projected medical claims for HMO Model plans In addition, Pharmacy projected claims (with rebates) are $39,239,534 for HMO Model plans	$192,142,211 projected medical claims for HMO Model plans In addition, Pharmacy projected claims (with rebates) are $42,754,702 for HMO Model plans	$208,166,871 projected medical claims for HMO Model plans In addition, Pharmacy projected claims (with rebates) are $47,347,902 for HMO Model plans
Expected Change in Claim Reserves (PEPM)	N/A	N/A	N/A
ASO Fees (PEPM)	$29.95	$29.95	$29.95
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)	N/A	N/A	N/A
Drug Utilization Review Fees (PEPM)	Included	Included	Included
Claim Fiduciary Fees (PEPM)	Included	Included	Included
Credentialing	Included	Included	Included

Quality Assurance	Included	Included	Included
Customer Service	Included	Included	Included
Grievance/Appeals Administration	Included	Included	Included
Coordination of Benefits	Included	Included	Included
Subrogation Services	30.0% of recovered amount	30.0% of recovered amount	30.0% of recovered amount
Telehealth Services (PEPM/PPPM)	Included	Included	Included
Standard Reporting	Included	Included	Included
Ad hoc Reporting	Included	Included	Included
Interface with Other Carve-out Vendors	Charges vary based on carved out services	Charges vary based on carved out services	Charges vary based on carved out services
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	$29.95	$29.95	$29.95

1. Are you willing to provide rate guarantees/rate caps for years four and five? Yes X No__ If yes, describe the rate guarantees/ rate caps you are proposing.

   Years four and five not to exceed 3% fee increases.

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 #194 for a completion description of our disease management 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.

   Aetna's Enhanced Clinical Review program helps contain rapidly rising costs while enabling members to access care using evidence-based guidelines. Our outpatient precertification process includes high-tech radiology procedures, diagnostic cardiology, facility-based sleep studies, cardiac rhythm implant devices, interventional pain management and hip and knee replacement procedures in all HMO markets and most of our PPO markets. Our program aims to manage costs through prospective medical review and to encourage network utilization. The Enhanced Clinical Review Program charge is $0.70 per member per month through the claim wire for participation in this program. This fee is only assessed for membership in markets where the program operates. The School Board of Broward County's specific savings for this program was $1.76 PMPM.

   Capitations are not included.

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

   The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. The contracted rates component offers access to contracted rates for many medical claims from non-network providers, including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers. The Facility Charge Review component provides reasonable charge allowance review for most inpatient and outpatient facility claims where a NAP contracted rate is not available. The Itemized Bill Review Program applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. Aetna will forward IBR claims to a vendor to review and identify any billing inconsistencies and errors. We will retain 35% percent of savings from the Contracted Rates National Advantage Program, Facility Charge Review and Itemized Bill Review components. A maximum fee of $100,000.00 per claim will apply.

A contingency of up to 30.0% percent is paid to a vendor upon recovery of a self-funded customer's claims for certain claim overpayment programs such as the following: coordination of benefits, retroactive termination, audits (Hospital, DRG, High Cost Drugs, etc.), duplicate bills, contract compliance, claim and code review program. Also, a contingency fee of up to 30.0% is applicable for comprehensive subrogation services.

a) What was your average revenue (total recoveries retained by your organization) for your South Florida self-insured book of business for the following. State a a dollar amount including total claims paid for the year.

- Subrogation
- Standard facility charge review
- Code review (own or third party)
- Audits such as hospital claims, specialty drugs, DRG, etc. (list separately)
- Duplicate bills
- Contract compliance
- Out-of-network negotiated rates
- Large inpatient claim review
- Other (list any missing from the list)

Book of business values for overpayment recovery programs could vary by plan sponsor based on the type of claims that are paid and the amount identified and recovered.

In addition, the out of network negotiated revenue could vary depending on a plan sponsors NAP Fee %, product, plan design, network (i.e. narrow network), geography and member utilization. Due to the variables a book of business amount is not available.

b) Are or can the amounts retained by your organization be reported with each wire transfer request?

Yes, the claim detail report will have specific draft accounts that will outline the retained amounts for our overpayment recovery, subrogation, and out of network savings programs.

c) List every third party vendor that will be involved in the administration of the School Board's plans including name of vendor, amount paid to the vendor for services rendered including minimum and how long this vendor has been working with your organization.

We maintain stringent requirements and standards for all subcontractors. We define a subcontractor as an entity that we have engaged to provide goods or perform services for us. The following table identifies our Tier 1 subcontractors, which are a subset of our suppliers/vendors. Tier 1 subcontractors provide member constituent services directly related to the administration of a customer contract and for whom a portion of the services provided may include direct member contact or significant access to member identifiable data. Please note that not all subcontractors provide services to all lines of business, customers or members.

Subcontractor	**Scope of Services**
Clarity Software Solutions, Inc.	Production of plastic and paper identification cards included in administrative fee. Over 10 years
Conduent	Intake services: mailroom, imaging, data entry, X-ray handling, medical, dental, encounters, referrals, CATS and correspondence. Overpayment recovery for hospital credit balance review, call center services - PDP, FSA, SRC, ETech/SSHL, recertification. Print fulfillment included in administrative fee. Over 15 years
Cotiviti	Overpayment Recovery for Data Mining, Duplicate Payments, Provider Credit Balance 30.0% for recoveries. Two years.
Benefit Outsource	Provides onsite staff support, open enrollment support, retiree direct billing, COBRA administration, overage dependent billing and wellness consultant support additional well consultant included in fee. Aetna has been doing business with BOI for 15 years.
End-Game Strategy, Inc.	Overpayment recovery - data mining 30.0% recoveries. Aetna has been doing business with End-Game for over 13 years.
Equian	Overpayment recovery - retro termination, contract compliance, out-of-network review, duplicate payment 30.0% recoveries. Aetna has been doing business with Equian for over 10 years.
EquiClaim, Inc.	Overpayment recovery - high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and inpatient contract compliance audit) 30.0% recoveries. Aetna has been doing business with EquiClaim for over 6 years.

Health Management Systems (MedRecovery Management LLC is now part of HMS)	Overpayment recovery for workers' compensation 30.0% recoveries. Aetna has been doing business with HMS for over 12 years.
Iron Mountain, Inc.	Records archiving, retrieving, transportation, and destruction services included in fees. Aetna has been doing business with Iron Mountain for over 20 years.
Optum Insights LLC	Overpayment recovery - hospital credit balance, audit complete (healthcare data solutions), coordination of benefits, data mining, RX overpayment recovery 30.0% of recoveries. Aetna has been doing business with Optum for over 14 years.
Quest Diagnostics	Determine individual health risk factors resulting in a personal summary report or personalized health action plan. Quest Diagnostics Blueprint for Wellness Fasting Venipuncture Heart & Glucose Panel; blood testing; metabolic syndrome testing - will draw blood and measure other metabolic tests - includes data processing and result communication. In the event biometric screenings are conducted. Quest services will be used. Fees can be taken out of the wellness fund. Aetna has been doing business with Quest for over 20 years.
Rawlings Company, LLC	Overpayment recovery for coordination of benefits and subrogation; medical/dental. Identification of subrogation potential for disability claims (disability is related to workers comp or accident, not an illness.) 30.0% of recoveries. Aetna has been doing business with Rawlings for over 15 years.
Source One Direct, Inc.	Production of plastic and paper identification cards. Printing of contracts, postcards and booklets for Aetna National Customer Operations. Included in Administrative fees. Aetna has been doing business with Source Once for over 6 years.
Teladoc	Resolve medical issues 24/7 through the convenience of phone or video consultations. Provides patients with access to national network of physicians who can diagnose, treat and prescribe medication for many common medical issues. No additional fees other than the claim for Teladoc services. Those services will be billed through the claims wire as a claim. The charge for Teladoc services is $47.00 for general medical, $85.00 for behavioral health and $190 psychiatry and $75.00 for dermatology. Aetna has been doing business with Teladoc for over 5 years.

The amounts paid to vendor vary based on amounts recovered and contracted rates.

5. Is there a difference in the stated ASO fees for sole carrier versus dual carrier? Yes X 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 administrative fees will need to be reviewed and discussed.

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

   Administrative fees are developed based on our core administrative costs including group specific requirements. Specific actuarial formulas and factors used to calculate our self-funded contract fees are proprietary in nature.

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

   Network charges are included in our $29.95 PEPM administrative fee. The network component of our administrative fee represents the managing of our network and contracting with providers. It includes network access, Institute of Quality Program, National Medical Excellence Program, Teladoc services and many other services.

   Our administrative fee also represents the servicing and processing of your claims accordingly to SBBC's Summary Plan Descriptions. We make sure that claims are valid and covered and we process payment for them. The claim services are claim processing, adjudication, member services, distribution, claim system, and home office support.

   The administration fee includes plan administration costs representing a designated service center, account management team, onsite open enrollment meeting preparation, ID cards, summary of benefits and coverage, claim fiduciary option 1 and external review.

   It also includes our care management programs such as Aetna Compassionate Care Program, Aetna Heath Connections Disease Management, Medquery with Member Messaging, Personal Health Record, Regional Case Management (Aetna One Essentials), and Utilization Management. Aetna is introducing two new medical management programs Aetna Advice and Healing Better.

   The member resources included in our administration fee are member website and mobile experience and enhanced customer servicing framework.

We have also included 5 dedicated account associates and 2 wellness coaches included in our administration fee as well as reporting charges and behavioral health administration such as behavioral health conditions management and applied behavioral analysis. In addition, we are able to support SBBC's COBRA administration and wellness initiatives.

- As a percent of claims?

  Not applicable since administrative fees are not derived as a percent of claims.

- As a capitated dollar amount per employee?

Capitations are not included.

FINANCIAL RESPONSE FORMS – SELF-FUNDED MODELS

High Deductible Health Plan WITH A Health Saving Account

SBBC is requesting a 36-month rate guarantee for the ASO fees, as outlined below, for each self-funded option. The Proposer shall state its proposed prices for providing all services as stated in the RFP. Note that fees in the initial Calendar Year (2021) shall be quoted on a Mature basis, i.e., fees/premiums are inclusive of run-out administration. Fees shall be quoted for 2021, 2022 and 2023. If the fee for one of the listed services is included in the fee for another service (e.g. if the utilization Management fee is included in the ASO fee), the enter "included" in the cell for that fee.

