AGREEMENT BETWEEN BROWARD COUNTY AND UNITED HEALTHCARE SERVICES, INC., FOR ADMINISTRATIVE MANAGEMENT SERVICES FOR SELF-INSURED GROUP HEALTH INSURANCE COVERAGE AND BENEFITS AND PHARMACY BENEFIT MANAGEMENT SERVICES FOR BROWARD COUNTY BENEFITS-ELIGIBLE INDIVIDUALS (RFP # TEC2122482P1)

This Agreement ("Agreement") is made and entered by and between Broward County, a political subdivision of the State of Florida ("County"), and United Healthcare Services, Inc., a Minnesota corporation authorized to transact business in the State of Florida ("Plan Manager") (each a "Party" and collectively referred to as the "Parties").

RECITALS

A. County has established and currently sponsors a self-funded employee welfare benefit plan and desires to offer cost-effective health benefits, wellness, and disease management programs to Plan Participants (as defined in Exhibit A).

B. County also desires to offer cost-effective prescription benefit services and cost-effective dispensing of prescription drugs and other covered products to Plan Participants.

C. County seeks to contract with an experienced company that can provide health benefits management services (including plan administration), pharmacy benefits management services, and wellness and disease management programs, in a cost-effective, transparent, and ethical manner.

D. Plan Manager is committed to providing employers such as County the services they need as well as providing Plan Participants quality health and pharmacy benefits management consistent with the requirements of County.

Now, therefore, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

ARTICLE 1. DEFINITIONS

Except as terms may be defined within a provision of this Agreement, all definitions for this Agreement are stated in Exhibit A.

ARTICLE 2. EXHIBITS

The following exhibits are attached hereto and incorporated into this Agreement:

Exhibit A	**Definitions**
Exhibit B	**Relationship Between the Parties**
Exhibit C	**Scope of Services**
Exhibit D	**Schedule of Fees/Discounts**
Exhibit E	**Shared Savings (Naviguard) Program and Subrogation, Payment**

Integrity and Recovery Services
Exhibit F Carrier-Specific Medical Discount Guarantee
Exhibit G Claims Administration
Exhibit H Performance Measures
Attachment 1 Reporting and Data Requirements
Attachment 2 Account Management Scorecard
Exhibit I COBRA/Retiree Administrative Services
Exhibit J Clinical Program Services
Exhibit K Networks
Exhibit L Persons Authorized to Receive Private Health Information
Exhibit M Wellness Program
Exhibit N Retiree Drug Subsidy Requirements
Exhibit O Claims Processing for Arrestees
Exhibit P Banking Arrangement
Exhibit Q Insurance Requirements
Exhibit R Work Authorization
Exhibit S Certification of Payments to Subcontractors and Suppliers
Exhibit T Business Associate Agreement
Exhibit U Service Level Agreement
Exhibit V Enterprise Technology Services Security Requirements – High Risk
Exhibit W FLEX Formulary Prescriptive Drug List and Preventative Drug List
Exhibit X FLEX Formulary Key Exclusions and Alternatives
Exhibit Y Identification of the Plans/Summary Plan Descriptions

ARTICLE 3. SCOPE OF SERVICES

3.1. Scope of Services. Plan Manager shall perform all Services required under this Agreement including, without limitation, the work specified in Exhibit C (the "Scope of Services"). The Scope of Services is a description of Plan Manager's obligations and responsibilities and is deemed to include preliminary considerations and prerequisites, and all labor, materials, equipment, and tasks that are such an inseparable part of the work described that exclusion would render performance by Plan Manager impractical, illogical, or unconscionable.

3.2. Optional Services. Plan Manager acknowledges that the Contract Administrator has no authority to make changes that would increase, decrease, or otherwise modify the Scope of Services except as expressly set forth in this Agreement or, to the extent applicable, set forth in the Broward County Procurement Code. If any goods or services under this Agreement, or the quantity thereof, are identified as optional ("Optional Services"), County may select the type, amount, and timing of such goods or services pursuant to a work authorization ("Work Authorization") in substantially the form attached as Exhibit R executed by Plan Manager and County pursuant to this section. Notwithstanding anything to the contrary in this Agreement, Work Authorizations for Optional Services shall be executed on behalf of County as follows: (a) the Contract Administrator may execute Work Authorizations for which the total cost to County in the aggregate is less than $50,000.00; (b) the Purchasing Director may execute Work

Authorizations for which the total cost to County in the aggregate is within the Purchasing Director's delegated authority; and (c) any Work Authorization above the Purchasing Director's delegated authority requires express approval by the Board (as defined in Exhibit A). Subsequent to the full execution of any Work Authorization, the Contract Administrator will issue a Notice to Proceed for those authorized Optional Services. Plan Manager shall not commence work on any Work Authorization until after receipt of a purchase order and Notice to Proceed.

ARTICLE 4. TERM AND TIME FOR PERFORMANCE

4.1. Term. The term of this Agreement shall begin upon full execution by the Parties ("Effective Date") and shall end at 11:59 p.m. on December 31, 2024 ("Initial Term"), unless sooner terminated. The Initial Term, all Renewal Terms defined in Section 4.2, and the additional extension described in Section 4.3 are collectively referred to as the "Term."

4.2. Extensions. This Agreement may be renewed for up to two (2) additional one-year renewal terms upon written mutual consent of both County and Plan Manager (each renewal period is individually a "Renewal Term" and collectively "Renewal Terms"). County's Purchasing Director is authorized to exercise renewal options if the same terms and conditions in effect during the immediately preceding term are accepted by Plan Manager (as provided below). If this Agreement is renewed, the first Renewal Term shall commence on January 1, 2025, and shall end on December 31, 2025. The second renewal term shall commence on January 1, 2026, and shall end on December 31, 2026. Plan Manager shall give County notice at least two hundred seventy (270) days prior to the expiration of the Initial Term or Renewal Term, as applicable, that Plan Manager either accepts renewal on the same terms and conditions then in effect, or that Plan Manager requests a change to any term or condition including, but not limited to, an increase in fees for the next applicable Renewal Term. If Plan Manager fails to timely provide such notice, Plan Manager shall be conclusively deemed to have accepted renewal for the next applicable Renewal Term on the same terms and conditions then in effect.

4.3. Additional Extension. If unusual or exceptional circumstances, as determined in the sole discretion of the Purchasing Director, render the exercise of a Renewal Term not practicable, or if no renewal remains available and expiration of this Agreement would, as determined by the Purchasing Director, result in a gap in the provision of Services, as both Parties agree that the Services are necessary for the ongoing operations of County, then the Purchasing Director may extend this Agreement on the same terms and conditions on a month-to-month basis for up to a maximum of six (6) months ("Extension Term"). The Purchasing Director may exercise this option by written notice stating the duration of the Extension Term, which notice shall be provided to Plan Manager at least thirty (30) days prior to the end of the Initial Term or Renewal Term, as applicable. The Extension Term shall be on the same terms and conditions as existed at the time of its exercise. However, if either Party proposes any changes to the terms and conditions of the Agreement that would become effective during the Extension Term, such extension shall be subject to Board approval.

4.4. Fiscal Year. The continuation of this Agreement beyond the end of any County fiscal year is subject to both the appropriation and the availability of funds in accordance with Chapter 129, Florida Statutes.

4.5. Time of the Essence. Time is of the essence for Plan Manager to perform the duties, obligations, and responsibilities required by this Agreement.

ARTICLE 5. COMPENSATION

5.1. Amounts Due to Plan Manager. Fees for the Services shall be in the amounts stated in Exhibit D, Schedule of Fees/Discounts. The amounts stated in Exhibit D shall be paid only for Services actually performed and completed pursuant to this Agreement, which amounts shall be accepted by Plan Manager as full compensation for all Services. Plan Manager shall not be compensated for any Services or work performed during the Implementation Period (as defined in Exhibit A). Plan Manager acknowledges that the amounts set forth in this Agreement (including, but not limited to those stated in Exhibit D) are the maximum amounts payable and constitute a limitation upon County's obligation to compensate Plan Manager for work under this Agreement. These maximum amounts, however, do not constitute a limitation of any sort upon Plan Manager's obligation to perform all Services. Unless and except to the extent expressly required under this Agreement, Plan Manager shall not be reimbursed for any expenses it incurs.

5.2. Implementation Period. Any Services, including but not limited to equipment purchases, programming, testing, or system upgrades performed by Plan Manager during the Implementation Period shall be at no cost to County or any Plan Participant.

5.3. Method of Billing and Payment.

5.3.1. Plan Manager shall be paid a monthly Administrative Fee for the Services in accordance with Exhibit D. The Administrative Fee shall be remitted to Plan Manager by the 15th calendar day of each month, or the next business day if this day falls on a weekend or holiday. If Plan Manager subcontracts any Services under this Agreement, Plan Manager shall submit a Certification of Payments to Subcontractors and Suppliers (Exhibit S). The certification shall be accompanied by a copy of the notification sent to each unpaid Subcontractor (as defined in Exhibit A) listed on the form, explaining the good cause why payment has not been made to that Subcontractor.

5.3.2. Plan Manager shall pay Subcontractors and suppliers within fifteen (15) days following receipt of payment from County for such subcontracted work or supplies. Plan Manager agrees that if it withholds an amount as retainage from Subcontractors or suppliers, it will release such retainage and pay same within fifteen (15) days following receipt of payment of retained amounts from County. Failure to pay a Subcontractor or supplier in accordance with this subsection shall be a material breach of this Agreement, unless Plan Manager demonstrates that such failure to pay results from a bona fide dispute with the Subcontractor or supplier and, further, Plan Manager promptly pays the applicable amount(s) to the Subcontractor or supplier upon resolution of the dispute.

Plan Manager shall include requirements substantially similar to those set forth in this subsection in its contracts with Subcontractors and suppliers.

5.4. Withholding by County. Notwithstanding any provision of this Agreement to the contrary, County may withhold, in whole or in part, payment to the extent necessary to protect itself from loss on account of inadequate or defective work that has not been remedied or resolved in a manner satisfactory to the Contract Administrator or failure to comply with any provision of this Agreement. The amount withheld shall not be subject to payment of interest by County.

ARTICLE 6. PERFORMANCE MEASURES

6.1. Performance Measures. Plan Manager agrees to meet the performance measures as set forth in Exhibit H (collectively, "Performance Measures") in performing Services. Plan Manager shall submit performance reports to County for each Performance Measure within forty-five (45) days after the conclusion of the applicable measurement period set forth in Exhibit H.

6.2. Extension Request. Plan Manager may request an extension of any Performance Measure deadline. Such request shall be submitted in writing to the Contract Administrator no less than five (5) business days before the deadline, unless the need for an extension could not reasonably be foreseen by Plan Manager or the Contract Administrator determines that the need for an extension occurred for a reason beyond Plan Manager's control. If the need for an extension could not be reasonably foreseen by Plan Manager, Plan Manager shall submit a written request for an extension as soon as reasonably possible, but in no event later than five (5) business days after the occurrence of the event giving rise to the extension request. If the Contract Administrator determines that the request for an extension is based upon extenuating circumstances or other causes beyond Plan Manager's control, approval of the request shall not be unreasonably withheld by County. Plan Manager's written request must identify the section of Exhibit H to which the request applies and the reasons why the deadline could not be met. The Contract Administrator may approve the extension request for such period as the Contract Administrator deems appropriate. The Contract Administrator shall give notice to Plan Manager of its decision on an extension request within three (3) business days after receipt of Plan Manager's written extension request.

6.3. Retention Invoices. If after receipt and review of all quarterly and annual performance reports provided by Plan Manager as required by Section 6.1 and described in Exhibit H, County, through its Contract Administrator, finds that Plan Manager has failed at any time to meet any Performance Measure, County will submit a written retention invoice to Plan Manager detailing alleged Performance Measure failure(s); the applicable date(s) of such failure(s); and the total amount of deductions attributable to such failure(s) due County in accordance with Exhibit H. Unless Plan Manager files an appeal in strict accordance with the requirements of Section 6.4, Plan Manager must pay County the amount set forth on the invoice within twenty (20) days after the date of County's invoice. If no such appeal is filed and Plan Manager fails to timely pay the invoice, County may set off and deduct the invoice amount from County's next premium payment. This section shall survive the expiration or earlier termination of this Agreement.

6.4. Appeal. Plan Manager may appeal County's written notice of failure to meet Performance Measures within ten (10) days after the date of the notice. The appeal must be in writing to the Purchasing Director and must state the reasons why the deductions should be reduced or not assessed. If the appeal is not resolved by mutual agreement, the Purchasing Director shall promptly issue a decision in writing after consulting with the Office of the County Attorney. The decision shall state the reasons for the action taken and, if the appeal is denied in whole or in part, the decision shall inform Plan Manager of its right to an administrative hearing under Part XII of the Broward County Procurement Code, as amended. Plan Manager shall file a written request for an administrative hearing with the Purchasing Director no later than ten (10) days after the date the Purchasing Director issues the denial of the appeal. County and Plan Manager agree that the administrative hearing procedures shall be those set forth in Part XII of the Broward County Procurement Code, as amended. If the administrative hearing officer sustains County's finding that Plan Manager failed to meet the identified Performance Measure(s), County shall deduct the amount set forth in the invoice from County's next premium payment. This section shall survive the expiration or earlier termination of this Agreement.

ARTICLE 7. BANKING

7.1. The rights and obligations of County and Plan Manager under this article shall be regulated through a Banking Arrangement as specified in Exhibit P.

7.2. County agrees that sufficient funds will be available on a timely basis to honor all Claim reimbursements under the Plan. Upon notice from Plan Manager that additional funds are required, County agrees that adequate funds will be immediately provided to fund approved Claims.

7.3. County agrees that funds provided to honor all Claim reimbursements under this Plan will be by United States currency, which may be transmitted by wire transfer or other medium agreed to by Plan Manager and County.

ARTICLE 8. REPRESENTATIONS AND WARRANTIES

8.1. Representation of Authority. Plan Manager represents and warrants that this Agreement constitutes the legal, valid, binding, and enforceable obligation of Plan Manager, and that neither the execution nor performance of this Agreement constitutes a breach of any agreement that Plan Manager has with any third party or violates any law, rule, regulation, or duty arising in law or equity applicable to Plan Manager. Plan Manager further represents and warrants that execution of this Agreement is within Plan Manager's legal powers, and each individual executing this Agreement on behalf of Plan Manager is duly authorized by all necessary and appropriate action to do so on behalf of Plan Manager and does so with full legal authority.

8.2. Solicitation Representations. Plan Manager represents and warrants that all statements and representations made in Plan Manager's proposal, bid, or other supporting documents submitted to County in connection with the solicitation, negotiation, or award of this Agreement, including during the procurement or evaluation process, were true and correct when made and

are true and correct as of the date Plan Manager executes this Agreement, unless otherwise expressly disclosed in writing by Plan Manager.