	2021	**2022**	**2023**
Expected Paid Claims	$2,588,368 projected medical claims for HDHP plans In addition, Pharmacy projected claims (with rebates) $419,031 for HDHP plans	$2,804,238 projected medical claims for HDHP plans In addition, Pharmacy projected claims (with rebates) are $456,569 for HDHP plans	$3,038,111 projected medical claims for HDHP plans In addition, Pharmacy projected claims (with rebates) are $505,618 for HDHP plans
Expected Change in Claim Reserves (PEPM)	N/A	N/A	N/A
ASO Fees (PEPM)	$29.95	$29.95	$29.95
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)	N/A	N/A	N/A
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	30.0% of recovered amount	30.0% of recovered amount	30.0% of recovered amount
Telehealth Services (PEPM/PPPM)	Included	Included	Included
Standard Reporting	Included	Included	Included
Ad hoc Reporting	Included	Included	Included
Interface with Other Carve-out Vendors	Charges vary based on carved out services	Charges vary based on carved out services	Charges vary based on carved out services
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	$29.95 Per Employee Per Month	$29.95 Per Employee Per Month	$29.95 Per Employee Per Month

1. Are you willing to provide rate guarantees/rate caps for years four and five? Yes X No__ If yes, describe the rate guarantees/ rate caps you are proposing.

   Years four and five not to exceed 3% fee increases.

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 #194 for a completion description of our disease management 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.

   Aetna's Enhanced Clinical Review program helps contain rapidly rising costs while enabling members to access care using evidence-based guidelines. Our outpatient precertification process includes high-tech radiology procedures, diagnostic cardiology, facility-based sleep studies, cardiac rhythm implant devices, interventional pain management and hip and knee replacement procedures in all HMO markets and most of our PPO markets. Our program aims to manage costs through prospective medical review and to encourage network utilization. The Enhanced Clinical Review Program charge is $0.70 per member per month through the claim wire for participation in this program. This fee is only assessed for membership in markets where the program operates. The School Board of Broward County's specific saving for this program was 1.76 PMPM.

   Capitations are not included.

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

The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. The contracted rates component offers access to contracted rates for many medical claims from non-network providers, including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers. The Facility Charge Review component provides reasonable charge allowance review for most inpatient and outpatient facility claims where a NAP contracted rate is not available. The Itemized Bill Review Program applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. Aetna will forward IBR claims to a vendor to review and identify any billing inconsistencies and errors. We will retain 35% percent of savings from the Contracted Rates National Advantage Program, Facility Charge Review and Itemized Bill Review components. A maximum fee of $100,000.00 per claim will apply.

A contingency of up to 30.0% percent is paid to a vendor upon recovery of a self-funded customer's claims for certain claim overpayment programs such as the following: coordination of benefits, retroactive termination, audits (Hospital, DRG, High Cost Drugs, etc.), duplicate bills, contract compliance, claim and code review program. Also, a contingency fee of up to 30.0% is applicable for comprehensive subrogation services.

a) What was your average revenue (total recoveries retained by your organization) for your South Florida self-insured book of business for the following. State a dollar amount including total claims paid for the year.

- Subrogation
- Standard facility charge review
- Code review (own or third party)
- Audits such as hospital claims, specialty drugs, DRG, etc. (list separately)
- Duplicate bills
- Contract compliance
- Out-of-network negotiated rates
- Large inpatient claim review
- Other (list any missing from the list)

Book of business values for overpayment recovery programs could vary by plan sponsor based on the type of claims that are paid and the amount identified and recovered.

In addition, the out of network negotiated revenue could vary depending on a plan sponsors NAP Fee %, product, plan design, network (i.e. narrow network), geography and member utilization. Due to the variables a book of business amount is not available.

b) Are or can the amounts retained by your organization be reported with each wire transfer request?

Yes, the claim detail report will have specific draft accounts that will outline the retained amounts for our overpayment recovery, subrogation, and out of network savings programs.

c) List every third party vendor that will be involved in the administration of the School Board's plans including name of vendor, amount paid to the vend

We maintain stringent requirements and standards for all subcontractors. We define a subcontractor as an entity that we have engaged to provide goods or perform services for us. The following table identifies our Tier 1 subcontractors, which are a subset of our suppliers/vendors. Tier 1 subcontractors provide member constituent services directly related to the administration of a customer contract and for whom a portion of the services provided may include direct member contact or significant access to member identifiable data. Please note that not all subcontractors provide services to all lines of business, customers or members.

Subcontractor	Scope of Services
Clarity Software Solutions, Inc.	Production of plastic and paper identification cards included in administrative fee. Over 10 years
Conduent	Intake services: mailroom, imaging, data entry, X-ray handling, medical, dental, encounters, referrals, CATS and correspondence. Overpayment recovery for hospital credit balance review, call center services - PDP, FSA, SRC, ETech/SSHL, recertification. Print fulfillment included in administrative fee. Over 15 years
Cotiviti	Overpayment Recovery for Data Mining, Duplicate Payments, Provider Credit Balance 30.0% for recoveries. Two years.
Benefit Outsource	Provides onsite staff support, open enrollment support, retiree direct billing, COBRA administration, overage dependent billing and wellness consultant support additional well consultant included in fee. Aetna has been doing business with BOI for 15 years.
End-Game Strategy, Inc.	Overpayment recovery - data mining 30.0% recoveries. Aetna has been doing business with End-Game for over 13 years.
Equian	Overpayment recovery - retro termination, contract compliance, out-of-network review, duplicate payment 30.0% recoveries. Aetna has been doing business with Equian for over 10 years.
EquiClaim, Inc.	Overpayment recovery - high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and inpatient contract compliance audit) 30.0% recoveries. Aetna has been doing business with EquiClaim for over 6 years.
Health Management Systems (MedRecovery Management LLC is now part of HMS)	Overpayment recovery for workers' compensation 30.0% recoveries. Aetna has been doing business with HMS for over 12 years.
Iron Mountain, Inc.	Records archiving, retrieving, transportation, and destruction services included in fees. Aetna has been doing business with Iron Mountain for over 20 years.
Optum Insights LLC	Overpayment recovery - hospital credit balance, audit complete (healthcare data solutions), coordination of benefits, data mining, RX overpayment recovery 30.0% of recoveries. Aetna has been doing business with Optum for over 14 years.

Quest Diagnostics	Determine individual health risk factors resulting in a personal summary report or personalized health action plan. Quest Diagnostics Blueprint for Wellness Fasting Venipuncture Heart & Glucose Panel; blood testing; metabolic syndrome testing - will draw blood and measure other metabolic tests - includes data processing and result communication. In the event biometric screenings are conducted. Quest services will be used. Fees can be taken out of the wellness fund. Aetna has been doing business with Quest for over 20 years.
Rawlings Company, LLC	Overpayment recovery for coordination of benefits and subrogation; medical/dental. Identification of subrogation potential for disability claims (disability is related to workers comp or accident, not an illness.) 30.0% of recoveries. Aetna has been doing business with Rawlings for over 15 years.
Source One Direct, Inc.	Production of plastic and paper identification cards. Printing of contracts, postcards and booklets for Aetna National Customer Operations. Included in Administrative fees. Aetna has been doing business with Source Once for over 6 years.
Teladoc	Resolve medical issues 24/7 through the convenience of phone or video consultations. Provides patients with access to national network of physicians who can diagnose, treat and prescribe medication for many common medical issues. No additional fees other than the claim for Teladoc services. Those services will be billed through the claims wire as a claim. The charge for Teladoc services is $47.00 for general medical, $85.00 for behavioral health and $190 psychiatry and $75.00 for dermatology. Aetna has been doing business with Teladoc for over 5 years.

The amounts paid to vendor vary based on amounts recovered and contracted rates.

5. Is there a difference in the stated ASO fees for sole carrier versus dual carrier? Yes X _ 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 administrative fees will need to be reviewed and discussed.

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

   Administrative fees are developed based on our core administrative costs including group specific requirements. Specific actuarial formulas and factors used to calculate our self-funded contract fees are proprietary in nature.

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

     Network charges are included in our $29.95 PEPM administrative fee. The network component of our administrative fee represents the managing of our network and contracting with providers. It includes network access, Institute of Quality Program, National Medical Excellence Program, Teladoc services and many other services.

     Our administrative fee also represents the servicing and processing of your claims accordingly to SBBC's Summary Plan Descriptions. We make sure that claims are valid and covered and we process payment for them. The claim services are claim processing, adjudication, member services, distribution, claim system, and home office support.

     The administration fee includes plan administration representing a designated service center, account management team, onsite open enrollment meeting preparation, ID cards, summary of benefits and coverage, claim fiduciary option 1 and external review.

     It also includes our care management programs such as Aetna Compassionate Care Program, Aetna Heath Connections Disease Management, Medquery with Member Messaging, Personal Health Record, Regional Case Management (Aetna One Essentials), and Utilization Management. Aetna is introducing two new medical management programs Aetna Advice and Healing Better.

     The member resources included in our administration fee are member website and mobile experience and enhanced customer servicing framework.

We have also included 5 dedicated account associates and 2 wellness coaches included in our administration fee as well as reporting charges and behavioral health administration such as behavioral health conditions management and applied behavioral analysis. In addition, we are able to support SBBC's COBRA administration and wellness initiatives.

- As a percent of claims?

  Not applicable since administrative fees are not derived as a percentage of claims.

- As a capitated dollar amount per employee?

  Capitations are not included.

FINANCIAL RESPONSE FORMS – SELF-FUNDED MODELS
Kids Plan Options

SBBC is requesting a 36-month rate guarantee for the ASO fees, as outlined below, for each self-funded option. The Proposer shall state its proposed prices for providing all services as stated in the RFP. Note that fees in the initial Calendar Year (2021) shall be quoted on a Mature basis, i.e., fees/premiums are inclusive of run-out administration. Fees shall be quoted for 2021, 2022 and 2023. If the fee for one of the listed services is included in the fee for another service (e.g. if the utilization Management fee is included in the ASO fee), the enter “included” in the cell for that fee.