8.3. Contingency Fee. Plan Manager represents that it has not paid or agreed to pay any person or entity, other than a bona fide employee working solely for Plan Manager, any fee, commission, percentage, gift, or other consideration contingent upon or resulting from the award or making of this Agreement.

8.4. Truth-In-Negotiation Representation. Plan Manager's compensation under this Agreement is based upon its representations to County, and Plan Manager certifies that the wage rates, factual unit costs, and other information supplied to substantiate Plan Manager's compensation including, without limitation, in the negotiation of this Agreement, are accurate, complete, and current as of the date Plan Manager executes this Agreement. Plan Manager's compensation will be reduced to exclude any significant sums by which the contract price was increased due to inaccurate, incomplete, or noncurrent wage rates and other factual unit costs.

8.5. Public Entity Crime Act. Plan Manager represents that it is familiar with the requirements and prohibitions under the Public Entity Crime Act, Section 287.133, Florida Statutes, and represents that its entry into this Agreement will not violate that Act. Plan Manager further represents that there has been no determination that it committed a "public entity crime" as defined by Section 287.133, Florida Statutes, and that it has not been formally charged with committing an act defined as a "public entity crime," regardless of the amount of money involved, or whether Plan Manager has been placed on the convicted vendor list.

8.6. Discriminatory Vendor and Scrutinized Companies Lists; Countries of Concern. Plan Manager represents that it has not been placed on the "discriminatory vendor list" as provided in Section 287.134, Florida Statutes, and that it is not a "scrutinized company" pursuant to Section 215.473, Florida Statutes. Plan Manager represents and certifies that it is not ineligible to contract with County on any of the grounds stated in Section 287.135, Florida Statutes. Plan Manager represents that it is, and for the duration of the Term will remain, in compliance with Section 286.101, Florida Statutes.

8.7. Claims Against Plan Manager. Plan Manager represents and warrants that there is no action or proceeding, at law or in equity, before any court, mediator, arbitrator, governmental or other board or official, pending or, to the knowledge of Plan Manager, threatened against or affecting Plan Manager, the outcome of which may: (a) affect the validity or enforceability of this Agreement, (b) materially and adversely affect the authority or ability of Plan Manager to perform its obligations under this Agreement, or (c) have a material and adverse effect on the consolidated financial condition or results of operations of Plan Manager or on the ability of Plan Manager to conduct its business as presently conducted or as proposed or contemplated to be conducted.

8.8. Verification of Employment Eligibility. Plan Manager represents that Plan Manager and each Subcontractor has registered with and uses the E-Verify system maintained by the United States Department of Homeland Security to verify the work authorization status of all newly hired

employees in compliance with the requirements of Section 448.095, Florida Statutes, and that entry into this Agreement will not violate that statute. If Plan Manager violates this section, County may terminate this Agreement for cause and Plan Manager shall be liable for all costs incurred by County due to the termination.

8.9. Warranty of Performance. Plan Manager represents and warrants that it possesses the knowledge, skill, experience, and financial capability required to perform and provide all required and optional Services under this Agreement, and that each person and entity that will provide Services under this Agreement is duly qualified to perform such services by all appropriate governmental authorities, where required, and is sufficiently experienced and skilled in the area(s) for which such person or entity will render Services. Plan Manager represents and warrants that the Services under this Agreement shall be performed in a skillful and respectful manner, and that the quality of all such services shall equal or exceed prevailing industry standards for the provision of such services.

8.10. Prohibited Telecommunications Equipment. Plan Manager represents and certifies that it and its Subcontractors do not use any equipment, system, or service that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system, as such terms are used in 48 CFR §§ 52.204-24 through 52.204-26. Plan Manager represents and certifies that Plan Manager and its Subcontractors shall not provide or use such covered telecommunications equipment, system, or services during the Term.

8.11. Criminal History Screening Practices. If this Agreement is subject to the requirements of Section 26-125(d) of the Broward County Administrative Code, Plan Manager represents and certifies that its policies, practices, and procedures regarding inquiry into the criminal history of an applicant for employment, including a criminal history background check, preclude inquiry into an applicant's criminal history until the applicant is selected as a finalist and interviewed for the position.

8.12. Domestic Partnership Requirement. Unless this Agreement is exempt from the provisions of the Broward County Domestic Partnership Act, Section 16½-157, Broward County Code of Ordinances, Plan Manager certifies and represents that it will comply with the provisions of Section 16½-157 for the duration of this Agreement, and the contract language referenced in Section 16½-157 is deemed incorporated in this Agreement as though fully set forth in this section.

8.13. Breach of Representations. In entering into this Agreement, Plan Manager acknowledges that County is materially relying on the representations, warranties, and certifications of Plan Manager stated in this article. County shall be entitled to recover any damages it incurs to the extent any such representation or warranty is untrue. In addition, if any such representation, warranty, or certification is false, County shall have the right, at its sole discretion, to terminate this Agreement without any further liability to Plan Manager, to deduct from any amounts due Plan Manager under this Agreement the full amount of any value paid in violation of a representation or warranty, or to recover all sums paid to Plan Manager under this Agreement.

Furthermore, a false representation may result in debarment from County's competitive procurement activities.

ARTICLE 9. INDEMNIFICATION, LIABILITY, CLAIMS RESOLUTION, MEDIATION, CHOICE OF LAW, AND WAIVER OF JURY TRIAL AND EXEMPLARY/PUNITIVE DAMAGES

9.1. Indemnification. Plan Manager shall indemnify, hold harmless, and defend County and all of County's current, past, and future officers, agents, servants, and employees (collectively, "Indemnified Party") from and against any and all causes of action, demands, claims, losses, liabilities, and expenditures of any kind, including attorneys' fees, court costs, and expenses, including through the conclusion of any appellate proceedings, raised or asserted by any person or entity not a party to this Agreement, and caused or alleged to be caused, in whole or in part, by any intentional, reckless, or negligent act or omission of Plan Manager, its officers, employees, agents, or servants, arising from, relating to, or in connection with this Agreement (collectively, a "Plan Manager Claim"). If any Plan Manager Claim is brought against an Indemnified Party, Plan Manager shall, upon written notice from County, defend each Indemnified Party against each such Plan Manager Claim by counsel satisfactory to County or, at County's option, pay for an attorney selected by the County Attorney to defend the Indemnified Party. The obligations of this section shall survive the expiration or earlier termination of this Agreement. If considered necessary by the Contract Administrator and the County Attorney, any sums due Plan Manager under this Agreement may be retained by County until all Plan Manager Claims subject to this indemnification obligation have been settled or otherwise resolved. Any amount withheld shall not be subject to payment of interest by County.

9.2. Liability for Retail and Mail-Order Pharmacies and Pharmacist Actions. County acknowledges that a Plan Manager may not be an operator of retail pharmacies nor exercise control over the professional judgment used by any retail pharmacist when dispensing drugs or medical supplies to Plan Participants. County also acknowledges that the Plan Manager may operate its own mail-order drug pharmacies and exercise control over the professional judgment used by the Plan Manager's pharmacist when dispensing drugs or medical supplies to Plan Participants. Nothing in the Agreement shall be construed to usurp the dispensing pharmacist's professional judgment with respect to the dispensing or refusal to dispense any drugs or medical supplies to Plan Participants. Except as may arise from a breach of this Agreement by Plan Manager, or Plan Manager's negligent act or omission or intentionally wrongful conduct, County agrees that it shall not hold Plan Manager responsible for the actions of the retail pharmacist, nor shall Plan Manager be liable to County or any Plan Participants for any liability arising from the dispensing of drugs or medical supplies to Plan Participants by any retail pharmacy or retail pharmacist.

9.3. Claims Resolution. Plan Manager shall reimburse County one hundred percent (100%) of any amount incorrectly invoiced or credited by Plan Manager to County as a result of any error by Plan Manager, as well as any reasonable administrative costs incurred by County necessary to correct the consequences of any such error, including any required notification to patients, prescribers, and/or pharmacies affected. Once an incorrectly dispensed claim

is identified, resolution of such claims paid or dispensed incorrectly shall be completed within two (2) weeks from the date the error was detected.

9.4. Mediation. If either Party to this Agreement should declare a breach of this Agreement, or if any dispute arises from this Agreement or concerns the subject matter of this Agreement, the Parties shall first submit the matter to non-binding mediation (not arbitration) with a Florida certified mediator agreed to by the Parties and attempt to resolve the matter, in good faith, prior to the institution of any other legal action. The Parties agree that litigation may be initiated only after each Party has presented its position on the dispute to a qualified mediator and such mediator has declared an impasse. Any statements made at such mediation shall be for settlement purposes only and shall not be construed to be an admission. A Party demanding mediation shall be entitled to obtain a court order mandating mediation if the other Party does not agree to commence mediation within thirty (30) days after written demand. The fees and costs incurred by the Party seeking such court order shall be reimbursed by the other Party; otherwise, each Party shall pay its own costs of mediation. All such mediation proceedings shall be conducted on a confidential basis. The mediation shall be conducted in Broward County, Florida.

9.5. Law, Jurisdiction, Venue, Waiver of Jury Trial. This Agreement shall be interpreted and construed in accordance with and governed by the laws of the State of Florida. The exclusive venue for any lawsuit arising from, related to, or in connection with this Agreement shall be in the state courts of the Seventeenth Judicial Circuit in and for Broward County, Florida. If any claim arising from, related to, or in connection with this Agreement must be litigated in federal court, the exclusive venue for any such lawsuit shall be in the United States District Court or United States Bankruptcy Court for the Southern District of Florida. **BY ENTERING INTO THIS AGREEMENT, EACH PARTY HEREBY EXPRESSLY WAIVES ANY RIGHTS IT MAY HAVE TO A TRIAL BY JURY OF ANY CIVIL LITIGATION RELATED TO THIS AGREEMENT. IF A PARTY FAILS TO WITHDRAW A DEMAND FOR A JURY TRIAL AFTER WRITTEN NOTICE BY THE OTHER PARTY, THE PARTY MAKING THE DEMAND FOR JURY TRIAL SHALL BE LIABLE FOR REASONABLE ATTORNEYS' FEES AND COSTS OF THE OTHER PARTY TO CONTEST THE DEMAND FOR JURY TRIAL, AND SUCH AMOUNTS SHALL BE AWARDED BY THE COURT IN ADJUDICATING THE MOTION.**

ARTICLE 10. INSURANCE

10.1. For the duration of the Agreement, Plan Manager shall, at its sole expense, maintain the minimum insurance coverages stated in Exhibit Q in accordance with the terms and conditions of this article. Plan Manager shall maintain insurance coverage against claims relating to any act or omission by Plan Manager, its agents, representatives, employees, or Subcontractors in connection with this Agreement. County reserves the right at any time to review and adjust the limits and types of coverage required under this article.

10.2. Plan Manager shall ensure that "Broward County" is listed and endorsed as an additional insured as stated in Exhibit Q on all policies required under this article.

10.3. On or before the Effective Date or at least fifteen (15) days prior to commencement of Services, Plan Manager shall provide County with a copy of all Certificates of Insurance or other documentation sufficient to demonstrate the insurance coverage required in this article. If and to the extent requested by County, Plan Manager shall provide complete, certified copies of all required insurance policies and all required endorsements within thirty (30) days after County's request.

10.4. Plan Manager shall ensure that all insurance coverages required by this article shall remain in full force and effect for the duration of this Agreement and until all performance required by Plan Manager has been completed, as determined by Contract Administrator. Plan Manager or its insurer shall provide notice to County of any cancellation or modification of any required policy at least thirty (30) days prior to the effective date of cancellation or modification, and at least ten (10) days prior to the effective date of any cancellation due to nonpayment, and shall concurrently provide County with a copy of its updated Certificates of Insurance or other documentation evidencing continuation of the required coverage(s). Plan Manager shall ensure that there is no lapse of coverage at any time during the time period for which coverage is required by this article.

10.5. Plan Manager shall ensure that all required insurance policies are issued by insurers: (1) assigned an A. M. Best rating of at least "A-" with a Financial Size Category of at least Class VII; (2) authorized to transact insurance in the State of Florida; or (3) a qualified eligible surplus lines insurer pursuant to Section 626.917 or 626.918, Florida Statutes, with approval by County's Risk Management Division.

10.6. If Plan Manager maintains broader coverage or higher limits than the minimum insurance requirements stated in Exhibit Q, County shall be entitled to any such broader coverage and higher limits maintained by Plan Manager. All required insurance coverages under this article shall provide primary coverage and shall not require contribution from any County insurance, self-insurance or otherwise, which shall be in excess of and shall not contribute to the insurance required and provided by Plan Manager.

10.7. Plan Manager shall declare in writing any self-insured retentions or deductibles over the limit(s) prescribed in Exhibit Q and submit to County for approval at least fifteen (15) days prior to the Effective Date or commencement of Services. Plan Manager shall be solely responsible for and shall pay any deductible or self-insured retention applicable to any claim against County. County may, at any time, require Plan Manager to purchase coverage with a lower retention or provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. Plan Manager agrees that any deductible or self-insured retention may be satisfied by either the named insured or County, if so elected by County, and Plan Manager agrees to obtain same in endorsements to the required policies.

10.8. Unless prohibited by the applicable policy, Plan Manager waives any right to subrogation that any of Plan Manager's insurers may acquire against County and agrees to obtain same in an endorsement of Plan Manager's insurance policies.

10.9. Plan Manager shall require that each Subcontractor maintains insurance coverage that adequately covers the Services provided by that Subcontractor on substantially the same insurance terms and conditions required of Plan Manager under this article. Plan Manager shall ensure that all such Subcontractors comply with these requirements and that "Broward County" is named as an additional insured under the Subcontractors' applicable insurance policies.

10.10. If Plan Manager or any Subcontractor fails to maintain the insurance required by this Agreement, County may pay any costs of premiums necessary to maintain the required coverage and deduct such costs from any payment otherwise due to Plan Manager. Plan Manager shall not permit any Subcontractor to provide Services under this Agreement unless and until the requirements of this article are satisfied. If requested by County, Plan Manager shall provide, within one (1) business day, evidence of each Subcontractor's compliance with this section.

10.11. If any of the policies required under this article provide claims-made coverage: (1) any retroactive date must be prior to the Effective Date; (2) the required coverage must be maintained after termination or expiration of the Agreement for at least the duration stated in Exhibit Q; and (3) if coverage is canceled or nonrenewed and is not replaced with another claims-made policy form with a retroactive date prior to the Effective Date, Plan Manager must obtain and maintain "extended reporting" coverage that applies after termination or expiration of the Agreement for at least the duration stated in Exhibit Q.

ARTICLE 11. TERMINATION

11.1. This Agreement may be terminated for cause by the aggrieved Party if the Party in breach has not corrected the breach within ten (10) days after receipt of written notice from the aggrieved Party identifying the breach. This Agreement may also be terminated for convenience by the Board. Termination for convenience by the Board shall be effective on the termination date stated in written notice provided by County, which termination date shall be not less than thirty (30) days after the date of such written notice. Unless otherwise stated in this Agreement, if this Agreement was approved by Board action, termination for cause by County must be by action of the Board or the County Administrator; in all other instances termination for cause may be made by the County Administrator, any other County representative expressly authorized under this Agreement, or the County representative (including any successor) who executed the Agreement on behalf of County. This Agreement may also be terminated by the County Administrator upon such notice as the County Administrator deems appropriate under the circumstances if the County Administrator determines that termination is necessary to protect the public health, safety, or welfare. If County erroneously, improperly, or unjustifiably terminates for cause, such termination shall be deemed a termination for convenience and shall be effective thirty (30) days after such notice of termination for cause was provided and Plan Manager shall be eligible for the compensation provided in Section 11.6 as its sole remedy.

11.2. This Agreement may be terminated for cause by County for reasons including, but not limited to, any of the following:

11.2.1. Plan Manager's failure to suitably or continuously perform the Services in a manner calculated to meet or accomplish the objectives in this Agreement, or repeated submission (whether negligent or intentional) for payment of false or incorrect bills or invoices;

11.2.2. Plan Manager ceases offering the specific plan coverage provided for in this Agreement or large group coverage;

11.2.3. If Plan Manager is a "scrutinized company" pursuant to Section 215.473, Florida Statutes, if Plan Manager is placed on a "discriminatory vendor list" pursuant to Section 287.134, Florida Statutes, or if Plan Manager provides a false certification submitted pursuant to Section 287.135, Florida Statutes; or

11.2.4. By the Contract Administrator or the Director of Office of Economic and Small Business Development ("OESBD") for any fraud, misrepresentation, or material misstatement by Plan Manager in the award or performance of this Agreement or that otherwise violates any applicable requirement of Section 1-81, Broward County Code of Ordinances.

11.3. This Agreement may be terminated by Plan Manager for one or more of the following reasons upon ninety (90) days' written notice to County, if County fails to cure any one or more of the following deficiencies before the end of the ninety (90) day curative period:

11.3.1. County failed to pay Plan Manager in accordance with the terms of this Agreement or Plan Manager has not received timely payment from County and Plan Manager provided County with notice in accordance with this Agreement and Florida law.

11.3.2. County failed to comply with a material provision of this Agreement that relates to rules for employer contributions to employer-sponsored group insurance plans.

11.4. If Plan Manager files a petition seeking bankruptcy protection or enters into an arrangement with creditors because of its insolvency, then upon thirty (30) days' notice to Plan Manager, County may declare this Agreement cancelled.

11.5. Notice of termination shall be provided in accordance with the "Notices" section of this Agreement except that notice of termination by the County Administrator to protect the public health, safety, or welfare may be oral notice that shall be promptly confirmed in writing.

11.6. If this Agreement is terminated for convenience by County, Plan Manager shall be paid for any Services properly performed under this Agreement through the termination date specified in the written notice of termination, subject to any right of County to retain any sums otherwise due and payable. Plan Manager acknowledges that it has received good, valuable, and sufficient consideration for County's right to terminate this Agreement for convenience in the form of County's obligation to provide advance notice to Plan Manager of such termination in accordance with Section 11.1.

11.7. Effect of Termination. Termination shall have no effect upon the rights and obligations of the Parties arising out of any Claims occurring prior to the effective date of such termination or such other matters that expressly survive the termination or expiration of this Agreement. Except for the preceding matters, upon termination: (i) all further obligations of the Parties under this Agreement shall terminate as of the termination date (except as provided in this Agreement); (ii) no Party shall be relieved of any obligation or liability arising from any prior breach by such Party of any provision of this Agreement; and (iii) the Parties shall, in all events, remain bound by and continue to be subject to the provisions set forth in this Agreement, to the extent necessary to satisfy this Agreement's terms.

11.8. If this Agreement is terminated or cancelled for any reason, Plan Manager shall provide the Contract Administrator with access to records or information concerning the Health Benefits Plan (as defined in Exhibit A) and Pharmacy Benefits Plan (as defined in Exhibit A) in its possession, upon written request. Plan Manager shall, within a reasonable time, honor requests for copies of records and information. Plan Manager shall have the right to retain copies of such property and records as agreed to by County or as otherwise required by law.

11.9. Upon termination of this Agreement, Plan Manager shall process Run-Out Claims (as defined in Exhibit A) for a period of twelve (12) months ("Run-Out Period"). County agrees that Plan Manager will have no obligation to process claims beyond the end date of the Run-Out Period. The obligations of this section survive the expiration or earlier termination of this Agreement.

11.10. In addition to any right of termination stated in this Agreement, County shall be entitled to seek any and all available remedies, whether stated in this Agreement or otherwise available at law or in equity.

ARTICLE 12. EQUAL EMPLOYMENT OPPORTUNITY AND CBE COMPLIANCE

12.1. No party to this Agreement may discriminate on the basis of race, color, sex, religion, national origin, disability, age, marital status, political affiliation, sexual orientation, pregnancy, or gender identity and expression in the performance of this Agreement. Plan Manager shall include the foregoing or similar language in its contracts with any Subcontractors, except that any project assisted by the U.S. Department of Transportation funds shall comply with the nondiscrimination requirements in 49 C.F.R. Parts 23 and 26.

12.2. Plan Manager shall comply with all applicable requirements of Section 1-81, Broward County Code of Ordinances, in the award and administration of this Agreement. Failure by Plan Manager to carry out any of the requirements of this article shall constitute a material breach of this Agreement, which shall permit County to terminate this Agreement or exercise any other remedy provided under this Agreement, the Broward County Code of Ordinances, the Broward County Administrative Code, or under other applicable law, all such remedies being cumulative.

12.3. Although no County Business Enterprise ("CBE") goal has been set for this Agreement, County encourages Plan Manager to give full consideration to the use of CBE firms to perform work under this Agreement.

ARTICLE 13. MISCELLANEOUS

13.1. Contract Administrator Authority. The Contract Administrator is authorized to coordinate and communicate with Plan Manager to manage and supervise the performance of this Agreement. Unless expressly stated otherwise in this Agreement or otherwise set forth in an applicable provision of the Broward County Procurement Code, Broward County Code of Ordinances, or Broward County Administrative Code, the Contract Administrator may exercise any ministerial authority under this Agreement in connection with the day-to-day management of this Agreement. The Contract Administrator may approve in writing minor modifications to the Scope of Services provided that such modifications do not increase the total cost to County or waive any rights of County.

13.2. Rights in Documents and Work. Any and all reports, photographs, surveys, documents, materials, or other work created by Plan Manager in connection with performing Services shall be owned by County, and Plan Manager hereby transfers to County all right, title, and interest, including any copyright or other intellectual property rights, in or to the work. Upon termination of this Agreement, any reports, photographs, surveys, and other data and documents prepared by Plan Manager, whether finished or unfinished, shall become the property of County and shall be delivered by Plan Manager to the Contract Administrator within seven (7) days after termination of this Agreement. Any compensation due to Plan Manager may be withheld until all documents are received as provided in this Agreement. Plan Manager shall ensure that the requirements of this section are included in all agreements with its Subcontractor(s).

13.3. Public Records. To the extent Plan Manager is acting on behalf of County as stated in Section 119.0701, Florida Statutes, Plan Manager shall:

13.3.1. Keep and maintain public records required by County to perform the Services;

13.3.2. Upon request from County, provide County with a copy of the requested records or allow the records to be inspected or copied within a reasonable time and at a cost that does not exceed that provided in Chapter 119, Florida Statutes, or as otherwise provided by law;

13.3.3. Ensure that public records that are exempt or confidential and exempt from public record requirements are not disclosed except as authorized by law for the duration of this Agreement and following completion or termination of this Agreement if the records are not transferred to County; and

13.3.4. Upon completion or termination of this Agreement, transfer to County, at no cost, all public records in possession of Plan Manager or keep and maintain public records required by County to perform the services. If Plan Manager transfers the records to

County, Plan Manager shall destroy any duplicate public records that are exempt or confidential and exempt. If Plan Manager keeps and maintains the public records, Plan Manager shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to County upon request in a format that is compatible with the information technology systems of County.

A request for public records regarding this Agreement must be made directly to County, who will be responsible for responding to any such public records requests. Plan Manager will provide any requested records to County to enable County to respond to the public records request.

Any material submitted to County that Plan Manager contends constitutes or contains trade secrets or is otherwise exempt from production under Florida public records laws (including Chapter 119, Florida Statutes) ("Trade Secret Materials") must be separately submitted and conspicuously labeled "EXEMPT FROM PUBLIC RECORD PRODUCTION – TRADE SECRET." In addition, Plan Manager must, simultaneous with the submission of any Trade Secret Materials, provide a sworn affidavit from a person with personal knowledge attesting that the Trade Secret Materials constitute trade secrets under Section 688.002, Florida Statutes, and stating the factual basis for same. If a third party submits a request to County for records designated by Plan Manager as Trade Secret Materials, County shall refrain from disclosing the Trade Secret Materials, unless otherwise ordered by a court of competent jurisdiction or authorized in writing by Plan Manager. Plan Manager shall indemnify and defend County and its employees and agents from any and all claims, causes of action, losses, fines, penalties, damages, judgments and liabilities of any kind, including attorneys' fees, litigation expenses, and court costs, relating to the nondisclosure of any Trade Secret Materials in response to a records request by a third party.

IF PLAN MANAGER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO PLAN MANAGER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT (954) 357-8600, BENEFITSRECORDS@BROWARD.ORG, 115 S. ANDREWS AVE., SUITE 508, FORT LAUDERDALE, FLORIDA 33301.

13.4. Audit Rights and Retention of Records. County shall have the right to Audit the books, records, and accounts of Plan Manager and its Subcontractors that are related to this Agreement (including, without limitation, the adjudication of claims resulting from this Agreement), including but not limited to providing County with access to third-party agreements between Plan Manager and third-parties relating to the services performed by Plan Manager ("Third-Party Agreements"), the review of which may include but is not limited to review needed by County to verify costs charged to County or services provided to County or on behalf of County, and Plan Manager's verification that all third parties (whether referenced in this Agreement or not) have satisfied their obligations to County. Such Third-Party Agreements include, but are not limited to agreements between Plan Manager and all Participating Pharmacies, the Mail-Order Pharmacy, the Specialty Drug Pharmacy, and Pharmaceutical Manufacturers, as defined in Exhibit A. Plan Manager shall provide County with access to Third-Party Agreements within seventy-two (72) hours after County's request for such access. Plan Manager and its

Subcontractors shall keep such books, records, and accounts as may be necessary in order to record complete and correct entries related to this Agreement and performance under this Agreement. All such books, records, and accounts shall be kept in written form, or in a form capable of conversion into written form within a reasonable time, and upon request to do so, Plan Manager or its Subcontractor shall make same available in written form at no cost to County. If requested by County, Plan Manager shall provide all such books, records, and accounts to County electronically. Upon County's request, Plan Manager shall provide to County any and all information necessary in order for County to evaluate and Audit Rebates or other Financial Benefits, as defined in Exhibit A, remitted to County. Such information includes, without limitation, full access to any and all agreements regarding Rebates between Plan Manager or any of its affiliates with drug manufacturers or other third parties, and documentation evidencing payment of Rebates to Plan Manager.

Plan Manager and its Subcontractors shall preserve and make available, at reasonable times within Broward County, Florida, for examination and Audit, all financial records, supporting documents, statistical records, and any other documents pertinent to this Agreement for at least three (3) years after expiration or termination of this Agreement or until resolution of any Audit findings, whichever is longer. Any Audit or inspection pursuant to this section may be performed by any County representative (including any outside representative engaged by County). Plan Manager hereby grants County the right to conduct such Audit or review at Plan Manager's place of business, if deemed appropriate by County, within seventy-two (72) hours' advance notice. Plan Manager agrees to provide adequate and appropriate work space. Plan Manager shall provide County with reasonable access to Plan Manager's facilities, and County shall be allowed to interview all current or former employees to discuss matters pertinent to the performance of this Agreement.

Any incomplete or incorrect entry in such books, records, and accounts shall be a basis for County's disallowance and recovery of any payment upon such entry. If an Audit or inspection in accordance with this section discloses overpricing or overcharges to County of any nature by Plan Manager in excess of five percent (5%) of the total contract billings reviewed by County, the reasonable actual cost of County's Audit shall be reimbursed to County by Plan Manager in addition to making adjustments for the overcharges. Any adjustments or payments due as a result of such Audit or inspection shall be made within thirty (30) days after presentation of County's findings to Plan Manager.

Plan Manager shall ensure that the requirements of this section are included in all agreements with its Subcontractor(s).

13.5. Legislative, Regulatory, or Administrative Change. If there is a change in the relevant federal statutes or regulations, the adoption of new federal or state legislation, or a change in any reimbursement system, any of which are reasonably likely to materially and adversely affect the manner in which either Party may perform under this Agreement or that makes this Agreement unlawful, the Parties shall immediately enter into good faith negotiations regarding

a new service agreement that complies with the law, regulation, or policy and that approximates as closely as possible the position of the Parties prior to the change.

13.6. Independent Contractor. Plan Manager is an independent contractor of County, and nothing in this Agreement shall constitute or create a partnership, joint venture, or any other relationship between the Parties. In providing Services, neither Plan Manager nor its agents shall act as officers, employees, or agents of County. Plan Manager shall not have the right to bind County to any obligation not expressly undertaken by County under this Agreement.

13.7. Regulatory Capacity. Notwithstanding the fact that County is a political subdivision with certain regulatory authority, County's performance under this Agreement is as a Party to this Agreement and not in its regulatory capacity. If County exercises its regulatory authority, the exercise of such authority and the enforcement of any rules, regulation, laws, and ordinances shall have occurred pursuant to County's regulatory authority as a governmental body separate and apart from this Agreement, and shall not be attributable in any manner to County as a party to this Agreement.

13.8. Sovereign Immunity. Except to the extent sovereign immunity may be deemed to be waived by entering into this Agreement, nothing herein is intended to serve as a waiver of sovereign immunity by County nor shall anything included herein be construed as consent by County to be sued by third parties in any matter arising out of this Agreement. County is a political subdivision as defined in Section 768.28, Florida Statutes, and shall be responsible for the negligent or wrongful acts or omissions of its employees pursuant to Section 768.28, Florida Statutes.

13.9. Third-Party Beneficiaries. Neither Plan Manager nor County intends to directly or substantially benefit a third party by this Agreement. Therefore, the Parties acknowledge that there are no third-party beneficiaries to this Agreement and that no third party shall be entitled to assert a right or claim against either of them based upon this Agreement.

13.10. Notices and Payment Address. In order for a notice to a Party to be effective under this Agreement, notice must be sent via U.S. first-class mail, hand delivery, or commercial overnight delivery, each with a contemporaneous copy via e-mail, to the addresses listed below and shall be effective upon mailing or hand delivery (provided the contemporaneous email is also sent). Payments shall be made to the noticed address for Plan Manager or such other address identified by Plan Manager in writing. The addresses for notice shall remain as set forth in this section unless and until changed by providing notice of such change in accordance with the provisions of this section.