	2021	2022	2023
Expected Paid Claims	$11,791,453 projected medical claims for KIDS plans In addition, Pharmacy projected claims (with rebates) are $1,829,629 for KIDS plans Note: There would be an additional 5% Anticipated Savings for the Pediatric Narrow Network.	$12,774,861 projected medical claims for KIDS plans In addition, Pharmacy projected claims (with rebates) are $1,993,532 for KIDS plans Note: There would be an additional 5% Anticipated Savings for the Pediatric Narrow Network	$13,840,283 projected medical claims for KIDS plans In addition, Pharmacy projected claims (with rebates) are $2,207,700 for KIDS plans Note: There would be an additional 5% Anticipated Savings for the Pediatric Narrow Network
Expected Change in Claim Reserves (PEPM)	N/A	N/A	N/A
ASO Fees (PEPM)	$29.95	$29.95	$29.95
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)	N/A	N/A	N/A
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	30.0% of recovered amount	30.0% of recovered amount	30.0% of recovered amount
Telehealth Services (PEPM/PPPM)	Included	Included	Included
Standard Reporting	Included	Included	Included
Ad hoc Reporting	Included	Included	Included
Interface with Other Carve-out Vendors	Charges vary based on carved out services	Charges vary based on carved out services	Charges vary based on carved out services
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	$29.95	$29.95	$29.95

1. Are you willing to provide rate guarantees/rate caps for years four and five? Yes X No__ If yes, describe the rate guarantees/ rate caps you are proposing.

   Years four and five not to exceed 3% fee increases.

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 #194 for a completion description of our disease management 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.

   Aetna's Enhanced Clinical Review program helps contain rapidly rising costs while enabling members to access care using evidence-based guidelines. Our outpatient precertification process includes high-tech radiology procedures, diagnostic cardiology, facility-based sleep studies, cardiac rhythm implant devices, interventional pain management and hip and knee replacement procedures in all HMO markets and most of our PPO markets. Our program aims to manage costs through prospective medical review and to encourage network utilization. The Enhanced Clinical Review Program charge is $0.70 per member per month through the claim wire for participation in this program. This fee is only assessed for membership in markets where the program operates. The School Board of Broward County's specific savings for this program was $1.76 PMPM.

   Capitations are not included.

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

The National Advantage Program includes three components, Contracted Rates, Facility Charge Review and Itemized Bill Review. The contracted rates component offers access to contracted rates for many medical claims from non-network providers, including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers. The Facility Charge Review component provides reasonable charge allowance review for most inpatient and outpatient facility claims where a NAP contracted rate is not available. The Itemized Bill Review Program applies to inpatient facility claims submitted by Aetna network providers (directly contracted) if (a) the submitted claim amount exceeds a certain threshold as determined by Aetna; and (b) Aetna's contracted rate with the provider uses a "percentage of billed charges" methodology. Aetna will forward IBR claims to a vendor to review and identify any billing inconsistencies and errors. We will retain 35% percent of savings from the Contracted Rates National Advantage Program, Facility Charge Review and Itemized Bill Review components. A maximum fee of $100,000.00 per claim will apply.

A contingency of up to 30.0% percent is paid to a vendor upon recovery of a self-funded customer's claims for certain claim overpayment programs such as the following: coordination of benefits, retroactive termination, audits (Hospital, DRG, High Cost Drugs, etc.), duplicate bills, contract compliance, claim and code review program. Also, a contingency fee of up to 30.0% is applicable for comprehensive subrogation services.

a) What was your average revenue (total recoveries retained by your organization) for your South Florida self-insured book of business for the following. State a dollar amount including total claims paid for the year.

- Subrogation
- Standard facility charge review
- Code review (own or third party)
- Audits such as hospital claims, specialty drugs, DRG, etc. (list separately)
- Duplicate bills
- Contract compliance
- Out-of-network negotiated rates
- Large inpatient claim review
- Other (list any missing from the list)

Book of business values for overpayment recovery programs could vary by plan sponsor based on the type of claims that are paid and the amount identified and recovered.

In addition, the out of network negotiated revenue could vary depending on a plan sponsors NAP Fee %, product, plan design, network (i.e. narrow network), geography and member utilization. Due to the variables a book of business amount is not available.

b) Are or can the amounts retained by your organization be reported with each wire transfer request?

Yes, the claim detail report will have specific draft accounts that will outline the retained amounts for our overpayment recovery, subrogation, and out of network savings programs.

c) List every third party vendor that will be involved in the administration of the School Board's plans including name of vendor, amount paid to the

We maintain stringent requirements and standards for all subcontractors. We define a subcontractor as an entity that we have engaged to provide goods or perform services for us. The following table identifies our Tier 1 subcontractors, which are a subset of our suppliers/vendors. Tier 1 subcontractors provide member constituent services directly related to the administration of a customer contract and for whom a portion of the services provided may include direct member contact or significant access to member identifiable data. Please note that not all subcontractors provide services to all lines of business, customers or members.

Subcontractor	Scope of Services
Clarity Software Solutions, Inc.	Production of plastic and paper identification cards included in administrative fee. Over 10 years
Conduent	Intake services: mailroom, imaging, data entry, X-ray handling, medical, dental, encounters, referrals, CATS and correspondence. Overpayment recovery for hospital credit balance review, call center services - PDP, FSA, SRC, ETech/SSHL, recertification. Print fulfillment included in administrative fee. Over 15 years
Cotiviti	Overpayment Recovery for Data Mining, Duplicate Payments, Provider Credit Balance 30.0% for recoveries. Two years.
Benefit Outsource	Provides onsite staff support, open enrollment support, retiree direct billing, COBRA administration, overage dependent billing and wellness consultant support additional well consultant included in fee. Aetna has been doing business with BOI for 15 years.
End-Game Strategy, Inc.	Overpayment recovery - data mining 30.0% recoveries. Aetna has been doing business with End-Game for over 13 years.
Equian	Overpayment recovery - retro termination, contract compliance, out-of-network review, duplicate payment 30.0% recoveries. Aetna has been doing business with Equian for over 10 years.
EquiClaim, Inc.	Overpayment recovery - high cost drug audits, implant audits, medical bill audit (hospital bill audit, DRG audit and inpatient contract compliance audit) 30.0% recoveries. Aetna has been doing business with EquiClaim for over 6 years.
Health Management Systems (MedRecovery Management LLC is now part of HMS)	Overpayment recovery for workers' compensation 30.0% recoveries. Aetna has been doing business with HMS for over 12 years.
Iron Mountain, Inc.	Records archiving, retrieving, transportation, and destruction services included in fees. Aetna has been doing business with Iron Mountain for over 20 years.
Optum Insights LLC	Overpayment recovery - hospital credit balance, audit complete (healthcare data solutions), coordination of benefits, data mining, RX overpayment recovery 30.0% of recoveries. Aetna has been doing business with Optum for over 14 years.

Quest Diagnostics	Determine individual health risk factors resulting in a personal summary report or personalized health action plan. Quest Diagnostics Blueprint for Wellness Fasting Venipuncture Heart & Glucose Panel; blood testing; metabolic syndrome testing - will draw blood and measure other metabolic tests - includes data processing and result communication. In the event biometric screenings are conducted. Quest services will be used. Fees can be taken out of the wellness fund. Aetna has been doing business with Quest for over 20 years.
Rawlings Company, LLC	Overpayment recovery for coordination of benefits and subrogation; medical/dental. Identification of subrogation potential for disability claims (disability is related to workers comp or accident, not an illness.) 30.0% of recoveries. Aetna has been doing business with Rawlings for over 15 years.
Source One Direct, Inc.	Production of plastic and paper identification cards. Printing of contracts, postcards and booklets for Aetna National Customer Operations. Included in Administrative fees. Aetna has been doing business with Source Once for over 6 years.
Teladoc	Resolve medical issues 24/7 through the convenience of phone or video consultations. Provides patients with access to national network of physicians who can diagnose, treat and prescribe medication for many common medical issues. No additional fees other than the claim for Teladoc services. Those services will be billed through the claims wire as a claim. The charge for Teladoc services is $47.00 for general medical, $85.00 for behavioral health and $190 psychiatry and $75.00 for dermatology. Aetna has been doing business with Teladoc for over 5 years.

The amounts paid to vendor vary based on amounts recovered and contracted rates.

5. Is there a difference in the stated ASO fees for sole carrier versus dual carrier? Yes X 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 administrative fees will need to be reviewed and discussed.

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

Administrative fees are developed based on our core administrative costs including group specific requirements. Specific actuarial formulas and factors used to calculate our self-funded contract fees are proprietary in nature.

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

  Network charges are included in our $29.95 PEPM administrative fee. The network component of our administrative fee represents the managing of our network and contracting with providers. It includes network access, Institute of Quality Program, National Medical Excellence Program, Teladoc services and many other services.

  Our administrative fee also represents the servicing and processing of your claims accordingly to SBBC's Summary Plan Descriptions. We make sure that claims are valid and covered and we process payment for them. The claim services are claim processing, adjudication, member services, distribution, claim system, and home office support.

  The administration fee includes plan administration costs representing a designated service center, account management team, onsite open enrollment meeting preparation, ID cards, summary of benefits and coverage, claim fiduciary option 1 and external review.

  It also includes our care management programs such as Aetna Compassionate Care Program, Aetna Heath Connections Disease Management, Medquery with Member Messaging, Personal Health Record, Regional Case Management (Aetna One Essentials), and Utilization Management. Aetna is introducing two new medical management programs Aetna Advice and Healing Better.

  The member resources included in our administration fee are member website and mobile experience and enhanced customer servicing framework.

We have also included 5 dedicated account associates and 2 wellness coaches included in our administration fee as well as reporting charges and behavioral health administration such as behavioral health conditions management and applied behavioral analysis. In addition, we are able to support SBBC's COBRA administration and wellness initiatives.

- As a percent of claims?

  Not applicable since administrative fees are not derived as a percentage of claims.

- As a capitated dollar amount per employee?

  Capitations are not included.

Medical Network Guarantee Discount

Exhibit C

The School Board of Broward County, Florida

General Performance Guarantee Provisions

Aetna Life Insurance Company, on behalf of itself and its affiliates ("Aetna", "our" or "we") provides health benefits administration and other services (set forth in this document) for the self-funded Medical plans operated on behalf of The School Board of Broward County, Florida (also "you" or "your").

These performance guarantees are considered are an Exhibit to the Agreement.

What we guarantee

We guarantee that your in-network discount for the guarantee period will be ____ percent or better, assuming current enrollment and service mix. Each period is measured on a 12 month basis and is valid for the Guarantee Period defined below. Annually this may be adjusted upward upon mutual agreement.

Products: Open Access Aetna Select℠ (OA-AS) & Aetna Choice® Point of Service II (CPII)

Guarantee period: January 1, 2021 through December 31, 2021
Guarantee period: January 1,2022 through December 31, 2022
Guarantee period: January 1, 2023 through December 31, 2023
Guarantee period: January 1, 2024 through December 31, 2024
Guarantee period: January 1, 2025 through December 31, 2025
*Note: Aetna claims that any areas in red and highlighted in yellow are a trade secret.