FOR COUNTY:
Broward County Human Resources Division
Attn: Human Resources Director
115 South Andrews Avenue, Room 508
Fort Lauderdale, Florida 33301
Email address: benefitsrecords@broward.org

FOR PLAN MANAGER:
Attn: Laurie Mandell
3100 SW 145th Avenue, Suite 201
Miramar, Florida 33027
Email address: laurie_mandell@uhc.com

With a copy to:

Attn: Jim Moore
3100 SW 145th Avenue, Suite 201
Miramar, Florida 33027
Email address: James_J_Moore@uhc.com

13.11. Assignment. All Subcontractors must be expressly identified in this Agreement or otherwise approved in advance and in writing by County's Contract Administrator. Except for approved subcontracting, neither this Agreement nor any right or interest in it may be assigned, transferred, subcontracted, or encumbered by Plan Manager without the prior written consent of County. Any assignment, transfer, encumbrance, or subcontract in violation of this section shall be void and ineffective, constitute a breach of this Agreement, and permit County to immediately terminate this Agreement, in addition to any other remedies available to County at law or in equity. County reserves the right to condition its approval of any assignment, transfer, encumbrance, or subcontract upon further due diligence and an additional fee paid to County to reasonably compensate it for the performance of any such due diligence.

13.12. Conflicts. Neither Plan Manager nor its employees shall have or hold any continuing or frequently recurring employment or contractual relationship that is substantially antagonistic or incompatible with Plan Manager's loyal and conscientious exercise of judgment and care related to its performance under this Agreement. During the term of this Agreement, none of Plan Manager's officers or employees shall serve as an expert witness against County in any legal or administrative proceeding in which he, she, or Plan Manager is not a party, unless compelled by court process. Further, such persons shall not give sworn testimony or issue a report or writing as an expression of his or her expert opinion that is adverse or prejudicial to the interests of County in connection with any such pending or threatened legal or administrative proceeding unless compelled by court process. The limitations of this section shall not preclude Plan Manager or any persons in any way from representing themselves, including giving expert testimony in support of such representation, in any action or in any administrative or legal proceeding. If Plan Manager is permitted pursuant to this Agreement to utilize Subcontractors

to perform any Services required by this Agreement, Plan Manager shall require such Subcontractors, by written contract, to comply with the provisions of this section to the same extent as Plan Manager.

13.13. Materiality and Waiver of Breach. Each requirement, duty, and obligation set forth in this Agreement was bargained for at arm's-length and is agreed to by the Parties. Each requirement, duty, and obligation set forth in this Agreement is substantial and important to the formation of this Agreement, and each is, therefore, a material term of this Agreement. County'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. To be effective, any waiver must be in writing signed by an authorized signatory of the Party granting the waiver.

13.14. Compliance with Laws. Plan Manager and the Services must comply with all applicable federal, state, and local laws, codes, ordinances, rules, and regulations including, without limitation, Americans with Disabilities Act, 42 U.S.C. § 12101, Section 504 of the Rehabilitation Act of 1973, and any related federal, state, or local laws, rules, and regulations.

13.15. Severability. If any part of this Agreement is found to be unenforceable by any court of competent jurisdiction, that part shall be deemed severed from this Agreement and the balance of this Agreement shall remain in full force and effect.

13.16. Joint Preparation. This Agreement has been jointly prepared by the Parties and shall not be construed more strictly against either Party.

13.17. Interpretation. The titles and headings contained in this Agreement are for reference purposes only and shall not in any way affect the meaning or interpretation of this Agreement. All personal pronouns used in this Agreement shall include the other gender, and the singular shall include the plural, and vice versa, unless the context otherwise requires. Terms such as "herein," "hereof," "hereunder," and "hereinafter" refer to this Agreement as a whole and not to any particular sentence, paragraph, or section where they appear, unless the context otherwise requires. Whenever reference is made to a section or article of this Agreement, such reference is to the section or article as a whole, including all of the subsections of such section, unless the reference is made to a particular subsection or subparagraph of such section or article. Any reference to "days" means calendar days, unless otherwise expressly stated.

13.18. Priority of Provisions. If there is a conflict or inconsistency between any term, statement, requirement, or provision of any document or exhibit attached to, referenced by, or incorporated in this Agreement and any provision of Articles 1 through 13 of this Agreement, the provisions contained in Articles 1 through 13 shall prevail and be given effect.

13.19. Amendments. No modification, amendment, or alteration in the terms or conditions contained in this Agreement shall be effective unless contained in a written document prepared with the same or similar formality as this Agreement and executed by duly authorized

representatives of County and Plan Manager. County or Plan Manager may request changes that would increase, decrease, or otherwise modify the Scope of Services to be provided by Plan Manager under this Agreement. Such changes must be contained in a written amendment, prepared and executed consistent with this section, prior to any deviation from the terms of this Agreement, including the initiation of any additional services. County shall compensate Plan Manager for such additional services as mutually agreed to by the Parties.

13.20. Prior Agreements. This Agreement represents the final and complete understanding of the Parties regarding the subject matter and supersedes all prior and contemporaneous negotiations and discussions regarding that subject matter. There is no commitment, agreement, or understanding concerning the subject matter of this Agreement that is not contained in this written document.

13.21. HIPAA Compliance. County has access to protected health information ("PHI") that is subject to the requirements of 45 C.F.R. Parts 160, 162, and 164 and related regulations. If Plan Manager is considered by County to be a covered entity or business associate or is required to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Health Information Technology for Economic and Clinical Health Act ("HITECH"), Plan Manager shall fully protect individually identifiable health information as required by HIPAA or HITECH and shall execute a Business Associate Agreement in the form set forth at http://www.broward.org/Purchasing/Pages/StandardTerms.aspx. The County Administrator is authorized to execute a Business Associate Agreement on behalf of County. Where required, Plan Manager shall handle and secure such PHI in compliance with HIPAA, HITECH, and related regulations and, if required by HIPAA, HITECH, or other laws, include in its "Notice of Privacy Practices" notice of Plan Manager's and County's uses of client's PHI. The requirement to comply with this provision, HIPAA, and HITECH shall survive the expiration or earlier termination of this Agreement. Plan Manager shall ensure that the requirements of this section are included in all agreements with its Subcontractors.

13.22. Transparency in Coverage. Plan Manager shall comply with the group health plan disclosure requirements under the Transparency in Coverage Final Rules proposed by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury in CMS-9915P and issued on October 29, 2020 (the "Final Rules"). In addition to the indemnification provision contained elsewhere in this Agreement, Plan Manager shall indemnify and defend County and its past, present, and future employees and agents from any and all claims, causes of action, losses, fines, penalties, damages, judgments and liabilities of any kind, including attorney's fees, litigation expenses, and court costs, relating to or arising out of Plan Manager's failure to comply with the obligations of this section, Plan Manager's nondisclosure of information required to be disclosed under the Final Rules, or Plan Manager's failure to make timely or full disclosure as required under the Final Rules.

13.23. Payable Interest

13.23.1. Payment of Interest. County shall not be liable to pay any interest to Plan Manager for any reason, whether as prejudgment interest or for any other purpose, and

in furtherance thereof Plan Manager waives, rejects, disclaims, and surrenders any and all entitlement it has or may have to receive interest in connection with a dispute or claim arising from, related to, or in connection with this Agreement. This subsection shall not apply to any claim for interest, including for post-judgment interest, if such application would be contrary to applicable law.

13.23.2. Rate of Interest. If the preceding subsection is inapplicable or is determined to be invalid or unenforceable by a court of competent jurisdiction, the annual rate of interest payable by County under this Agreement, whether as prejudgment interest or for any other purpose, shall be, to the full extent permissible under applicable law, one quarter of one percent (0.25%) simple interest (uncompounded).

13.24. Piggyback. Plan Manager acknowledges that for the Term of this Agreement, including any Renewal Terms, other public corporations, entities, or agencies within Broward County, Florida (each, a "Piggyback Entity") may request to piggyback on the Services on the same terms and conditions set forth in this Agreement. If Plan Manager receives a request to piggyback on this Agreement, Plan Manager must provide written notice of the request to County within three (3) business days of receipt. If Plan Manager accepts, and County approves the request to piggyback, the administration of the services provided to any Piggyback Entity must be governed under a separate agreement between Plan Manager and such Piggyback Entity. County shall have no obligation or liability to Plan Manager, any Piggyback Entity, or any third party in connection with Plan Manager's administration of services provided to any Piggyback Entity.

13.25. Incorporation by Reference. Any and all Recital clauses stated above are true and correct and are incorporated in this Agreement by reference. The attached Exhibits are incorporated into and made a part of this Agreement.

13.26. Counterparts and Multiple Originals. This Agreement may be executed in multiple originals, and may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

13.27. Use of County Logo. Plan Manager shall not use County's name, logo, or otherwise refer to this Agreement in any marketing or publicity materials without the prior written consent of County.

13.28. Drug-Free Workplace. To the extent required under Section 21.23(f), Broward County Administrative Code, or Section 287.087, Florida Statutes, Plan Manager certifies that it has a drug-free workplace program that it will maintain such drug-free workplace program for the duration of this Agreement.

13.29. Remedies Cumulative. The rights and remedies of the Parties to this Agreement shall be cumulative (and not alternative). The Parties agree that to the extent permitted by applicable law, in the event of any breach or threatened breach by any Party to this Agreement of any covenant, obligation, or other provision set forth in this Agreement for the benefit of the other Party, such other Party shall be entitled (in addition to any other remedy that may be

available to it) to: (i) a decree or order of specific performance to enforce the observance and performance of such covenant, obligation or other provision; and (ii) an injunction restraining such breach or threatened breach. No Party shall be required to provide any bond or other security in connection with any such decree, order, or injunction or in connection with any related action or legal proceeding.

13.30. Provision of Basic Documents. Plan Manager shall provide SAS 70 reports on an annual basis, or any other publicly available information, upon request, by County and/or any requesting government entity.

13.31. Standards of Performance: Plan Manager shall perform its obligations under this Agreement with care, skill, prudence, and diligence, and in accordance with the standards of conduct applicable to a fiduciary. Plan Manager shall disclose all administrative fees and drug costs charged to County, disclose all Financial Benefits as defined in Exhibit A) earned by County and paid to Plan Manager or any Subcontractor by pharmaceutical manufacturers or other third parties, and permit County to Audit such fees, costs, and revenues. Plan Manager shall also disclose to County any activity, policy, or practice of which Plan Manager is aware (that presents a conflict of interest with the performance of its obligations hereunder. County agrees that it retains the sole responsibility for the terms and conditions of its Health Benefits Plan and Pharmacy Benefits Plan. Unless otherwise agreed in writing, County shall also be responsible for the disclosing or reporting of information regarding the Health Benefits Plan and Pharmacy Benefits Plan or changes in such plans (e.g., calculation of Copayments (as defined in Exhibit A), deductibles, or creditable coverage) as may be required by law to be disclosed to governmental agencies or Plan Participants.

(Remainder of page intentionally left blank.)

IN WITNESS WHEREOF, the Parties hereto have made and executed this Agreement: BROWARD COUNTY, through its BOARD OF COUNTY COMMISSIONERS, signing by and through its Mayor or Vice-Mayor authorized to execute same by Board action on the 4th day of November 2021, and Plan Manager, signing by and through its Secretary, duly authorized to execute same.

COUNTY

ATTEST:

_____
Broward County Administrator, as
ex officio Clerk of the Broward County
Board of County Commissioners

BROWARD COUNTY, by and through
its Board of County Commissioners

By:_____

_____ day of _____, 20___

Approved as to form by
Andrew J. Meyers
Broward County Attorney
Governmental Center, Suite 423
115 South Andrews Avenue
Fort Lauderdale, Florida 33301
Telephone: (954) 357-7600
Telecopier: (954) 357-7641

By: Sandy Steed Digitally signed by Sandy Steed Date: 2021.10.20 10:10:02 -04'00'
Sandy Steed (Date)
Assistant County Attorney

By: Danielle W. French, Esq. Digitally signed by Danielle W. French, Esq. Date: 2021.10.20 10:13:28 -04'00'
Danielle W. French (Date)
Deputy County Attorney

SS
Combined Health and PBM Agreement
10/19/2021

AGREEMENT BETWEEN BROWARD COUNTY AND UNITED HEALTHCARE SERVICES, INC., FOR ADMINISTRATIVE MANAGEMENT SERVICES FOR SELF-INSURED GROUP HEALTH INSURANCE COVERAGE AND BENEFITS AND PHARMACY BENEFIT MANAGEMENT SERVICES FOR BROWARD COUNTY BENEFITS-ELIGIBLE INDIVIDUALS (RFP # TEC2122482P1)

Plan Manager

WITNESSES:

Signature

Lisa Sekely
Print Name of Witness above

Signature

Print Name of Witness above

United Healthcare Services, Inc.

By: _____
Authorized Signor

Payman Pezhman, Secretary
Print Name and Title

15th day of October, 2021

ATTEST:

_____
Corporate Secretary or other person authorized to attest

(CORPORATE SEAL OR NOTARY)

ALLISON N FAUTCH
NOTARY PUBLIC - MINNESOTA
My Commission Expires
January 31, 2025

EXHIBIT A
Definitions

1.1. **Account Management Team** means Plan Manager's client team dedicated to fulfilling the requirements of this Agreement. The team includes, but is not limited to: Account Manager, Medical Director, Pharmacist, customer service representative(s), financial analyst(s), customer service manager and Claims manager. The Account Management Team shall be knowledgeable about all aspects of the Services and at the request of County, shall be onsite during the implementation process until County is satisfied that all transitional issues have been resolved. County reserves the right to recall Plan Manager onsite in the event of ongoing problems. The Account Manager shall serve as the primary contact to respond to County's needs, questions, and/or issues.

1.2. **Account Manager** means Plan Manager's primary contact for County's Contract Administrator and Benefits Administration Team.

1.3. **Additional Fee(s)** refers to all expenses charged to County by Plan Manager for programs not covered by the base Administrative Fee. The Additional Fee(s) shall be quoted on a billable amount per item or Per Enrolled Employee Per Month rate basis, as applicable. All proposed programs and services not included in the base Administrative Fee or identified as an Additional Fee will be assumed to be included in the Administrative Fee. The Additional Fee(s) shall be priced separately, but added to the monthly Administrative Fee for payment purposes.

1.4. **Administrative Fee(s)** are the Per Enrolled Employee Per Month fees and the billable amount per item fees Plan Manager charges for all Services, including, but not limited to, medical and pharmacy claim processing, customer service, electronic enrollment file management, billing, application of discounts, collection, payment of rebates, state surcharge reporting, annual plan summaries, acute case management, and core clinical programs. All proposed programs and services not included in the base Administrative Fee or identified as an Additional Fee will be assumed to be included in the Administrative Fee.

1.5. **Administrative Services Only (ASO)** means an arrangement in which a company funds its own employee benefit plan, such as a health insurance program, while purchasing only administrative services from the insurer. This alternative funding option is a group health self-insurance program often used by large employers who opt to assume responsibility for all the risk, remaining exclusively liable for all financial and legal elements of the group benefits plan.

1.6. **Age Restriction Program** means a cost-savings program implemented by Plan Manager for County whereby County has imposed age restriction limitations on any Covered Item (to the extent allowed by law) by restricting the use of certain drugs to certain age ranges or preventing the use of certain drugs within certain age ranges.

1.7. **Audit(s)** means: (1) County's assessment of Plan Manager's satisfaction of all terms under this Agreement; and (2) Plan Manager's verification that all third parties referenced in this Agreement (including but not limited to inpatient & outpatient hospitals, primary & specialty

providers, labs, radiology, emergency rooms and urgent care facilities, Participating Pharmacies, the Mail-Order Pharmacy, the Specialty Drug Pharmacy, and Pharmaceutical Manufacturers) have satisfied their obligations under this Agreement.

1.8. **Average Annual Guarantee(s)** means the discounts set forth in Exhibit D, Schedule of Fees/Discounts, that are the effective average rates, in aggregate, as measured over the entirety of the Term. Discounts will be reconciled on an individual component basis with no offsets. Any excess discounts delivered in one component may not be used to offset underperformance in another component under the Agreement.

1.9. **Average Script Price (ASP)** means an alternative pricing structure to the standard market discount guarantees and rebates. Plan Manager guarantees an average script price for all medications dispensed and the ASP is auditable and payable should Plan Manager fail to meet its guarantees.

1.10. **Average Wholesale Price (AWP)** means the average wholesale price of a prescription drug or medication dispensed, on the date the prescription or medication is dispensed, as set forth in the most recent edition of the Medi-Span pricing guide or supplement as of that date. The applicable AWP for all prescriptions dispensed at retail pharmacies, the Mail-Order Pharmacy, and the Specialty Drug Pharmacy shall be based on the lesser of (i) the Unit AWP using the National Drug Code ("NDC") from which the medication was dispensed (not the package size of the prescription dispensed); and (ii) the actual manufacturer's AWP (repackager AWPs shall not be substituted for manufacturer AWPs); and (iii) the actual Unit prescribed (and an alternative Unit measure shall not be substituted, such as capsules for tablets, or tablets for capsules). Plan Manager shall not process any invalid NDC codes or repackagers' AWPs in connection with any claims.

1.11. **Benefit Change Form** or **BCF** means the agreed upon form to make modifications to County's Benefit Plan Design. County's Benefit Change Form must be executed by County's Contract Administrator. Plan Manager and County will each maintain a file of all Benefit Change Forms, but Plan Manager will provide County with said BCFs upon request for Audits.

1.12. **Benefit Effective Date** means the date when County begins receiving services for its Plan Participants from Plan Manager.

1.13. **Benefit-Eligible** means an employee deemed by County to be eligible to receive County benefits and designated as "Benefit-Eligible." Notwithstanding the foregoing, a Benefit-Eligible employee is an employee who works full-time, having a normal work week of twenty (20) or more hours, and who has met any applicable waiting period or other requirements as of January 1, 2022 ("Plan Effective Date"). Subject to any eligibility exceptions noted herein, an employee becomes eligible for coverage on the Plan Effective Date.

1.14. **Benefit Plan Design(s)**, **Plan Benefit(s)** or **Plan Design(s)** means all eligible services and products covered within the County's medical and pharmacy plan description.

1.15. **Benefit Specification Form** or **BSF** means the form that is completed by County that specifies the terms and provisions of County's Benefit Plan Design(s) and the configuration of system edits, including but not limited to which prescription and OTC medications are covered by County (and/or are not covered); Copayments and Coinsurance requirements; the Formulary selected; the Benefit Plan Design tier structure; any limitations on coverage such as deductibles and caps; and the Program(s) selected, together with the relevant protocols and services that must be rendered in connection with each Program.

Each Benefit Specification Form must be executed by Plan Manager and County. Plan Manager and County will each retain a copy of all Benefit Specification Forms, but Plan Manager will provide County with said forms upon request for Audits.

1.16. **Benefits Administration Team** means County staff who administer Plan on a day to day basis.

1.17. **Benefits Consultant** means an experienced professional who advises County on insurance, employee benefits and compliance. USI Insurance Services LLC, is County's current Benefits Consultant.

1.18. **Board** means the Board of County Commissioners of Broward County, Florida.

1.19. **Brand Drug(s)** means the following: As of the date dispensed, the Multisource Code field in Medi-Span contains a "M" (co-branded product), "O" (originator brand) (except where the Claim is submitted with a DAW Code of "3","5" or "6", in which case it shall be considered a Generic Drug), or a "N" (single source brand). The Parties agree that when a drug is identified as a Brand Drug, it shall be considered a Brand Drug for all purposes by Plan Manager, including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing County, determining the Copayment or Coinsurance to be paid by the Plan Participant, calculating the satisfaction of Average Annual Guarantees, calculating the satisfaction of Financial Benefit Guarantees and calculating the satisfaction of generic fill rates (if any). If any covered drug does not meet the specific contractual definition in this Agreement for Generic Drug or Specialty Drug, such covered drug shall be deemed a Brand Drug for all purposes.

1.20. **Case Management** means the process of assessing whether an alternative plan of care would more effectively provide necessary health care services in an appropriate setting, as required under the provisions of the Plan.

1.21. **Channel** means the way in which a Prescription Drug is dispensed; 30-day supply at retail pharmacy, 90-day supply at retail pharmacy, 90-day supply at mail-order, and Specialty Medications through a Plan Manager designated Specialty Pharmacy.

1.22. **Chronic Condition Management (CCM) or Disease Management (DM)** means support programs offered by Plan Manager through the Personnel Health Support 3.0 (PHS) program to provide guidance to enrolled Plan Participants who live with an ongoing health condition.

1.23. **Claim(s)** means all claims transmitted or sent to Plan Manager by any pharmacy, hospital, lab, urgent care, or free-standing medical facility or by Plan Participants as a result of dispensing covered prescriptions, services and other medical covered items, to Plan Participants including reversed and rejected Claims.

1.24. **Claim Adjudication System** means Plan Manager's on-line computerized claims processing system.

1.25. **Claim Processor Fee(s)** or **Click Fee(s)** means a payment made by retail pharmacies to Plan Manager, or a fee withheld by Plan Manager from retail pharmacy reimbursement, when Plan Manager processes an aggregated payment to a retail pharmacy. Claim Processor Fees shall be considered Financial Benefits and shall not be factored into Average Annual Guarantees for either Ingredient Costs or Dispensing Fees.

1.26. **Claims Administration** means an organization, Plan Manager, that processes insurance claims or certain aspects of employee benefit plans for a separate entity.

1.27. **Claims Appeal** means a Plan Participant has the right to challenge a decision for a claim that is denied payment for a treatment or prescription that the Plan Participant believes should be covered.

1.28. **Claims Fiduciary** means the named Plan Manager has the authority and responsibility to adjudicate claims in accordance with the provisions of the Plan. In the event of a Plan Participant appeal for review of a denied claim, the Claim Fiduciary makes the final determination as to whether the claim is covered.

1.29. **COBRA** means the Federal Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, which requires health care continuation coverage through amendments to the Employee Retirement Income Security Act of 1974, the Internal Revenue Code of 1986, and the Public Health Services Act of 1944.

1.30. **COBRA/Retiree Service Provider** means a provider of COBRA/Retiree administrative services retained by County to provide specific COBRA/Retiree administrative services as described in Exhibit I.

1.31. **COBRA Qualified Beneficiary** means a current or former employee of the County who is entitled to continued coverage under the Plan through COBRA and a spouse or dependent of a current or former employee who is entitled to continued coverage under the Plan through COBRA. A Qualified Beneficiary under COBRA law also includes a child born to the current or former employee during the coverage period or a child placed for adoption with the current or former employee during the coverage period. At the time COBRA election is made, these individuals are also referred to as a "COBRA Continuee(s)."

1.32. **Component** means the classification or type of Prescription dispensed; Generic, Brand or Specialty.

1.33. **Compound Drug(s)** means a drug that needs to be customized by a pharmacist because it is not commercially available in the required form and strength. A Compound Drug must consist of two or more solid, semi-solid, or liquid ingredients (not including water or flavoring), at least one of which is a Covered Item. Plan Manager shall administer and adjudicate Compound Drugs, not to exceed a value determined by the County. Plan Manager is obligated to provide Pass-Through Pricing for every ingredient of the Compound Drug. Plan Manager's invoiced Ingredient Cost to County for each Compound Drug shall be the same as Plan Manager's reimbursed Ingredient Cost to the retail pharmacy (and both shall be net of any Copayments, Coinsurance, and deductible). Plan Manager may also invoice County for the precise professional or compounding fee that Plan Manager has paid to the dispensing pharmacy, if any. However, Plan Manager shall not be allowed to make any profit on any Compound Drugs and shall pass through to County the exact Ingredient Cost and professional or compounding fee that Plan Manager pays the dispensing pharmacy. Compound Drugs are excluded from the calculation of all Average Annual Guarantees, Minimum Guaranteed Discounts, the Default Discount Guarantee, Maximum Guaranteed Prices, and Financial Benefit Guarantees.

In submitting a Benefit Specification Form or a Benefit Change Form, County may require that if any pharmacy transmits a Claim for a Compound Drug where the total Ingredient Cost is above a dollar amount specified in the Form (e.g., $500), Plan Manager shall (a) conduct a Prior Authorization evaluation to evaluate and verify that the cost of the Compound Drug is appropriate, and/or (b) block the dispensing of the Compound Drug.

1.34. **Concurrent Review** means the process of assessing the continuing appropriateness, utility, or necessity of additional days of hospital confinement, outpatient care, and other health care services.

1.35. **Consumer Driven Health Plan (CDHP)** means a Health Benefit Plan offering with a combination of copayments and a high deductible. This option does not allow for the option to use a Health Savings Account (HSA).

1.36. **Contract Administrator** means the Director of Human Resources, or such other person designated by same in writing.

1.37. **Coordination of Benefits** means the determination of which insurance plan has primary responsibility and the extent to which the other plan will contribute when a Plan Participant is covered by more than one plan.

1.38. **Copayment(s) or Coinsurance** means those amounts collected from Plan Participants by the relevant pharmacy or provider (including but not limited to pharmacies, facilities, providers, and suppliers Plan Manager has contracted with to provide health care services) pursuant to County's Benefit Plan Design as specified in its Benefit Specification Form, and if relevant, as amended in a Benefit Change Form. "Copayment" shall mean any flat amount that a Plan Participant is required to pay. "Coinsurance" shall mean any percentage amount that a Plan Participant is required to pay.

1.39. **Cost Share** means the amount of money that a Plan Participant must pay to the pharmacy to obtain a Covered Item in accordance with the terms of the Benefit Plan Design of County.

1.40. **County Administrator** means the Broward County Administrator appointed by the Board.

1.41. **County Business Enterprise** or **CBE** means an entity certified as meeting the applicable requirements of Section 1-81, Broward County Code of Ordinances.

1.42. **Coupon Program** means savings programs offered by drug makers. Also referred to as copay savings programs, copay coupons, or copay assistance cards, manufacturer copay cards. They help patients afford expensive prescription drugs by reducing their out-of-pocket costs. Copay coupons are typically for expensive, brand name drugs without a generic equivalent.

1.43. **Covered Item(s)** means the covered drugs, pharmaceutical supplies, small durable medical equipment ("DME"), provider's service, or medical supply items listed in County's Benefit Plan Design, as specified in its Benefit Specification Form, and if relevant, as amended in a Benefit Change Form. Plan Manager understands and agrees that it shall not be entitled to invoice or collect reimbursement from County for any Covered Item that is not included in, or that is excluded from, County's list of Covered Items. Small DME items must have a valid Universal Product Code ("UPC"), Health Related Item Code ("HRS"), or NDC in the Medi-Span Master Drug Pricing Source. Small DME shall include, but not be limited to, diabetic supplies.

1.44. **Covered Person** means an individual with respect to whom benefits may be or become payable under the provisions of the Plan.

1.45. **Covered Services** mean health care and pharmacy services to which a health care coverage or pharmaceutical provision of the Plan might apply.

1.46. **Data Warehouse** means a central repository of information that can be analyzed to make more informed decisions. Claims data from the Plan Manager flows into a data warehouse from their transactional systems and relational databases on a monthly timeline.

1.47. **Deductible** means the amount paid out-of-pocket by the Plan Participant before the Plan begins to pay in full or cost share with the Plan Participant.

1.48. **Default Discount Guarantee** means the automatic discount that must be provided by Plan Manager on any and all new-to-market Brand and Specialty Drugs.

1.49. **Discount(s)** means the percentage reduction from Average Wholesale Price of a Prescription Drug; and the reduction of, but not limited to billed Health Services from providers, facilities, labs and imaging.

1.50. **Discount Guarantee(s)** means the minimum Discount that Plan Manager has guaranteed will be provided for each prescription, by Channel and Component.

1.51. **Dispensed Claim(s)** means each Claim that is actually dispensed to a Plan Participant. With respect to any Claim, if the Claim is not dispensed, but is instead denied, rejected or reversed, the Claim shall not constitute a Dispensed Claim. If the Claim is adjusted in any way, the original Claim and the adjusted Claim(s) shall together constitute only one Dispensed Claim. If a Claim is partially filled, and subsequently the remainder of the Claim is filled, the fills will together constitute only one Dispensed Claim. Plan Manager may only invoice County for Dispensed Claims, may not invoice County for denied, rejected or reversed Claims, and may invoice only once for adjusted or partially filled Claims.

1.52. **Dispensing Fee(s)** means the per prescription dispensing fee paid by Plan Manager to the dispensing pharmacy. Dispensing Fees shall only be invoiced to County for Dispensed Claims and shall be based on Pass-Through Pricing for retail pharmacy and Mail-Order Pharmacy dispensed drugs, with said Pass-Through Pricing satisfying the Average Annual Guarantees for Dispensing Fees stated in Dispensing Fees for Specialty Drugs dispensed from the Specialty Drug Pharmacy shall be based on the stated Dispensing Fee in Exhibit D. For every Dispensed Claim that Plan Manager reimburses to the retail pharmacy based on U&C, Plan Manager shall allocate the entire U&C charge to the Ingredient Cost and shall not allocate any of the U&C charge to the Dispensing Fee.

1.53. **Electronic Prescribing Services or E-Prescribing** means the complete end-to-end process of electronic prescribing and prior authorization including, but not limited to transaction processing, network access fees (for all parties, including, but not limited to, prescribers, pharmacies, and Plan Manager), connectivity fees, maintenance, and reconciliation.

1.54. **Eligibility Change(s)** means a change in Plan Participant eligibility as reported to Plan Manager by County whether in paper or electronic format.