What we guarantee	How discounts are calculated
Discount Guarantee Attachment shows: • Our guaranteed network contracted discounts by network, for each of the following three service types: – Inpatient hospital – Outpatient hospital – Physician/other • Aggregate guaranteed network contracted discount based on a weighting of: – Projected, customer-specific employees by network – The School Board of Broward County,	The achieved discount percentage is calculated using the following calculation: In-network provider discounts in dollars Total in-network billed eligible charges* We calculate the discount using data from our Aetna Informatics® data warehouse. Three months of runout data will be included in the calculation. The guarantee reconciliation excludes each medical case where the claims in that medical case exceed $100,000. A medical case summarizes clinical events by linking or associating all of the claims submitted for a

Discount Guarantee

Florida weighting by service type We finalize the discount target during the reconciliation process. The reconciliation will be completed once the actual enrolled members by network and product, and the actual billed eligible charges are known. The final aggregate guaranteed discount will be determined by weighting the discounts by the actual aggregate billed eligible charges by product and service type.	member during the same treatment event. For example, all claims associate with an Inpatient Acute hospital stay or an Outpatient Facility based procedure. The guarantee results combine the OA AS and CPII product(s) and we report in aggregate for purposes of this guarantee reconciliation.
*Billed eligible charges are charges prior to application of plan design, discounts and member cost sharing (copays and deductibles). Billed eligible charges exclude the following: - Duplicate or other ineligible/not covered/denied claims - Claims paid by coordination of benefits where we are not primary (including Medicare) - - Claims incurred in passive or custom networks - Behavioral health claims - All non-medical claims (this includes pharmacy, specialty pharmacy, dental and vision hardware claims) - Non-facility billed eligible charges at a level equal to or within 3 percent of the negotiated rates - Some charges where the provider contract allows us to pay the lesser of the billed amount or the contractual rates - All pay for performance payments, including but not limited to, accountable care payments (ACP) and coordination of care (COC) payments.	

Guarantee reconciliation
We compare the guaranteed discount against the total discount achieved. The guaranteed discount is based on the actual enrollment by product and network, and billed eligible charges by product and service type. Based on the outcome of the comparison, we will make any applicable fee adjustments as shown in the table below.

Discount Guarantee

Fee adjustment
2.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 1%.
5.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 2%.
9.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 3%.
11.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 4%.
13.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 5%.
15.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 6%.
17.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 7%.
19.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 8%.
21.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 9%.
23.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 10%.
25.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 11%.
27.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 12%.
29.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 13%.
31.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 14%.
33.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 15%.
35.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 16%.
37.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 17%.
39.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 18%.
41.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 19%.
43.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 20%.
45.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 21%.
47.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 22%.
50.0% fee reduction if the discount achieved falls below the guaranteed discount by a full 23%.

Aggregate maximum	50% of actual collected administrative service fees for all guarantees combined**

**“Collected fees” means those fees collected for the guarantee period as of the time of the final reconciliation of the guarantee. Administrative service fees exclude:

- Wellness Allowances
- MBE / WBE Allowances
- Any charges for services performed, which are not included on the monthly administrative service fee bill
- ASO Fee Holiday and any other ASO Fee Credit

Discount Guarantee

The maximum guarantee for either this Medical Discount Guarantee or the Medical Claim Target Guarantee penalty is 50 percent of actual collected administrative service fees for the employees covered under this guarantee. The School Board of Broward County, Florida will need to select the guarantee of their choice before the effective date.

Conditions for the guarantee	
We reserve the right to revise or remove the guarantee if any of the following conditions are not met.	
Category	**Condition**
Group composition	You do not close any acquisitions or divestitures during the guarantee period.
Minimum enrollment	You must enroll a minimum of 15 percent below current enrollment of 28,869 subscribers in the quoted Aetna self-funded medical products.
Pharmacy claims	Pharmacy and specialty pharmacy claims are excluded.
Provider Practice	2021 provider billing and reimbursement practices remain consistent with current practices.
Coverage termination during guarantee period	The Medical Discount Guarantee is considered met if you terminate your Aetna medical plan prior to the end of any individual Guarantee Period.

Pharmacy
Service and Fee Schedule
to the Master Services Agreement

Effective January 01, 2021
The School Board of Broward County, FL
Aetna Standard Formulary (with exclusions)
Maintenance Choice (90 days at retail)

aetna®

Pharmacy Service and Fee Schedule- ASP Standard Plan

Pharmacy Discounts & Fees

Pricing Arrangement	Traditional
Network	Aetna National Network
Employees	28,869

RETAIL			
	01/01/2021	01/01/2022	01/01/2023
Brand Discount	AWP - 19.25%	AWP - 19.35%	AWP - 19.45%
Generic Discount	AWP - 84.00%	AWP - 84.20%	AWP - 84.40%
Dispensing Fee	$0.30 per script	$0.30 per script	$0.30 per script

MAIL ORDER PHARMACY			
Mail Benefit Type	Mandatory Maintenance Choice with opt out		
	01/01/2021	01/01/2022	01/01/2023
Brand Discount	AWP - 25.50%	AWP - 25.60%	AWP - 25.70%
Generic Discount	AWP - 86.75%	AWP - 86.95%	AWP - 87.15%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

AETNA SPECIALTY PHARMACY			
Network	Aetna Specialty Network		
Price List	Not Applicable		
	01/01/2021	01/01/2022	01/01/2023
Discount	AWP – 20.00%	AWP – 20.10%	AWP – 20.20%
Dispensing Fee	$0.00 per script	$0.00 per script	$0.00 per script

GENERIC DISPENSING RATE (GDR) GUARANTEE			
	01/01/2021	01/01/2022	01/01/2023
Retail GDR	85.75%	86.00%	86.00%
Mail GDR	89.00%	89.25%	89.25%
Annual Maximum	$750,000	$750,000	$750,000

Pharmacy Service and Fee Schedule- ASP Standard Plan

CLINICAL PROGRAM FEES/ADMIN FEES ETC.			
	01/01/2021	01/01/2022	01/01/2023
Drug Savings Review Program	$0.30 PMPM	$0.30 PMPM	$0.30 PMPM
Paper Claims	$0.00	$0.00	$0.00

DISCOUNTS			
	01/01/2021	01/01/2022	01/01/2023
Discount	$2.00 Per Employee Per Year*	N/A	N/A

*Will be applied to the March 2021 ASO Fee Invoice, due to no ASO Fee Invoice for January and February 2021 given the Medical Fee Holiday.

Pharmacy Service and Fee Schedule- ASP Standard Plan

Rebates

REBATES			
Formulary	Aetna Standard Formulary (with exclusions)		
Plan Design	3 Tier Qualifying		
Rebate Terms	Plan sponsor will receive the following minimum rebate guarantees:		
	01/01/2021	**01/01/2022**	**01/01/2023**
Retail	The greater of 100% or $243.34 Per Brand Script	The greater of 100% or $253.03 Per Brand Script	The greater of 100% or $256.15 Per Brand Script
Mail order	The greater of 100% or $527.45 Per Brand Script	The greater of 100% or $559.07 Per Brand Script	The greater of 100% or $589.62 Per Brand Script
Specialty Non-Hepatitis C	The greater of 100% or $2,201.55 Per Brand Script	The greater of 100% or $2,222.70 Per Brand Script	The greater of 100% or $2,219.57 Per Brand Script
Specialty Hepatitis C	The greater of 100% or $10,266.00 Per Brand Script	The greater of 100% or $10,266.00 Per Brand Script	The greater of 100% or $10,266.00 Per Brand Script

Pharmacy Service and Fee Schedule- ASP Standard Plan

Terms & Conditions

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

- Assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- 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:
  - Pricing guarantees are measured and reconciled as four separate components with the components defined as retail network, mail pharmacy, specialty pharmacy, and rebates.
  - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within ninety (90) 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, Exclusive Distribution and limited distribution drug (LDD) Claims, direct Plan Participant reimbursement / out-of-network claims, over-the-counter products, in-house

Pharmacy Service and Fee Schedule- ASP Standard Plan

pharmacy claims, and vaccines. In addition, we do not identify or administer any claims for 340B.

- Retail pricing guarantees exclude claims that reflect the Usual & Customary Retail Price.
- Single Source Generic Drugs are included in the Generic Discount guarantees.
- Prescriptions dispensed by Aetna Specialty Pharmacy are included in the Aetna Specialty Pharmacy Discount guarantee 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.

- Pricing and terms in this proposal assume the Customer has elected the Aetna Standard Formulary and the Choose Generics program.
- The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members.
- Aetna Specialty Network means members obtain all specialty medications through a participating specialty network pharmacy (no refills at retail allowed). The Specialty Overall Effective Discount (OED) offer is conditioned on (i) Aetna being the exclusive provider of Specialty Services. The Overall Effective Discount (OED) rate will apply to all Specialty drugs on the Specialty List dispensed from a Aetna Specialty owned or affiliated pharmacy, and with the exception of:
  - New to market Specialty Brand drugs will be priced at AWP - 15.00%
  - New to market limited distribution drugs will be priced at AWP -10.00%
  - New to market biosimilars will priced at AWP – 15.00%
- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.

Pharmacy Service and Fee Schedule- ASP Standard Plan

- Drug Savings Review Program - Aetna guarantees that the net savings realized from these services over the Clinical Program Year of the Agreement for the Drug Savings Review Program shall be [300%] of the expense to Client for these services over the Clinical Program Year. In the event Aetna fails to meet the targeted savings, Client shall be credited for any guaranteed savings short-fall following the end of the applicable Clinical Program Year, up to the amount of fees paid by Client for the Drug Savings Review Program during the Clinical Program Year. “Clinical Program Year” means the twelve (12) month period commencing on the start date of the Drug Savings Review Program and each full consecutive twelve (12) month period thereafter that the Drug Savings Review Program is provided.

- 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 90 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.

- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims may be shared with Customer in accordance with the Rebate terms described herein.

- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within 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.

- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.

- Rebate guarantees may be subject to:

Pharmacy Service and Fee Schedule- ASP Standard Plan

- The adoption of utilization management edits for Specialty Products, including for example, Prior Authorization (PA) and Quantity Limits.
- The adoption and maintenance of a biosimilar first plan design for Specialty Products.
- Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- Rebate guarantees assume that products that are not Specialty Products will not be subject to precertification or step therapy requirements, and that all drug classes included on the Aetna Standard Formulary be covered.