1.55. **Eligibility File** means the file created by County and transmitted to Plan Manager listing the names and other pertinent information necessary for Plan Manager to enroll Plan Participants, terminate enrollment, or to make changes to existing Plan Participant records. The initial Eligibility Files shall be called the Plan Participant List.

1.56. **Emergency Care** means Covered Services received by a Plan Participant related to an emergency medical condition provided by the emergency department of the hospital for purposes of a screening examination and treatment needed to stabilize a patient. An emergency medical condition means a condition that the average prudent person could reasonably expect to result in the following without immediate medical attention:

- A condition that places the health of the individual in serious jeopardy; or
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

1.57. **Employee** means both Benefit-Eligible (Full-time and Part-time 20 hours) and non-Benefit Eligible (Part-time 19 hours, Student, Will Call, etc.).

1.58. **Enrolled Employee** means a Benefit-Eligible employee who enrolls in one of County's health care plans.

1.59. **Enrollee** means an employee and/or spouse or domestic partner insured under a County Health Benefits Plan who voluntarily enrolls and participates in the Rally wellbeing program.

1.60. **Explanation of Benefits (EOB)** is a paper document provided to a Plan Participant by Plan Manager after a healthcare service for which a claim was submitted to Plan Manager. The EOB provides details about the health claim that has been processed and explains what portion was paid to the health care provider and what portion of the payment, if any, is the Plan Participant's responsibility. An EOB is not a bill.

1.61. **Extended AWP** means the product of the Unit AWP (as determined by Medi-Span) for a Dispensed Claim multiplied by the quantity of Units dispensed by the pharmacy for that Dispensed Claim.

1.62. **Financial Benefit Guarantee(s)** means the minimum amount the Plan Manager has guaranteed will be passed through as Financial Benefits to County.

1.63. **Financial Benefits** means County's Pro Rata Share of all Discounts and Rebates received by Plan Manager from all Pharmaceutical Manufacturers including, without limitation, County's Pro Rata Share of all Financial Benefits, or other fees, chargebacks, grants, all other monies of any kind whatsoever paid by Pharmaceutical Manufacturers, all discounts or credits or reimbursements of any kind provided by Pharmaceutical Manufacturers, all financial benefits paid by Pharmaceutical Manufacturers to Plan Manager for Covered Items dispensed on County's behalf from retail pharmacies, the Mail-Order Pharmacy, and the Specialty Drug Pharmacies, and all goods (or in-kind services) or other things of value provided by Pharmaceutical Manufacturers. Financial Benefits shall include Claim Processor Fees.

1.64. **Formulary or Preferred Drug List (PDL)** means the list of medications on the designated Formulary that County has approved under this Agreement. Plan Manager will provide the new Plan Year Formulary 180 days prior to the start of the Plan Year.

1.65. **Gaps in Care** means the discrepancy between recommended best practices and the care that is provided. The most common include individuals that are missing age-based or annual screenings or vaccines.

1.66. **Generic Drug(s)** means the following: as of the date the drug was dispensed in which the Multisource Code field in Medi-Span containing the value of "O" and also submitted with a DAW Code of "3","5", or "6" shall also be considered a Generic Drug. Plan Manager agrees that when a drug is identified as a Generic Drug, it shall be considered a Generic Drug for all purposes,

including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing County, determining the Copayment or Coinsurance to be paid by the Plan Participant, calculating the satisfaction of Average Annual Guarantees, calculating the satisfaction of Financial Benefit Guarantees, and calculating the satisfaction of generic fill rates (if any).

1.67. **Health Benefits Management Services** means claims processing, eligibility verification, all contracting, management and administration of contracts with Network Participating Providers and clinical support programs, and all other services related to the management and administration of health plan benefits described in or performed by Plan Manager as result of the Agreement.

1.68. **Health Benefits Plan** means all eligible services and products covered within the County's health plan description.

1.69. **Health Care Provider** means any physician, practitioner, hospital, facility, laboratory, or any other provider of health care services or supplies which are Covered Services under the terms of the Plan.

1.70. **Health Savings Account (HSA)** means a tax-advantaged medical savings account available to those who are enrolled in a qualified high-deductible health plan (HDHP). HSA funds may be used to pay for qualified medical expenses at any time without federal tax liability or penalty.

1.71. **Health Stations (currently provided by HIGI)** means free standing equipment that provides the user a critical access point to care with an easy and accurate way to measure and record weight and blood pressure. Health Stations should be easily accessible and located in places people go throughout their day.

1.72. **High Deductible Health Plan (HDHP)** means a Health Benefit Plan offering with a Health and Pharmacy combined high deductible and the option to use a Health Savings Account (HSA) using pre-tax income.

1.73. **HIPAA** means the Health Insurance Portability and Accountability Act of 1996. It is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

1.74. **Identification Card(s) or ID Card(s)** means the printed portable identification cards that contain specific information about the health and prescription drug benefits to which Plan Participants are entitled.

1.75. **Implementation Period** means the period of time between the Effective Date of the Agreement and December 31, 2021, during which time Plan Manager shall conduct all testing and implementation of new or existing systems or programming to perform the Services.

1.76. **Ingredient Cost(s)** means the amount charged for each Dispensed Claim prior to the deduction of any Copayment or Coinsurance or deductible (if any), not including Dispensing Fees or any sales or use taxes and without factoring in any Financial Benefits or Claim Processor Fees. For every Dispensed Claim that Plan Manager reimburses to a retail pharmacy based on U&C, Plan Manager shall allocate the entire U&C charge to the Ingredient Cost and shall not allocate any of the U&C charge to the Dispensing Fee.

1.77. **MAC** means the maximum allowable cost of a Brand Drug or Generic Drug, as established by Plan Manager for certain drugs in connection with reimbursing Participating Pharmacies. Plan Manager's inclusion (or exclusion) of a drug on its MAC list(s) shall not in any way impact any of Plan Manager's obligations in the Agreement, including without limitation its Pass-Through Pricing obligations, Average Annual Guarantees for Brand Drugs and Generic Drugs, or its Mandatory Generic Program obligations, because all such guarantees and obligations are to be applied as specified in the Agreement.

1.78. **Mail-Order Pharmacy** means a pharmacy, owned and operated by the Plan Manager, which dispenses new or refill Prescriptions through the mail upon receipt from a Plan Participant of a new Prescription and a completed order or refill form. Should Plan Manager wish to use an alternative mail-order pharmacy in fulfilling its mail-order obligations, Plan Manager shall notify County in writing of its intention to do so at least sixty (60) days before doing so and obtain written approval of its pharmacy substitution from County, or Plan Manager will not be authorized to substitute a different Mail-Order Pharmacy. Nothing herein shall prohibit Plan Manager from using an appropriately licensed alternative mail-order pharmacy as a back-up to the approved Mail-Order Pharmacy in the event of the short-term inability of the Mail-Order Pharmacy to provide services hereunder, without the prior approval of County. Said alternative mail-order pharmacy shall be bound to all terms in the Agreement, and Plan Manager shall ensure that said alternative mail-order pharmacy complies with all applicable terms in the Agreement.

1.79. **Mail-Order Pharmacy Program** means a cost-savings program implemented by Plan Manager for County to specify that certain Covered Items will be dispensed as a 90-day supply for Plan Participant.

1.80. **Mandatory Generic Program** means a cost-savings program by which Plan Participants are required to use a specified Generic Drug, even if the Plan Participants have obtained and present a prescription for a chemically equivalent Brand Drug. If the Plan Participant fails to use the Generic Drug, the Plan Participant must pay the difference, as is required by County, between the costs of the Brand Drug and Generic Drug.

1.81. **Maximum Guaranteed Price(s)** means the maximum amount that Plan Manager has guaranteed will be charged for certain commonly used Generic Drugs and certain new-to-market Generic Drugs.

1.82. **Maximum Out-of-Pocket (MOOP)** means the maximum amount a Plan Participant will have to pay of their own money for covered health services and prescriptions during the year. Depending upon the type of plan, this may include deductible, coinsurance and/or copayments.

1.83. **Maximum Out-of-Pocket Accumulator** means the process in which Plan Manager captures all expenses paid by the Plan Participant.

1.84. **Medical Necessity** means activities which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

1.85. **NCPDP** means the National Council for Prescription Drug Programs.

1.86. **NCQA** means the National Committee for Quality Assurance. It is an independent 501 nonprofit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

1.87. **Network** means a network of Preferred Providers and pharmacies which are available to provide services with respect to Plan Participants in connection with this Agreement.

1.88. **New Eligibility Implementation Date(s)** means the date on which Services for new eligible Plan Participants are to begin, or end. Plan Manager shall be obligated as of the New Eligibility Implementation Date to begin providing Covered Items for County's new Plan Participant(s), and, upon ineligibility of County's Plan Participant(s), to no longer provide Covered Items.

1.89. **New-to-Market Medication Program** means a cost-savings program implemented by County in which County reviews new-to-market Brand Drugs to establish protocols related to those drugs.

1.90. **Newly Available Generic Drug(s) or Single Source Generics** means (i) any Brand Drug that lost its patent during the two-year period before the Effective Date; (ii) any Brand Drug that lost its patent during the period when the Agreement is in effect, for at least two years from the date of the loss of patent; or (iii) all Generic Drugs that are chemical equivalents to the Brand Drugs identified in (i) and (ii) above. These are generic drugs that do not generate discounts traditionally delivered by generic drugs or have an exclusive pharmaceutical manufacturer. Single Source Generics will be included in the overall generic drug guarantee.

1.91. **Newly Available Generic Drug Guarantee(s)** means the Guaranteed Discount applied to Newly Available Generic Drugs.

1.92. **Non-Formulary and Excluded Drug Exception Program** means a County-specific program requiring Plan Participant's prescribing physician to submit a Prior Authorization request documenting Plan Participant failed or had contraindications or intolerance to at least one therapeutically equivalent Formulary drug.

1.93. **Non-Medicare and Medicare Primary** means Plan Participants who are either not eligible for Medicare or not enrolled in Medicare (Non-Medicare) or Retirees who are eligible for Medicare and Medicare becomes their primary coverage, and Plan becomes their secondary coverage.

1.94. **Notice to Proceed** means a written authorization to proceed with the project, phase, or task, issued by the Contract Administrator.

1.95. **Nurse Line Services** means a program offered by the Plan Manager to provide County's Plan Participant(s) access to Nurses 365 days a year to answer questions and provide guidance for appropriate place of service.

1.96. **Out-of-Pocket Cost** means costs the Plan Participant must satisfy prior to the Plan paying 100% of the cost of services within the Plan Year.

1.97. **Over-the-Counter Drug(s) or OTC Drug(s)** means a drug that is not required by law to be dispensed pursuant to a prescription and which is generally recognized as safe and effective because it meets each of the conditions contained in 21 C.F.R. Part 330 and each of the conditions contained in any applicable monograph.

1.98. **Overpayment** means payments that exceed the amount payable under the Plan. This term does not include overpayments caused by untimely or inaccurate eligibility information.

1.99. **Participating Pharmacy(ies)** and **Pharmacy Network** means those retail pharmacies that have contracted with Plan Manager to create a "Pharmacy Network," together with the specified Mail-Order Pharmacy and Specialty Drug Pharmacy. If County limits, in a Benefit Specification Form or Benefit Change Form, the retail pharmacies that can dispense Covered Items to County's Plan Participants, the Participating Pharmacies and Pharmacy Network for County will be only those pharmacies allowed by County.

1.100. **Participating Provider** means a hospital, facility, physician, supplier, or other licensed healthcare professional the Plan Manager has contracted with to provide health care services, who agree to accept Plan Manager's approved amount for their services.

1.101. **Pass-Through Pricing** means Plan Manager's agreement that it shall not derive any profits whatsoever from the difference between amounts invoiced to County by Plan Manager and amounts incurred by Plan Manager for any Covered Item dispensed from any retail pharmacy, any mail-order pharmacy, or any specialty drug pharmacy (including the Mail-Order Pharmacy and Specialty Drug Pharmacy). Pass-Through Pricing shall also mean:

- For each pharmacy, Plan Manager shall invoice for every Dispensed Claim - both for the Ingredient Cost and for the Dispensing Fee - the actual cost incurred by Plan Manager, including but not limited to those Covered Items included within

Average Annual Guarantees, and those Covered Items excluded from Average Annual Guarantees.

- Plan Manager shall pass through to County, as an invoiced cost, the identical Ingredient Cost and Dispensing Fee identified by County for all Covered Items dispensed from County's wholly owned pharmacies.

- Plan Manager shall invoice for every Coordination of Benefits Claim based on Plan Manager's exact amount paid for the Covered Item.

- Plan Manager shall invoice County for every 340(b) Drug Pricing Program, Department of Veterans Administration Claim, vaccine, long-term care facility dispensed, and home infusion therapy Covered Item based on Plan Manager's exact amount reimbursed for that Covered Item.

- Plan Manager shall invoice County for every Compound Drug based on Plan Manager's exact reimbursement to the retail pharmacy for the Compound Drug, including Plan Manager's exact reimbursement for the compounding fee.

- In connection with Financial Benefits: Plan Manager shall pass through to County its Pro Rata Share of all Financial Benefits.

- Plan Manager's only profits shall be those that may be embedded in (i) Administrative Fees; and (ii) Additional Fees specifically authorized by County under this Agreement.

1.102. **Percentage of Plan Manager's Aggregate Book of Business** means the percentage Plan Manager pays Participating Pharmacies (Ingredient Costs plus Dispensing Fees) on behalf of County compared to the total amount paid to Participating Pharmacies (Ingredient Costs plus Dispensing Fees) by Plan Manager on behalf of all Plan Manager's clients including County.

1.103. **Per Enrolled Employee Per Month** means the applicable rate paid by County to Plan Manager monthly. When calculating the total cost of fees to be paid to Plan Manager, County multiplies the Administrative Fee and Additional Fee by the number of Enrolled Employees in the Plan.

1.104. **Per Enrolled Employee Per Year** means the applicable rate paid by County to Plan Manager annually. When calculating the total cost of the PMA credit, County multiplies the PMA credit by the number of Enrolled Employees in the Plan.

1.105. **Performance Measures (PM)** means certain performance and customer service obligations of Plan Manager to County that if not satisfied, will result in an agreed to reduction in payment or an additional payment to be paid by Plan Manager to County.

1.106. **Per Net Paid Claim** (**PNPC)** means the administrative fee charged by Plan Manager for all paid Claims, minus any reversed Claims.

1.107. **Personal Health Support 3.0 (PHS)** means a comprehensive program encompassing chronic care, disease management, complex care, etc. This program monitors all Plan Participants to identify eligibility for any of the programs offered by Plan Manager.

1.108. **PM Notice** means written notice from the Contract Administrator to Plan Manager that Plan Manager has failed to meet one or more Performance Measures.

1.109. **Pharmaceutical Manufacturer(s)** are companies that manufacture, produce, build, or assemble pharmaceuticals. They include, but are not limited to, any pharmaceutical manufacturer or company, any drug wholesaler or distributor, or any other third party that provides Financial Benefits.

1.110. **Pharmaceutical Manufacturer Contract(s)** means all contracts, amendments or addendums thereto, letter agreements, or other written or oral agreements in any form, providing that any Financial Benefits shall be paid or provided by any Pharmaceutical Manufacturer to Plan Manager. Pharmaceutical Manufacturer Contracts shall include, but are not limited to, all: rebate agreements, administrative fee agreements, other fee agreements, service agreements, health or disease management agreements, data sales agreements, discount agreements, prompt payment agreements, bulk purchase agreements, pricing agreements, and pricing sheets/term sheets/discount sheets providing pricing terms.

1.111. **Pharmacy Benefits Management Services** means claims processing, eligibility verification, all contracting and management and administration of contracts with Participating Pharmacies and/or Pharmaceutical Manufacturers, Formulary and clinical support, and all other services related to the management of pharmacy benefits described in this Agreement or performed by Plan Manager as a result of the Agreement.

1.112. **Pharmacy Management Allowance (PMA)** means an annual credit provided by Plan Manager to County for integration of medical and pharmacy plans. PMA will be applied to County's account in February of each Plan Year based on enrollment submitted for January of each Plan Year.

1.113. **Plan(s)** means the health care plan (or plans) and pharmacy benefit coverage maintained by County, or portions of that plan (or plans), with respect to which administrative services are to be provided under the Agreement.

1.114. **Plan Participant(s)** or **member(s)** means those individuals who are identified in Eligibility Files as being entitled to receive services and Covered Items under the Plan. This includes Benefit-Eligible employees, Retirees and COBRA participants and dependents, as enrolled.

1.115. **Plan Participant's Benefit Effective Date** means the date Plan Manager is obligated to start processing claims for each Plan Participant. Plan Participants Benefit Effective Date shall

be included in County's Eligibility Files for Benefit-Eligible employees and the Third-Party Administrator's Eligibility Files for Retiree and COBRA participants.

1.116. **Plan Participant List(s)** means the Eligibility File(s) identifying all eligible Plan Participants.

1.117. **Plan Manager Participating Pharmacy Contract(s)** means all contracts, amendments or addendums thereto, letter agreements, or other written or oral agreements in any form, setting forth any terms between Plan Manager and any retail, mail-order pharmacy, or specialty drug pharmacy, whether independent, or owned by or affiliated with Plan Manager.

1.118. **Plan Manager Services** means claims processing, eligibility verification, all contracting and management and administration of contracts with Participating Pharmacies and/or Pharmaceutical Manufacturers, Formulary and clinical support, and all other services described in or performed by Plan Manager as a result of the Agreement.

1.119. **Plan Year** means a calendar year during the Term of the Agreement.

1.120. **Precertification** means the process of assessing the appropriateness, utility, or necessity of proposed non-emergency hospital admissions, surgical procedures, outpatient care, and other health care services.

1.121. **Preferred Provider** means a Health Care Provider that is available by virtue of this Agreement to furnish services or supplies with respect to Plan Participants under applicable utilization management or case management provisions of the Plan.

1.122. **Preferred Provider Services** means Covered Services provided by a Preferred Provider or for emergency care.

1.123. **Premium Equivalent Rate** means for self-insured plans, the actuarial cost per Benefit-Eligible employee by plan and tier of coverage, or the amount the County would expect to reflect the cost of claims, administrative costs and stop-loss premiums.

1.124. **Prescriber** means a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Dentistry (D.D.S.), or other licensed health practitioner with independent prescribing authority in the state in which the dispensing pharmacy is located.

1.125. **Prescription Drug Program (PDP)** means a plan to help Plan Participants pay for self-administered prescription drugs through insurance premiums.

1.126. **Preventive Drug and Preventive Drug Therapy List** means special coverage as allowed under IRS guidelines for certain preventive medications that help protect against or manage a medical condition, such as preventing blood clots and reducing the risk of stroke, preventing heart disease and reducing high blood pressure, preventing osteoporosis. These lists include medications considered preventive by the IRS.

1.127. **Preventive Drug Therapy List** means special coverage as allowed under IRS guidelines for certain preventive medications that help protect against or manage a medical condition, such as preventing blood clots and reducing the risk of stroke, preventing heart disease and reducing high blood pressure, preventing osteoporosis.

1.128. **Prior Authorization** means a cost-savings program whereby benefits are not available unless approved by Plan Manager, which may be required before Plan Participants receive service for the service to be covered by the Plan; and prescriptions that require pre-approval by Plan Manager. Physicians must prescribe a more cost-effective drug prior to prescribing a more costly equivalent.

1.129. **Program(s)** or **program(s)** means any Plan Manager programs for which the County chooses to implement, in writing, via the Agreement, a Benefit Specification Form and/or Benefit Change Form, based on specified written protocols provided to the Plan Manager, including, but not limited to the following programs: Prior Authorization, Chronic Condition Management, Case Management, Wellness, Pharmacy Step Therapy, Mandatory Generic, Mail-Order Pharmacy, Specialty Pharmacy, New-to-Market Medications Quantity Limits, Age Restriction, Retail 90, and Too Soon Refill.

1.130. **Pro Rata Share** means the proportion of total Financial Benefits that Plan Manager collects from third parties or affiliates of Plan Manager that Plan Manager is required to pass through to County. Pro Rata Share, as it relates to Plan Manager's obligation to pass-through to County all Financial Benefits received from third parties, shall be defined to include, but not be limited to, the following:

1.130.1. In connection with any Plan Manager/Pharmaceutical Manufacturer Contract that calls for the payment of a flat amount per prescription (or per Dispensed Claim), Plan Manager shall pass through to County that amount times the number of prescriptions (or Dispensed Claims) dispensed to County's Plan Participants.

1.130.2. In connection with any Plan Manager/Pharmaceutical Manufacturer Contract that calls for the payment of a percentage amount (of the total AWP, or total WAC, or total ASP, etc.) dispensed, Plan Manager shall pass through to County the percentage amount times the total AWP, or total WAC, or total ASP (or other identified amount) dispensed to County's Plan Participants.

1.130.3. In connection with any Plan Manager/Pharmaceutical Manufacturer Contract that calls for the payment of tiered additional payments based on any factor (such as the added market share, or added number of prescriptions dispensed, etc.), Plan Manager shall multiply the total amount paid as a tiered additional payment, by the "Percentage of Plan Manager's Aggregate Book Of Business" that County represents.

1.130.4. In connection with any Plan Manager/Pharmaceutical Manufacturer Contract that calls for a flat payment of money related – or unrelated - to any drugs dispensed (e.g., the payment by a Pharmaceutical Manufacturer of a health management fee, or data sales fee, or educational grant, etc.), Plan Manager shall calculate County's Pro Rata Share of said payment by multiplying the amount of the payment, by the "Percentage of Plan Manager's Aggregate Book of Business" that County represents.

1.131. **Provider Discounts** means the difference between the charge rate for health care services and the contractually determined reimbursement rate. The discount from charges is important to the health care provider, the carrier, and the patient because this determines the amount that will be paid for the service.

1.132. **Purchasing Director** means County's Director of Purchasing as appointed by the Broward County Administrator.

1.133. **Quantity Limit Program** means a cost-savings program implemented by Plan Manager for County in which pharmaceutical manufacturers' recommended quantity limits that are imposed on a specified Covered Item(s), and/or Plan Participants are required to obtain authorization for quantities of drugs greater than those outlined in written protocols.

1.134. **Rally®** means a digital health platform designed to engage and motivate Enrollees through a variety of interactions, events (missions, challenges, communities, coaching, etc.) and personalized health recommendations. Enrollees can earn a maximum of $300 in Rally Employer Rewards in a Plan Year by completing specified program activities.

1.135. **Rally Employer Rewards** means an amount of money each Enrollee can earn in a Plan Year based on completing specified program activities such as a comprehensive preventive eye exam, biometric screening, annual flu shot, attending a Rally wellbeing event, confirming a visit with the dentist, completing online quizzes, receiving an annual physical or preventive screening, etc. Employer Rewards vary by activity and range from $10 to $50. Employer Rewards can be redeemed for a wide variety of gift cards.

1.136. **Rebate(s)** means any discount or fees of any kind paid to Plan Manager, directly or indirectly, from pharmaceutical manufacturers, manufacturer-related entities, wholesalers, or distributors as a result of County prescription utilization by Plan Participants. Rebates include, without limitation, all benefits, including, but not limited to all Rebates, Financial Benefits, discounts, credits, fees, grants, bonus', bonus overrides, chargebacks or other payments or financial benefits of any kind, whether from pharmaceutical companies or third-parties, that Plan Manager or any other subsidiary or affiliate of Plan Manager actually receives or is otherwise entitled to receive as a result of prescription utilization by Plan Participants.

1.137. **Rebate Minimum Guarantee(s)** means the minimum amount that Plan Manager has guaranteed will be provided for Brand and Specialty prescription utilization for Plan Participants. Rebates are calculated for Brand and Specialty obtained through all retail pharmacies, mail-

order facilities and specialty drug pharmacies. Rebate amounts are not subject to a minimum days' supply (i.e. 30 or 90).

1.138. **Retail 30 Program** means a program implemented by Plan Manager for County for maintenance medication taken on a regular basis to treat conditions that are considered chronic or long-term, such as diabetes, high blood pressure, heart disease, etc. Plan Participants may obtain a 30-day maintenance drug with 2 refills while trying out a new drug. Once the 3 30-day fills have been processed, Plan Participant must obtain maintenance medications as a 90-day supply under the Retail 90 Program through a Retail Maintenance Network or Mail Order Pharmacy.

1.139. **Retail 90 Program** means a cost-savings program implemented by Plan Manager for County in which Plan Participants may obtain prescriptions of greater than eighty-four (84) days, but no more than ninety-one (91) days, from specified retail Participating Pharmacies that have accepted certain pricing terms and conditions.

1.140. **Retail Maintenance Network** means Plan Participants can use their local pharmacy to fill up to a 90-day supply of their covered prescription medications. Retail 90 is convenient and easy for Plan Participants.

1.141. **Retiree** means a Benefit-Eligible employee of the County who has met the Florida Retirement System's retirement requirements and continues coverage within thirty (30) days of termination of active employee coverage. These individuals are also referred to as "Retiree Continuee(s)."

1.142. **Retiree Drug Subsidy** (RDS) means a program offered by the Centers for Medicare & Medicaid Services to reimburse health plan sponsors for a portion of their eligible expenses for retiree prescription drug benefits. This enables plan sponsors to continue providing drug coverage to their Medicare-eligible retirees at a lower cost.

1.143. **Retrospective Review** means the process of assessing after the fact the appropriateness, utility, or necessity of hospital admissions, additional days of hospital confinement, surgical procedures, outpatient care, and other health care services, as required under the provisions of the Plan.

1.144. **Run-Out Claims** means Claims that are incurred but not reported (IBNR) prior to the termination of the Agreement, termination of a plan benefit option, or termination of a Plan Participant, as applicable.

1.145. **Self-Funded** is an arrangement in which a company funds its own employee benefit plan. This alternative funding option is a group health self-insurance program often used by large employers who opt to assume responsibility for all the risk, remaining exclusively liable for all financial and legal elements of the group benefits plan.

1.146. **Service Area** means the Zip Code Areas in which each Network provides health care services in accordance with the terms of this Agreement and the Plan.

1.147. **Services** means all work required by Plan Manager under this Agreement, including Health Benefits Management Services, Pharmacy Benefits Management Services, and the administration of Wellness Program(s), unless otherwise specified, including without limitation all deliverables, consulting, training, project management, or other services specified in Exhibit C ("Scope of Services"), and any optional services procured under this Agreement.

1.148. **Shared Savings (Naviguard) Program** means the County shares with Plan Manager the savings achieved through established discounts with certain providers who are not participating in the Plan Managers Network.

1.149. **Specialty Drug(s)** means each drug identified in the formulary. The term "Specialty Drug" shall also include any new-to-market specialty drug that County allows to be dispensed. County shall have the right to select which Specialty Drugs shall (or shall not) be dispensed to its Plan Participants. County shall also have the right to determine whether (i) to allow a new-to-market specialty drug to be dispensed automatically from the Specialty Drug Pharmacy at the Default Discount Rate prior to the specialty drug being added; or (ii) to prohibit and block the dispensing of a new-to-market specialty drug until it has been added to the Formulary, or County has specified in writing that it wants the drug added.

1.150. **Specialty Drug Pharmacy** means a facility that is duly licensed to operate as a pharmacy at its location and to dispense Specialty Drugs to individuals, including Plan Participants. Plan Manager shall identify the Specialty Pharmacy that will be the only specialty drug pharmacy Plan Manager uses to service County. Should Plan Manager wish to use an alternative Specialty Drug Pharmacy in fulfilling its Specialty Drug obligations, Plan Manager shall be obligated to notify County in writing of its intention to do so at least sixty (60) days prior to Plan Manager's intention to substitute pharmacies and obtain written approval of its pharmacy substitution from County, or Plan Manager will not be allowed to use the alternative Specialty Drug Pharmacy. Notwithstanding the above limitations concerning use of other pharmacies, Plan Manager and the Specialty Drug Pharmacy may rely on other specialty drug pharmacies to dispense certain Specialty Drugs to the extent said Specialty Drugs are only available through those alternative specialty drug pharmacies. In any instance that Plan Manager and the Specialty Drug Pharmacy rely on said alternative pharmacies, Plan Manager and the Specialty Drug Pharmacy remain bound to satisfy all contractual obligations concerning Specialty Drugs, including but not limited to: Pass-Through Pricing obligations, Minimum Guaranteed Discount obligations, Default Discount Guarantee obligations, Financial Benefit Guarantee obligations, Performance Guarantee obligations, and Dispensing Fee obligations.

1.151. **Specialty Drug Report(s)** means a quarterly report provided by Plan Manager to County, identifying new-to-market Specialty Drugs, and a forecast of Specialty Drugs that are likely to be entering the market in the coming six months.

1.152. **Specialty Pharmacy Program** means a program implemented by Plan Manager for County to restrict the pharmacy from which Specialty Drugs will be dispensed.

1.153. **Standard of Care** means in providing all services set forth in this Agreement, Plan Manager shall use the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent claims administrator/fiduciary acting in a like capacity and familiar with such matters would use under similar circumstances.

1.154. **Step Therapy Program** means a Program by which Plan Manager dispenses certain drugs only after Plan Participants have tried alternative, less expensive, therapeutically similar or equivalent drugs, including OTC Drugs, based on Plan Manager's written Step Therapy protocols.

1.155. **Subcontractor** means an entity or individual providing services to County through Plan Manager for all or any portion of the work under this Agreement. The term "Subcontractor" shall include all subconsultants, third-party administrators, and third-party aggregators.

1.156. **Summary of Benefits and Coverage (SBC)** means a Department of Labor (DOL) mandated uniform Summary of Benefits and Coverage provided to Plan Participants. The Summary of Benefits and Coverage are uniform across all Health TPA's, health insurance companies, Medicare, and state and federal offerings.