- The above rebate guarantees exclude:
  - Over the Counter (OTC) Claims
  - Exclusive Distribution and limited distribution drug (LDD) Claims
  - 340B Claims
  - Compound Drug Claims
  - Paper or Member Submitted Claims
  - Coordination of Benefits (COB) or secondary payor Claims
  - Vaccine and vaccine administration Claims
  - New to Market Biosimilar Claims
- Rebate guarantees assume alignment with proposed formulary, including utilization management programs to support formulary strategy, and standard prior authorization/utilization management criteria.
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to specialty drug claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:

Pharmacy Service and Fee Schedule- ASP Standard Plan

- Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a $15.00 co-payment differential between preferred and non-preferred Brand Drugs, at least a $15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).

- We are providing a separate rebate guarantee for the specialty brand drug claims within the Hepatitis C therapeutic class. Rebate guarantees are conditioned upon Harvoni, Epclusa, and Vosevi as the preferred formulary drugs for Hepatitis C treatment with at least 95% drug claim share, all other drugs are excluded or non-preferred, coverage is provided for all fibrosis scores (F0/F1-F4), utilization management criteria aligns with drug labeling, and client is not utilizing starter or split fill programs.

- Plan design and benefits must be finalized 90 days prior to the effective date to support mailing of impacted members moving to Aetna's Standard Formulary. Less than 90 day notice of acceptance of the Aetna Standard formulary renewal quote may require implementation of a temporary benefit design until benefits are ready. This will not interrupt claims adjudication and service to members.

Pharmacy Service and Fee Schedule- ASP Standard Plan

Discounts

Aetna is including a one-time discount of $2.00 PEPY to be applied to the Customer's March 2021 monthly bill only.

Market Check

On an annual basis in the second quarter of each Contract Year upon SBBC's reasonable request, a third party consulting firm may review the financial terms of this Agreement compared to financial offering presented to similar employers in the marketplace as deemed appropriate. The parties agree for the purpose of this market check that the third party consulting firm will compare, among other things, the following factors to determine whether SBBC is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable clients of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, rebates and guarantees; (ii) the services provided by Aetna to such clients; and (iii) the plan design of such clients, which may include plan formulary, brand/generic utilization information and mail and retail utilization information. If SBBC, third party, and Aetna agree to any revisions to the financial terms as a result of this review (i) the agreement shall be amended and (ii) shall be effective January 1 of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply. If agreement cannot be reached, SBBC has the right to open up contract without penalty.

Pharmacy Service and Fee Schedule- ASP Standard Plan

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) a change in the Plan that is initiated by Customer, (v) AWP is discontinued or modified in whole or in part, or (vi) a greater than 15% change in enrollment or a material change, as defined by Aetna, in the drug utilization, plan design, geographic mix or demographic mix of the covered population from what was assumed at the time of underwriting. Aetna shall provide the Customer with at least sixty (60) days written notice of such changes together with a sufficiently detailed explanation supporting these price point changes. If sixty (60) days written notice is not practicable under the circumstances, Aetna shall provide written notice as soon as practicable.

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.

Pharmacy Service and Fee Schedule- ASP Standard Plan

Rebate Payment Terms

Rebates will be distributed on a quarterly basis by claim wire credit. We will pay the minimum rebate guarantee within 90 days of the end of each calendar quarter. Annual reconciliation will occur within 180 days after the end of the policy period. 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.

The rebate payments will be made in March, June, September, and December.

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.

Pharmacy Service and Fee Schedule- ASP Standard Plan

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.

Other Payments

The term "Rebates" as defined in the Prescription Drug Services Schedule does not mean or include any manufacturer administrative fees that may be paid by pharmaceutical manufacturers to cover the costs related to the reporting and administration of the pharmaceutical manufacturer agreements. Such manufacturer administrative fees are not shared with Customer hereunder.

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.

Pharmacy Service and Fee Schedule- ASP Standard Plan

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.

Early Termination

In the event SBBC terminates Aetna's arrangement of prescription drug benefit services as described in the Prescription Drug Services Schedule and Pharmacy Service and Fee Schedule to the Agreement prior to December 31, 2021 (an "Early Termination") SBBC shall refund a pro-rata portion based on the remaining months from the date of termination to December 31, 2021 , prior to the termination date, to Aetna, the allowance in the amount of $2.00 Per Employee Per Year. The payment will be due and paid in full within sixty (60) days after the termination effective date.

In the event of an Early Termination, the pharmacy guarantees described hereunder, if any, shall be considered null and void for the Plan year and, therefore, not subject to reconciliation.

Pharmacy Service and Fee Schedule- ASP Standard Plan

Late Payment Charges

If the Customer fails to provide funds on a timely basis to cover benefit payments and/or fails to pay service fees on a timely basis as required in the Agreement, Aetna will assess a late payment charge. The current charges are outlined below:

i. Late funds to cover benefit payments (e.g., late wire transfers): 1.5% annual rate
ii. Late payments of Service Fees: 1.5%, annual rate

In addition, Aetna will make a charge to recover its costs of collection including reasonable attorney's fees. We will notify the Customer of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Service and Fee Schedule or at law or in equity for failure to pay.

Pharmacy Audit Rights and Limitations

SBBC 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.

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

Pharmacy audits shall be conducted at SBBC’s own expense unless otherwise agreed to between SBBC and Aetna.

PERFORMANCE STANDARD GUARANTEES

Please review the outlined Performance Standard Guarantees and liquidated damages. Fully explain all deviations and how your company will track and meet each of the below performance standards.

Performance Standard Guarantees	Amount of Liquidated Damages	Yes, Can Comply	Yes, Can Comply with Deviations
Implementation Measurements			
Brochures/descriptive literature must be delivered to SBBC, or to its designee, as directed, in final form, within 60 calendar days prior to open enrollment. Additional materials to be provided within 30 calendar days of the Benefits Department request.	$250.00 per calendar day	Yes, Can Comply	
Claim Timeliness			
On average 90% of all claims will be processed within 10 calendar days. The turnaround time is calculated from the date the claim is received in the claim office to the date that it is processed.	$2,000	Yes, Can Comply	
Claims Payment Accuracy — financial dollar accuracy standard is 97% and the non-financial accuracy amount is 95%.	$2,000	Yes, Can Comply	
Claim Inquiries/Complaints			
All claims, written claim inquiries or complaints, and other contacts with the vendor by the Benefits Department, the Payroll Deduction Unit, or SBBC employees and their covered dependents must have a written response within ten (10) calendar days of receipt by the vendor.	$100 per occurrence per day beyond, as outlined	Yes, Can Comply	
Telephone Responsiveness			
The employees of SBBC must have their telephone calls returned within twenty-four hours from receipt.	$100 per occurrence per day beyond, as outlined	Yes, Can Comply	
Average response time of 30 seconds or better. (Monthly)	$2,000	Yes, Can Comply	
Abandonment rate of 5% or less. (Monthly)	$2,000	Yes, Can Comply	

Administration			
Proposer agrees to liquidated damages for employee satisfaction ratings below 85%.	$1,500 for each percentage point below 85%.	Yes, Can Comply	
The Supplier Diversity Outreach Program office will require a 30-day written notice for the substitution of an S/M/WBE vendor.	$100 per calendar day for the first 30 calendar days, $1,000 beyond	Yes, Can Comply	
The Awardee will be required to submit a monthly S/M/WBE Utilization Report, which will track payments to S/M/WBE(s).	$100 per calendar day	Yes, Can Comply	
At a minimum, provide annual reporting metrics for each outlined performance standard.	If reporting is not provided the fully 7% penalty will apply.	Yes, Can Comply	
Early Termination Provision			
If the awardee cancels or terminates this contract within the initial contract period, awardee will provide SBBC, with the cost of replacement of such TPA services and any difference in ASO fees.		Yes, Can Comply	

Performance penalties will be capped at 7% of annual premium.

	General Performance Guarantee Requirements	**PBM Response (Confirmed, Not Confirmed)**	**Explanation (If Not Confirmed)**
1	PBM will measure, report and pay implementation guarantees within 90 days after implementation	Refer to Performance Guarantee Number 8 below.	
2	For all other performance guarantees, PBM will agree to put an annual lump sum amount at risk on an annual basis (preferably measured on a Per Member basis, where "member" is counted as EE + Spouse + Dependent = 3. **(Confirm "Yes" or "No"; Amount at risk is requested within the "Financial Offer")**	Confirmed. In total, Aetna agrees to place **$750,000** at risk through the Performance Guarantees outlined in this document. SBBC can re-allocate up to 20% of total maximum at risk on any one guarantee.	
3	PBM agrees to allow CLIENT to flexibility to allocate in writing the total amount at risk among the various performance guarantees at least 30 days prior to the contract year start. PBM will proactively reach out to CLIENT each year to obtain the allocations. **(Confirm "Yes" or "No"; Amount at risk is requested within the "Financial Offer")**	Confirmed. SBBC can re-allocate up to 20% of total maximum at risk on any one guarantee.	

4	PBM agrees that the performance guarantees will be measured and reconciled on a quarterly basis within 45 days from the close of the quarter, with the exception of annual performance guarantees which will be measured and reconciled with 45 days from the close of the year. PBM will proactively measure and reconcile for the CLIENT, providing reporting without CLIENT request.	Confirmed. Aetna will guarantee that the performance guarantee reporting will be provided within 45 business days after end of each reporting period.	Up to $30,000 at risk
5	PBM agrees that any penalties will be paid within 90 days from the close of the measurement period. Payments will be made proactively, without CLIENT request.	Confirmed, Aetna agrees that performance guarantee penalties will be paid within 90 days from the close of the measurement period.	Up to $30,000 at risk
6	PBM agrees that all performance guarantees must be measured and reported on a CLIENT specific basis. If any performance guarantee is not CLIENT specific, it must be noted below.	Confirmed. Our guarantees are on a book of business basis unless noted below.	
7	**Performance Guarantees**	**PBM Response (Confirmed, Not Confirmed)**	**Explanation (If Not Confirmed)**
8	PBM will provide an Implementation Satisfaction guarantee that is separate from all other performance guarantees. The Implementation Satisfaction guarantee will be at the sole discretion of CLIENT, in that the CLIENT can determine, in good faith, between responses such as "Yes, CLIENT is satisfied with the implementation", "No, CLIENT is not satisfied with the implementation", or "CLIENT is x% satisfied with the implementation". **(Confirm "Yes" or "No"; Amount at risk is requested within the "Financial Offer")**	Confirmed, Aetna developed and utilizes the implementation team concept to carefully coordinate all aspects of the implementation. An implementation manager will be assigned to assemble SBBC's implementation team and working with SBBC team, will help determine the implementation priorities. The implementation manager will develop an implementation management plan that will outline the tasks to be accomplished and will also indicate mutually agreed upon target dates for their completion. As new information becomes available and priorities change, the plan will be updated. SBBC will be responsible for providing key information to Aetna by the mutually agreed upon target dates. The performance guarantee is contingent upon SBBC required	Up to $60,000 at risk

		participation in reviewing Aetna's plan of benefits detail document. Aetna is confident that SBBC will be pleased with our implementation team approach and therefore we are offering an implementation performance guarantee. This guarantee is effective for the implementation period in the first guarantee period. The implementation period commences at the initial implementation meeting and runs through the implementation sign-off.	

9	PBM agrees to four (4) in person meetings with CLIENT annually, and up to weekly calls via phone (at client's discretion). Additionally, meeting materials delivered electronically to the client at least three (3) business days in advance of the meeting, and will follow-up on all open issues within three (3) business days after the meeting.	Confirmed Client Specific Aetna agrees to four (4) in person meetings with SBBC annually, and up to weekly calls via phone (at SBBC's discretion). Additionally, meeting materials delivered electronically to the client at least three (3) business days in advance of the meeting and will follow-up on all open issues within three (3) business days after the meeting.	Up to $60,000 at risk
	General Performance Guarantee Requirements	**PBM Response (Confirmed, Not Confirmed)**	**Explanation (If Not Confirmed)**
10	PBM will provide an annual Account Management Satisfaction guarantee. The Account Management Satisfaction guarantee will be at the sole discretion of CLIENT, in that the CLIENT can determine, in good faith, between responses such as "Yes, CLIENT is satisfied with the performance of the Account Team and related integral support", "No, CLIENT is not satisfied with the performance of the Account Team and related internal support", or "CLIENT is x% satisfied with the performance of the Account Team and related internal support".	Confirmed, Client Specific Aetna guarantees that the services (i.e., on-going financial, eligibility, drafting, and benefit administration and continued customer support) provided by the Pharmacy Account Team during the guarantee period will be satisfactory to SBBC and to the Consultant. Average evaluation score of 3.5 or higher. Average evaluation score of 3.5 or higher.	Up to $60,000 at risk
11	PBM will provide an annual Consultant Satisfaction guarantee. The Account Management Satisfaction guarantee will be at the sole discretion of the Consultant, in that the Consultant can determine, in good faith, between responses such as "Yes, the Consultant is satisfied with the performance of the Account Team and related integral support", "No, the Consultant is not satisfied with the performance of the Account Team and related internal support", or "The Consultant is x% satisfied with the performance of the Account Team and related internal support". While the Consultant will complete the survey, any financial penalties would go to CLIENT.	Confirmed. Client Specific Aetna guarantees overall pharmacy consultant satisfaction. We will work with SBBC and the pharmacy consultant to develop an agreed upon survey in which a score of 3.5 out of 5 needs to be achieved.	Up to $50,000 at risk

12	PBM will guarantee that all inquiries and issues sent the Account Management team will be responded to within 1 business day. For inquiries and issues that cannot be resolved within 1 business day, the Account Team will add them to an issue tracking log and provide an update on weekly call (or more frequently via email is at CLIENT request). Updates will be made at least every 7 calendar days.	Confirmed. Client Specific Aetna guarantees that within 1 business day of receipt by account manager, 100% of any issues that cannot be resolved in 2 business days, will have estimated time of resolution communicated by account manager via electronic communication to requestor.	Up to $50,000 at risk
13	PBM will guarantee that all responses to CLIENT contract inquiries, redlines, etc. will be provided within 10 business days of receipt, and all open issues will be resolved in good faith within 14 business days.	Confirmed. Client Specific Aetna will guarantee that all responses to client contract inquiries, redlines, etc. will be provided within 5 business days of receipt, and all open issues will be resolved in good faith within 7 business days.	Up to $50,000 at risk
14	PBM will conduct an annual benefit plan review 45 days prior to effective date of any plan benefit changes, i.e. copayments, co-insurance, clinical rules, etc.	Confirmed. Client Specific Aetna guarantees to conduct an annual benefit plan review of any plan benefit changes, i.e. copayments, co-insurance, clinical rules, etc. 45 days prior to the effective date.	Up to $50,000 at risk
15	PBM will guarantee that all member communications will be sent to impacted members 90 days in advance of the plan change, including formulary changes.	Confirmed. Client Specific Aetna will guarantee that all member communications will be sent to impacted members 30 - 45 days in advance of the plan change, including formulary changes.	Up to $50,000 at risk
16	PBM will guarantee to issue at least 99% of all new member ID cards within 4 business days following receipt of a clean eligibility file	Not Confirmed. ID Cards are produced and mailed by Medical as part of a single ID card. Refer to Medical Performance Guarantees.	
17	PBM will guarantee that 100% of retail direct reimbursement claims will be processed for payment or rejected and responded to within 5 business days	Confirmed – Client Specific. Aetna guarantees that the claim payment processing turnaround time for all retail pharmacy claims submitted on paper will be 100% within 5 business days of receipt.	Up to $5,000 at risk

	General Performance Guarantee Requirements	PBM Response (Confirmed, Not Confirmed)	Explanation (If Not Confirmed)
18	PBM will guarantee that the mail order turnaround time for prescription drugs requiring no intervention will be 99% shipped within 2 business days (measured in business days from the date the prescription drug claim is received by the vendor either paper, phone, fax or e-prescribed	Confirmed. Book of Business Aetna guarantees that at least 99.0% of all mail order claims not requiring intervention will be dispensed and shipped within 2 business days of receipt.	Up to $5,000 at risk
No number provided here.	PBM will guarantee that the mail order turnaround time for prescription drugs requiring administrative/clinical intervention will be 100% shipped within 5 business days	Confirmed. Book of Business Aetna guarantees that at least 100% of all mail order claims requiring intervention will be dispensed and shipped within 5 business days of receipt.	Up to $5,000 at risk
19	PBM will guarantee that 100% of member calls that are transferred to a pharmacist or supervisor will be answered within 5 minutes	Confirmed. Client Specific Aetna guarantees that the time elapsed once a participant requests to speak to a pharmacist from a CSR or selects this option from the IVR to the time the call is answered by a pharmacist will not exceed 5 minutes.	Up to $30,000 at risk
20	PBM will guarantee that, on average, 100% of calls will be answered by a live voice within 20 seconds or less. This is measured as the amount of time that elapses between the time a call is received into a member service queue to the time the phone is answered by a Customer Service Representative. Measurement excludes calls routed to IVR	Confirmed. Book of Business	Up to $5,000 at risk
21	PBM will guarantee that 2% or less of calls will be abandoned before the call is answered by CSR.	Confirmed. Book of Business Aetna guarantees that the rate of telephone abandonment will not exceed 2.0%.	Up to $5,000 at risk

22	PBM will guarantee that at least 98% of all calls will be resolved at the first point of contact.	Confirmed. Book of Business Aetna guarantees that 98.0% of member service calls with be successfully resolved on the first call. Resolution shall be deemed successfully resolved if there are no handoffs via resolution manager.	Up to $5,000 at risk

23	PBM will guarantee to provide digital call recordings within 2 business days of request.	Confirmed. Client Specific Aetna will guarantee to provide digital call recordings within 5 business days of request.	Up to $5,000 at risk
24	PBM will promptly review and respond to requests for prior approval for specific drugs following receipt of all required information. PBM will guarantee a response no later than within 2 business days	Confirmed. Book of Business Aetna will promptly review and respond to requests for prior approval for specific drugs following receipt of all required information. Aetna will guarantee a response no later than within 1 business days for urgent requests and 3 business days for non-urgent requests.	Up to $30,000 at risk

25	PBM will guarantee that 100% of all e-mailed member inquires will be responded to and resolved within 48 hours	Confirmed. Client Specific Aetna guarantees to provide an initial response rate to 98.0% of email inquiries within 24 hours and provide a resolution to 100% of email inquiries within 2 business days for all emails that are sent to the SBBC onsite.	Up to $5,000 at risk
26	PBM will guarantee a result of 95% from a member satisfaction survey. Satisfied will be defined as achieving the 80% threshold or better. (i.e., a "4" on a "5" scale).	Confirmed. Client Specific Aetna guarantees an 80.0% or better member satisfaction rate.	Up to $50,000 at risk
27	PBM will guarantee delivery of standard financial and clinical reports within 30 days from the close of each reporting period	Confirmed. Client Specific Aetna guarantees on-line Quarterly Pharmacy Utilization Managements Reports will be made available to SBBC within 30 days after the end of a calendar quarter.	Up to $5,000 at risk
28	PBM will guarantee that each quarterly report will be provided to the client 5 business days prior to the meeting	Confirmed. Client Specific	Up to $50,000 at risk
29	PBM will calculate, report, and pay all financial settlements (including but not limited to formulary guarantee true-up, discount and dispensing fee guarantees for retail/mail/specialty, clinical program guarantees, minimum rebate guarantees, etc.) to CLIENT within 90 days from the close of each reporting period. The penalty for this standalone guarantee is $100k for EACH reconciliation that is not provided within 90 days from the close of each reporting period.	Confirmed. Client Specific Aetna will calculate, report, and pay all financial settlements (including but not limited to formulary guarantee true-up, discount and dispensing fee guarantees for retail/mail/specialty, clinical program guarantees) to SBBC within 90 days from the close of each reporting period. Rebate guarantees will be reconciled annually within 180 days of the	Up to $5,000 at risk

		end of the reporting period.	

	General Performance Guarantee Requirements	PBM Response (Confirmed, Not Confirmed)	Explanation (If Not Confirmed)
30	PBM will provide a Termination Satisfaction guarantee that is separate from all other performance guarantees. The Termination Satisfaction guarantee will be at the sole discretion of CLIENT, in that the CLIENT can determine, in good faith, between responses such as "Yes, CLIENT is satisfied with the termination process", "No, CLIENT is not satisfied with the termination process", or "CLIENT is x% satisfied with the termination process". The termination process will include PBM's performance from the point of notification of termination through post-termination deliverables. **(Confirm "Yes" or "No"; Amount at risk is requested within the "Financial Offer")**	Confirmed. Client Specific Aetna guarantees satisfaction with the termination process. The termination process will include Aetna's performance from the point of notification of termination through post-termination deliverables.	Up to $50,000 at risk

Provider Type HMO Network	Broward	Miami-Dade	Palm Beach
Ambulatory Surgery Centers	22	26	35
Bone Density Testing	75*	102*	67*
Convenient Care Clinics/Retail Clinics	23	15	18
DME Providers	63	41	47
Home Health Care Agencies	44	46	35
Hospice Agencies	27**	17**	4**
Hospice Facilities	27**	17**	4**
Mammogram Facilities	75*	102*	67*
Occupational Therapists	42	39	41
Outpatient Laboratories	60	78	57
Physical Therapists	53	24	56
Radiology Centers	75	102	67
Rehabilitation Facilities (Inpatient)	27	32	22
Skilled Nursing Facilities	27	33	39
Speech Therapists	29	32	21
Urgent Care Facilities	75	59	59

High Deductible Network Provider Type	Broward	Miami-Dade	Palm Beach
Ambulatory Surgery Centers	22	26	35
Bone Density Testing	75*	102*	67*
Convenient Care Clinics/Retail Clinics	23	15	18
DME Providers	63	41	47
Home Health Care Agencies	44	46	35
Hospice Agencies	27**	17**	4**
Hospice Facilities	27**	17**	4**

Mammogram Facilities	75*	102*	67*
Occupational Therapists	42	39	41
Outpatient Laboratories	60	78	57
Physical Therapists	53	24	56
Radiology Centers	75	102	67
Rehabilitation Facilities (Inpatient)	27	32	22
Skilled Nursing Facilities	27	33	39
Speech Therapists	29	32	21
Urgent Care Facilities	75	59	59

* We consider Radiology Centers as facilities that provide bone density testing and mammograms.

** We have reported Hospice Agencies and Hospice Facilities the same as we do not track these separately.

Exhibit G

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("*Agreement*") is made and entered into as of this_________day of _____________, 2020 the "*Effective Date*"), by and between

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
(hereinafter referred to as "***SBBC***" or "***Covered Entity***"),
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 "Business Associate"),
whose principal place of business is
261 N. University Drive
Plantation, Florida 33324

WHEREAS, by virtue of some of the services that Business Associate performs for SBBC, Business Associate may be a "business associate," as that term is defined in 45 C.F.R. §160.103; and

WHEREAS, SBBC and Business Associate may share Protected Health Information ("PHI") (as defined below) in the course of their relationship; and

WHEREAS, SBBC and Business Associate understand that, with respect to coverages subject to regulation under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), they are subject to the requirements governing business associates, including but not limited to the Privacy Rule and the Security Rule (both defined below) of HIPAA, the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), the Omnibus Rule of 2013, and applicable Florida law, any of which may be amended from time to time or supplemented by new legislation or guidance (hereinafter collectively referred to as "Business Associate Requirements"); and

WHEREAS, SBBC and Business Associate intend to fully comply with current and future Business Associate requirements and mutually desire to outline their individual responsibilities with respect to Protected Health Information ("***PHI***") as mandated by the "Privacy Rule", the "Security Rule", and the HITECH Act; and

WHEREAS, SBBC and Business Associate understand and agree that the Business Associate requirements require SBBC and Business Associate to enter into a Business Associate Agreement which shall govern the use and/or disclosure of PHI and the security of Electronic PHI ("ePHI").

NOW, THEREFORE, the parties hereto agree as follows:

ARTICLE 1 – RECITALS

1. **Definitions**. When used in this Agreement and capitalized, the following terms have the following meanings:

(a) **"*Breach*"** has the same meaning as that term is defined in §13400 of the HITECH Act and shall include the unauthorized acquisition, access, use, or disclosure of PHI that compromises the security or privacy of such information.

ARTICLE 1 – RECITALS

(b) **"*Business Associate*"** shall mean Business Associate named above and shall include all successors, assigns, affiliates, subsidiaries, and related companies.

(c) "***Designated Record Set***" has the same meaning as the term "designated record set" in 45 CFR §164.501, which includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan, or other information used in whole or part by or for the Plan to make decisions about individuals.

(d) "***EDI Rule***" shall mean the Standards for Electronic Transactions as set forth at 45 CFR Parts 160, Subpart A and 162, Subpart A and I through R.

(e) "***Electronic PHI***" or "ePHI", shall mean PHI that is transmitted by or maintained in electronic media.

(f) **"*HIPAA*"** means the Health Insurance Portability and Accountability Act of 1996.

(g) **"*HITECH Act*"** means the Health Information Technology for Economic and Clinical Health Act of 2009.

(h) **"*Individual*"** shall have the same meaning as the term "Individual" in 45 C.F.R. §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).

(i) ***"Minimum Necessary"*** means the least amount of PHI needed to accomplish the intended purpose of the use or disclosure.

(j) ***"Omnibus Rule"*** means the HIPAA Omnibus Rule of 2013.

(k) **"*Privacy Rule*"** shall mean the Standards for Privacy of Individually Identifiable Health Information as set forth in 45 C.F.R. Parts 160 and 164, subparts A and E.

(l) **"*Protected Health Information*"** or **"*PHI*"** shall have the same meaning as the term "protected health information" in 45 C.F.R. §160.103 (as amended by the HITECH Act) limited to the information created or received by Business Associate from or on behalf of SBBC.

(m) **"*Required by Law*"** shall have the same meaning as the term "required by law" in 45 C.F.R. §164.103.

(n) **"*Secretary*"** shall mean the Secretary of the Department of Health and Human Services or his or her designee.

(o) ***"Security Rule"*** shall mean the Standards for Security of ePHI as set forth in 45 C.F.R. Parts 160 and 164 Subpart C.

ARTICLE 1 – RECITALS

(p) "*Unsecured PHI*" shall mean PHI that is not secured through the use of a technology or methodology specified by the Secretary in guidance or as otherwise defined in §13402(h) of the HITECH Act.

Terms used but not defined in this Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 164.103 and 164.501 and the HITECH Act.

ARTICLE 2 – SPECIAL CONDITIONS

2. Obligations and Activities of Business Associate Regarding PHI.

(a) Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as Required by Law.

(b) Business Associate agrees to comply with the "Minimum Necessary" rule when using, disclosing, or requesting PHI, except when a specific exception applies under HIPAA or the HITECH Act.

(c) Business Associate agrees to use appropriate safeguards and comply, where applicable, with the HIPAA Security Rule to prevent use or disclosure of the PHI other than as provided for by this Agreement.

(d) Business Associate agrees to report to SBBC, as soon as reasonably practicable, any impermissible use or disclosure of PHI it becomes aware of, and any use or disclosure of PHI not provided for by this Agreement. Any report of breach should be in substantially the same form as Exhibit A hereto.

(e) Business associate shall promptly inform SBBC of a Breach of Unsecured PHI within the next business day of when Business Associate knows of such Breach

(f) For the Breach of Unsecured PHI in its possession:

1. Business Associate will perform a Risk Assessment to determine if there is a low probability that the PHI has been compromised. Business Associate will provide SBBC with documentation showing the results of the Risk Assessment. The Risk Assessment will consider at minimum the following factors:

   a. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

   b. The unauthorized person who used the PHI or to whom the disclosure was made;

   c. Whether the PHI was actually acquired or viewed; and

   d. The extent to which the risk to the PHI has been mitigated.

2. Business Associate will prepare and distribute, at its own cost, any and all required notifications under Federal and Florida law, or reimburse SBBC any direct costs incurred by SBBC for doing so.

3. Business Associate shall be responsible for all fines or penalties incurred for failure to meet Breach notice requirements pursuant to Federal and/or Florida law.

(g) Business Associate agrees to ensure that, and obtain assurance from, any and all agents, including sub-contractors (excluding entities that are merely conduits), to whom it provides PHI, to agree to the same restrictions and conditions that apply to Business Associate with respect to such information. All agents and subcontractors engaged by the Business Associate that create, maintain, receive or transmit PHI must comply with the HIPAA Rules, including the rules to extend the requirements to the agent's or subcontractor's subcontractors.

(h) Business Associate agrees to provide SBBC access, at the request of SBBC, and in the time and manner designated by SBBC, to PHI in a Designated Record Set, in order for SBBC to meet the requirements under 45 C.F.R. § 164.524.

(i) Business Associate agrees to amend PHI in a Designated Record Set at SBBC's, or an Individual's, direction pursuant to 45 C.F.R. § 164.526, in the time and manner designated by SBBC. Business Associate agrees to make internal practices, policies, books and records relating to the use and disclosure of PHI available to SBBC, or at the request of SBBC to the Secretary, in a time and manner as designated by SBBC or the Secretary, for purposes of the Secretary determining SBBC's compliance with the Privacy Rule. Business Associate shall immediately notify SBBC upon receipt or notice of any and all requests by the Secretary to conduct an investigation with respect to PHI received from SBBC.

(j) Business Associate agrees to document any and all disclosures of PHI and information related to such disclosures that are not excepted under 45 C.F.R. § 164.528(a)(1) as would be reasonably required for SBBC to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

(k) Business Associate agrees to provide to SBBC or an Individual, in a time and manner designated by SBBC, information collected in accordance with paragraph (j) above, to permit SBBC to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

(l) Business Associate agrees to use or disclose PHI pursuant to the request of SBBC; provided, however, that SBBC shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by SBBC.

(m) Business Associate agrees to mitigate, to the extent practicable, any and all harmful effects that are known to Business Associate of a use or disclosure of PHI, or a Breach of Unsecured PHI, by Business Associate in violation of the requirements of this Agreement, the Privacy Rule, the Security Rule, the HITECH Act or HIPAA generally.

(n) Business Associate shall provide SBBC with a copy of any notice of privacy practices it produces in accordance with 45 C.F.R. § 164.520, as well as any and all changes to such notice.

(o) Business Associate, if performing a function that applies to Covered Entity, agrees to comply with the requirements that apply to the Covered Entity.

ARTICLE 2 – SPECIAL CONDITIONS

3. **Permitted Uses and Disclosures of PHI by "Business Associate".**

(a) Except as otherwise limited by this Agreement, Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, SBBC pursuant to any Agreements for services between the parties provided that such use or disclosure would not violate the Privacy Rule if done by SBBC.

(b) Except as otherwise limited by this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate.

(c) Except as otherwise limited by this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate and to carry out the legal responsibilities of Business Associate if: (i) such disclosure is Required by Law, or (ii) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that such information will remain confidential and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person agrees to notify Business Associate of any and all instances of which it is aware that the confidentiality of the information has been breached.

(d) Except as otherwise limited by this Agreement, Business Associate may use PHI to provide Data Aggregation services to SBBC as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).

4. **Obligations of SBBC Regarding PHI.**

(a) SBBC shall provide Business Associate with the notice of privacy practices that SBBC produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such notice.

(b) SBBC shall provide Business Associate with any and all changes in, or revocation of, authorization by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

(c) SBBC shall notify Business Associate of any and all restrictions to the use or disclosure of PHI that SBBC has agreed to in accordance with 45 C.F.R. § 164.522.

(d) SBBC and its representatives shall be entitled to audit Business Associate from time-to-time to verify Business Associate's compliance with the terms of this Agreement. SBBC shall provide Business Associate written notice at least ten (10) business days prior to the audit described in this paragraph. SBBC shall be entitled and enabled to inspect the records and other information relevant to Business Associate's compliance with the terms of this Agreement. SBBC shall conduct its review during the normal business hours of Business Associate, as the case may be, and to the extent feasible without unreasonably interfering with Business Associate's normal operations.

5. **Security of Electronic Protected Health Information.**

(a) Business Associate has implemented policies and procedures to ensure that its receipt, maintenance, or transmission of "electronic protected health information" **(as defined in 45 C.F.R. §160.103)** ("ePHI") on behalf of SBBC complies with the applicable administrative, physical, and technical safeguards required for protecting the confidentiality and integrity of ePHI in 45 C.F.R. Part 160 and 164 subpart C.

(b) Business Associate agrees that it will ensure that its agents or subcontractors agree to implement the applicable administrative, physical, and technical safeguards required to protect the confidentiality and integrity of ePHI pursuant to 45 C.F.R. Part 164.

(c) Business Associate agrees to report to SBBC all Security Incidents (as defined by 45 C.F.R. Part 164.304 and in accordance with applicable Florida law) of which it becomes aware. Business Associate agrees to report the Security Incident to SBBC as soon as reasonably practicable, but not later than 10 business days from the date the Business Associate becomes aware of the incident.

(d) SBBC agrees and understands that SBBC is independently responsible for the security of ePHI in its possession or for ePHI that it receives from outside sources including Business Associate.

6. Compliance with EDI Rule.

Business Associate agrees that it will comply with all applicable EDI standards. Business Associate further agrees that it will use its best efforts to comply with all applicable regulatory provisions in addition to the EDI Rule and the Privacy Rule that are promulgated pursuant to the Administrative Simplification Subtitle of HIPAA.

7. Subsequent Legislative or Regulatory Changes.

Any and all amendments to the laws or regulations affecting the Privacy Rule, Security Rule, the HITECH Act, Omnibus Rule, or HIPAA shall be deemed to amend this Agreement and be incorporated without further action of the parties.

8. Amendment.

The parties shall amend this Agreement, as is necessary, so that SBBC remains in compliance with any future changes to the Privacy Rule, the Security Rule, the HITECH Act and HIPAA. The parties may amend this Agreement for any other reasons as they deem appropriate. This Agreement shall not be amended except by written instrument executed by the parties.

9. Term and Termination.

(a) Term. This Agreement shall be effective upon the execution of all parties and shall remain in effect until such time as SBBC exercises its rights of termination under section 9(b) or 9(c) and until the requirements of Section 9(d) below are satisfied. The rights and obligations of Business Associate under Section 9(d) shall survive termination of this Agreement.

(b) Termination for Convenience. This Agreement may be terminated without cause and for convenience by SBBC during the term thereof upon thirty (30) days written notice to Business Associate.

(c) Termination for Cause by SBBC. Upon SBBC's knowledge of a material breach by Business Associate, SBBC shall provide an opportunity for Business Associate to cure the breach. If Business Associate does not cure the breach within thirty (30) days from the date that SBBC provides notice, SBBC shall have the right to terminate this Agreement, the Service Agreement, or both, by providing thirty (30) days advance written notice of such termination to Business Associate.

SBBC may terminate this Agreement without penalty or recourse to SBBC if SBBC determines that Business Associate has violated a material term of this Agreement.

Upon Business Associate knowledge of a material breach by SBBC, Business Associate shall provide an opportunity for SBBC to cure the breach. If SBBC does not cure the breach within thirty (30) days of the date that Business Associate provides notice of such breach to SBBC, Business Associate shall have the right to terminate this Agreement, the Service Agreement, or both, by providing thirty (30) days advance written notice of such termination to SBBC.

(d) ***Effect of Termination***. Upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from SBBC, or created or received by Business Associate on behalf of SBBC. Business Associate shall not retain any copies of the PHI except to the extent that the destruction or return of the PHI is infeasible. Business Associate shall provide to SBBC written notification of the conditions that make return or destruction of the PHI infeasible. If it is determined by SBBC that the return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that SBBC explicitly authorizes in writing for so long as Business Associate maintains such PHI.

10. Indemnification.

(a) By SBBC: SBBC agrees to be fully responsible for its acts of negligence or its agent's 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 Business Associate: Business Associate 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 cost, court costs and all other sums which SBBC, its agents, servants and employees must 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 Business Associate, its agents, servants or employees; the equipment of Business Associate, its agents, servants or employees while such equipment is on premises owned or controlled by SBBC; or the negligence of Business Associate's agents when acting within the scope of their employment or agency, whether such claims, judgments, costs and expenses be for damages, damage to property including Business Associate's property, and injury or death of any person whether employed by Business Associate, SBBC or otherwise.

11. No Waiver of Sovereign Immunity.

Nothing contained 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 as a waiver of limits to liability or rights existing under Section 768.28, Florida Statutes.

ARTICLE 3 – GENERAL CONDITIONS

12. 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. 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.

13. Non-Discrimination.

The parties shall not discriminate against any employee or participant in the performance of the duties, responsibilities and obligations under this Agreement because of age, color, disability, gender identity, gender expression, national origin, marital status, race, religion, sex or sexual orientation.

14. Records.

Each party shall maintain its own respective records and documents associated with this Agreement in accordance with the records retention requirements applicable to public records. Each party shall be responsible for compliance with any public documents request served upon it pursuant to Section 119.07, Florida Statutes, and any resultant award of attorney's fees for non-compliance with that law.

15. 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.

16. 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. A waiver of any breach of a provision of this Agreement shall not be deemed a waiver of any subsequent breach and shall not be construed to be a modification of the terms of this Agreement.

17. Compliance with Laws.

Each party shall comply with all applicable federal and state laws, codes, rules and regulations in performing its duties, responsibilities and obligations pursuant to this Agreement.

18. Binding Effect.

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

19. 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.

ARTICLE 3 – GENERAL CONDITIONS

20. 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.

21. 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.

22. Notices.

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 3rd Avenue
Fort Lauderdale, Florida 33301

With a Copy to:

Director, Benefits & Employment Services
7770 W. Oakland Park Blvd.
Sunrise, FL 33351

Privacy Officer
Risk Management Department
The School Board of Broward County, Florida
600 S.E. 3rd Avenue, 11th Floor
Ft. Lauderdale, FL 33301

To Business Associate:

Gabrielle Dimitrakis, Account Manager, Florida Public & Labor
261 N. University Drive
Plantation, Florida 33324

With a Copy to:

Cathy Aguirre, Market Head
Public & Labor Segment
261 N. University Drive
Plantation, Florida 33323

ARTICLE 3 – GENERAL CONDITIONS

23. Severability.

In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, unlawful, unenforceable or void in any respect, the invalidity, illegality, unenforceability or unlawful or void nature of that provision shall not affect any other provision and this Agreement shall be considered as if such invalid, illegal, unlawful, unenforceable or void provision had never been included herein.

24. Captions.

The captions, section numbers, title and headings appearing in this Agreement are inserted only as a matter of convenience 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 effect this Agreement and shall not be construed to create a conflict with the provisions of this Agreement.

25. 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.

26. No Waiver of Rights, Powers and Remedies.

The parties agree that each requirement, duty, right 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.

27. Regulatory References.

A reference in this Agreement to any part of the Privacy Rule, the Security Rule, the HITECH Act, or HIPAA shall refer to the most current form of legislation, and shall incorporate any future amendments.

28. Governing Law.

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.

29. Entire Agreement.

This Agreement 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 Agreement. Accordingly, the parties agree that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written.

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

FOR SBBC:

(Corporate Seal)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

By______________________________
Donna P. Korn, Chair

ATTEST:

____
Robert W. Runcie, Superintendent of Schools

Approved as to Form and Legal Content:

Office of the General Counsel

FOR BUSINESS ASSOCIATE

AETNA

______________________ By: Catherine R. Aguirre, Market Head Public Labor

Signature Print Name and Title

______________________ Witness

______________________ Witness

STATE OF Florida

COUNTY OF Broward

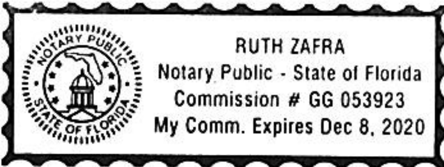
The foregoing instrument was acknowledged before me by Catherine Aguirre who is personally known to me or who produced ______________________ as identification and who did / did not first take an oath this 24 day of August, 20 20

My Commission Expires: ______________________

Signature – Notary Public

Ruth Zafra

Notary's Printed Name



GG053923

Notary's Commission No.

EXHIBIT G

NOTIFICATION TO THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

ABOUT A BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

This notification is made pursuant to Section 2(d) of the Business Associate Agreement between THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA ("SBBC") and

____ (Business Associate).

Business Associate hereby notifies SBBC that there has been a breach of unsecured (unencrypted) protected health information (PHI) that Business Associate has used or has had access to under the terms of the Business Associate Agreement.

Description of the breach: ____

____

Date or date range of the breach: __________________________________

Date of the discovery of the breach: ________________________________

Number of individuals affected by the breach: ___________________________

The types of unsecured PHI that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code): ____________________________

____

____

Description of what Business Associate is doing to investigate the breach, to mitigate losses, and to protect against any further breaches: ____

____

____

Recommended steps the individuals whose information was breached should take to protect themselves from potential harm resulting from the breach:____

____

Contact information to ask questions or learn additional information:

Name: ____

Title: ____

Address: ____

____

Email Address: ______________________________________

Phone Number: ______________________________________