1.157. **Summary Plan Descriptions** means a detailed guide to the benefits the program provides and how the plan works.

1.158. **Telephonic Coaching** means a personal health coaching program delivered through telephone support to help Plan Participants improve their health by making the best lifestyle changes.

1.159. **Third-Party Administrator (TPA)** means a company that provides operational services such as claims processing under contract to another company.

1.160. **Transplant Management/Transplant Resource Services** means hands-on support to Plan Participants in need of organ and tissue transplants. The Transplant Management Team guides Plan Participants to Plan Manager's National Transplant Network (NTN), designed to control costs and deliver a superior transplant experience. They review coverage, coordinate benefits, facilitate services and follow the transplant recipient's progress from initial referral through treatment and recovery.

1.161. **True-Up** means an adjustment made for the difference in the initial payment by Plan Manager for pharmaceutical manufacturer rebates, to the actual payment due.

1.162. **Usual and Customary or U&C** means the walk-in price charged by a retail pharmacy to customers who are without prescription drug coverage. County shall never be charged for more than the U&C for a transaction. For every Dispensed Claim that Plan Manager reimburses to the

retail pharmacy based on U&C, Plan Manager shall allocate the entire U&C charge to the Ingredient Cost and shall not allocate any of the U&C charge to the Dispensing Fee. Plan Manager represents and warrants that each of its contracts with retail pharmacies requires each retail pharmacy to include as its transmitted U&C price to Plan Manager any and all U&C discounted prices that the pharmacy provides to non-insured customers.

1.163. **Usual, Customary, and Reasonable Charges** means the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

1.164. **Unit AWP** means the Unit of measure price, as defined by the NCPDP, with the Unit of measure being per tablet, per capsule, per ml of liquid, per gm of cream, or per another Unit dispensed.

1.165. **URAC** means an organization that helps promote health care quality through the accreditation of organizations involved in medical care services, as well as by offering education and measurement programs.

1.166. **Utilization Management** means a set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care.

1.167. **Utilization Review** means the process of assessing the appropriateness, utility, or necessity of hospital admissions, surgical procedures, outpatient care, and other health care services as required under the provisions of the Plan.

1.168. **Wellness Allowance** means the annual amount that is accumulated by the Plan Manager for wellness activities, events, and equipment to support the County's Wellness Program.

1.169. **Wellness Coordinator** means an on-site registered nurse provided by Plan Manager five (5) days a week for Employee consultations and wellness programming at various locations throughout the County.

1.170. **Wellness Nutritionist/Health Coach** means an on-site nutritionist provided by the Plan Manager five (5) days a week for Employee consultations and wellness programming at various locations throughout the County.

1.171. **Wellness Program** means a County program intended to improve and promote health and fitness. Wellness programs typically include activities such as weight loss competitions, exercise, stress management or resiliency education, smoking cessation programs, and wellness assessments that are designed to help Plan Participants eat better, lose weight, and improve their physical health.

1.172. **Wellness Resource Center** means dedicated space at designated worksites throughout County which may include a HIGI health station, recumbent bicycles and ellipticals.

1.173. **Wholesale Acquisition Cost (WAC)** means the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price.

1.174. **Zip Code Area** means the geographical area described by any five-digit zip code established by the United States Post Office.

1.175. **180 Day Exclusivity Period** means the 180 days of exclusivity granted by the Food and Drug Administration under the Hatch-Waxman Amendments to the Federal Food, Drug and Cosmetic Act to a generic manufacturer. All generic drugs dispensed for a product during the 180 Day Exclusivity Period, whether under an abbreviated new drug application or new drug application to the United States Food and Drug Administration, shall be considered "within the 180 Day Exclusivity Period," subject to the detailed criteria described within the 180 Day Exclusivity Report.

1.176. **180 Day Exclusivity Report(s)** means a quarterly report provided by Plan Manager to County identifying all drugs or drug products that fall within the 180 Day Exclusivity Period.

(Remainder of page intentionally left blank.)

EXHIBIT B
Relationship Between the Parties

1.1. County, as the sponsor of the Health Benefits Plan and Pharmacy Benefits Plan (collectively, "Plan"), shall exercise business control over the Plan, including but not limited to determining the benefits and features offered by the Plan, amending the Plan, and Plan termination.

1.2. Plan Manager is an experienced and fully qualified administrative services provider for self-insured health and pharmacy benefit plans. In performing its obligations under this Agreement, Plan Manager shall take all reasonable steps to implement the goals and objectives of the County. Plan Manager, in doing so, must use its discretion in administering and managing the Plan in accordance with the Agreement and County directives. Therefore, Plan Manager shall operate as Plan fiduciary for all of its responsibilities under this Agreement. Such responsibilities shall include, but are not limited to, final determination of Claims, such as the evaluation of medical necessity, usual and customary rates of providers, and fees and expenses.

1.3. In addition, Plan Manager's fiduciary responsibilities shall also include, but not be limited to, acting solely in the interest of County and Plan Beneficiaries with the exclusive purpose of providing benefits to them; carrying out its duties as Plan Manager in a prudent manner; exercising expertise in all areas of administrative services and health and pharmacy plan management, including wellness and disease management, as a reasonably prudent administrative services provider; following the Plan documents, including the Agreement; and paying only reasonable Plan expenses.

1.4. Plan Manager shall act as an agent of County authorized to perform actions necessary to achieve the Performance Measures and delineated objectives of this Agreement. Plan Manager may act as an agent of the County authorized to perform specific actions or conduct specified transactions only as provided in this Agreement.

1.5. Plan Manager affirmatively accepts responsibility for and shall comply with all relevant local, state, and federal laws, including the Internal Revenue Code, and any applicable laws and regulations governing or affecting the Plan or administrators of health plans and pharmacy plans, unless otherwise directed by County.

1.6. Notwithstanding its fiduciary relationship with County, Plan Manager will not exercise discretionary authority or control regarding the disposition or management of assets of the Plan.

1.7. Accordingly, except as may otherwise be expressly provided in this Agreement, Plan Manager is not a trustee, sponsor, or fiduciary with respect to directing the operation of the Plan or managing any assets of the Plan.

1.8. Plan benefits shall be funded exclusively through the Plan. Plan Manager is not responsible or accountable for providing funds to pay Plan benefits under any circumstances.

General Duties of Plan Manager

2.1. Plan Manager shall process claims and make payments in accordance with the provisions of the Plan and related interpretations of the benefit provisions of the Plan that are made or approved by the Contract Administrator on a timely basis and confirmed in writing.

2.2. Plan Manager shall be entitled to rely and act based upon documents, letters, electronic communications, or telephone communications that are confirmed in writing and provided to it by the Contract Administrator. Reliance will continue until the time the Contract Administrator notifies the Plan Manager in writing of any change or amendment to those communications.

2.3. Plan Manager shall provide Plan Participants who have had a claim wholly or partially denied with a written explanation of the reason for the denial. Plan Manager shall provide Plan Participants with information about what steps may be taken if the Plan Participant wishes to submit the denied claim for review. Plan Manager shall have the ultimate responsibility and authority to make final determinations with respect to Claims. These obligations of Plan Manager will be discharged in accordance with the provisions of the Plan or as authorized by the Contract Administrator.

2.4. Plan Manager shall perform its duties under this Agreement using the same degree of care, skill, prudence, and diligence that an experienced and fully qualified provider of administrative services would use in similar circumstances. This includes, but is not limited to, making a good faith effort to correct any mistake or clerical error, which may occur due to actions or inaction by the Plan Manager, once the error or mistake is discovered.

2.5. Plan Manager shall comply with all applicable federal, state, and local laws, codes, ordinances, rules, and regulations in performing its duties, responsibilities, and obligations pursuant to this Agreement.

General Duties of County

3.1. County will identify and describe the Plan as to type in Exhibit Y, Identification of the Plans/Summary Plan Descriptions.

3.2. County shall make sufficient funds available on a timely basis to honor all Claims reimbursements under the Plan. Sufficient funds for making Claims payments must be made available, in accordance with this Agreement, to enable services under this Agreement to continue without interruption.

3.3. County shall use reasonable efforts to ensure that all methods employed to fund the Plan comply with all applicable laws or regulations.

3.4. County shall furnish each Plan Participant with written notification of the source of funding for Plan benefits to the extent required by applicable law.

3.5. County shall timely provide current copies of the documents describing the Plan to the Plan Manager along with other appropriate materials governing the administration of the Plan. These documents and materials may include employee booklets, summary descriptions, employee communications significantly affecting the Plan, and any amendments or revisions ("Plan Documents"). If Plan Manager drafts and provides any of these Plan Documents to County as part of the Services offered under this Agreement, County agrees to review, edit, and provide its signature approving those Plan Documents in a timely manner. Plan Manager shall provide County with adequate prior notice regarding any and all deadlines for reviewing the Plan Documents and, pursuant to its fiduciary duties, shall make good faith efforts to assist County with meeting such deadlines.

3.6. County shall provide reasonable prior notice to Plan Manager of the Plan's management policies and practices, interpretations of the benefit provisions of the Plan, and changes in the Plan provisions. Plan Manager, as a fiduciary of the Plan, shall advise County regarding Plan administration, including the amount of time Plan Manager needs to receive and implement Plan Documents and any amendments thereto.

3.7. County shall provide accurate information to the Plan Manager as to the number and names of persons covered by the Plan and any other information necessary to enable the Plan Manager to provide the Services required by this Agreement. This information shall be kept current on at least a monthly basis. Plan Manager is not responsible for any Claims paid in error due to inaccurate eligibility information. However, Plan Manager will use its best efforts to pursue repayment of Claims paid in error, once the County provides accurate eligibility information.

3.8. County acknowledges that the Plan Manager shall not provide professional tax or legal services to the County.

3.9. County shall comply with all applicable provisions of law addressing the County's duties with respect to the Plan. This includes compliance with all legal reporting and disclosure requirements, adoption and approval of all required documents regarding the Plan and compliance with state escheat and unclaimed or abandoned property laws. Even though Plan Manager may be required to perform certain duties under this Agreement, such as preparing drafts of documents for approval and adoption, County agrees that the Plan Manager does not undertake the responsibility for legal compliance for any other person.

3.10. Neither Party shall direct the other to act or refrain from acting in any way which would violate any applicable law or regulation. Neither Party shall behave in any way which could implicate or involve the other in a violation of these laws.

(Remainder of page intentionally left blank.)

EXHIBIT C
Scope of Services

A. Plan Administrative Services

County shall compensate Plan Manager for Services provided under this Agreement based on the monthly Administrative Fee specified in Exhibit D, Schedule of Fees/Discounts. The Administrative Fee payable to Plan Manager shall be considered full and complete compensation for all Services provided under this Agreement, whether directly provided or provided through a Subcontractor, excluding Claims costs and pharmacy Dispensing Fees. The Administrative Fee shall include, but is not limited to the following items and services:

a. Account management and personnel to assist with same
b. Claims Administration in accordance with Exhibit G, Claims Administration
c. Claims Fiduciary
d. Billing, enrollment, and eligibility administration
e. Customer service, communications, and training
f. Data management, monthly reporting package, and ad hoc reports
g. Preparation and posting of Summary Plan Description and Summary of Benefits
h. Case management
i. Catastrophic case management, including but not limited to: Cancer, End Stage Renal Disease (ESRD), Multiple Sclerosis (MS) and other Rare Diseases
j. Gaps in Care messaging
k. Mental health substance abuse full care management
l. Third-party file feeds in a HIPAA compliant format (including, but not limited to: Claims, stop loss, and data warehouse)
m. Vision Plan Rider
n. Dental Plan Rider
o. Premium equivalent active and COBRA rate development
p. Quarterly Plan performance review to include senior level management and medical director
q. Customer satisfaction survey
r. Access to employer portal including web-based reporting
s. Plan Participant on-line access to member services and call center
t. County specific internet website/page
u. Toll-free customer service number for Plan Participants
v. Toll-Free number for providers/pharmacies to contact Plan Manager
w. Plan Participants' enrollment materials
x. Plan Participants' Identification 'ID' Card and welcome kit production and delivery
y. Comprehensive online portal for Plan Participants' access to include, Network directory, Explanation of Benefits (EOB's), transparency tool, plan information, ID card printing/requests, etc.
z. Comprehensive online portal for County's access to include access to update eligibility, view Claims, run reports, and billing administration
aa. Electronic and paper Claims processing

bb. Provide paper Claim forms
cc. Pharmacy Claims integration
dd. Provider and facility Network management
ee. Provider contracting
ff. Appeal determinations (all levels)
gg. Preparation and distribution of Explanation of Benefits
hh. Quarterly benefit statements electronically sent or mailed to Plan Participants with savings opportunities through redirection of care, including more efficient providers as identified by Plan Manager
ii. Affordable Care Act (ACA) real-time Maximum Out-of-Pocket Accumulator
jj. Abuse/Fraud program development and management
kk. Evaluation of the appropriate site of service for IV infusion therapies and management of determined site with Plan Participant and provider guidance.
ll. Data processing of deductible and out of pocket accumulation aggregation services
mm. Implementation/transition assistance and printing and mailing costs.
nn. State surcharge reporting
oo. Coordination of Benefits (Medicare Part A and B, Medicaid, and Plan Participant-submitted Claims paid by other insurance)
pp. Integrated chronic condition management with clinical initiatives based on national clinical guidelines to assist a physician in optimizing patient care through the identification of potential gaps in care in a patient's treatment
qq. Clinical Programs including:
    i. Bariatric Management Program with separate deductible (all plans)
    ii. Orthopedic Support Program
    iii. Diabetes Health Plan including Living with Diabetes
    iv. Personal Health Support 3.0 (PHS 3.0)
    v. Chronic Condition Management:
        - Asthma
        - Cancer
        - Chronic Obstructive Pulmonary Disease (COPD)
        - Congestive Heart Failure (CHF)
        - Coronary Artery Disease (CAD)
        - Diabetes
        - End State Renal Disease (ESRD)
        - Multiple Sclerosis (MS)
        - Other rare diseases
    vi. Evaluation of the appropriate site of service for IV infusion therapies and management of determined site with Plan Participant and provider steerage
    vii. Health Pregnancy Program
    viii. Advocate 4Me/Nurse Line Package
rr. WellBeing Programs:
    i. Wellness Program and platform: administration, web structure, mobile app, and telephonic coaching

ii. Telemedicine/Telehealth – including behavioral health
iii. Wellness Program and Wellness Resource Centers - $300K allowance per Plan Year for health fairs, on-site biometric screenings, on-site flu shots, Wellness activities, Wellness events, equipment for Wellness Resource Centers (balance at end of Plan Year shall be paid to County by March 31 of each year
iv. One (1) Wellness Coordinator and (1) Wellness Nutritionist (five (5) days per week)
v. Eleven (11) Higi* health stations strategically located across Broward County within government facilities
(*Higi is a consumer health engagement company that makes it easier for consumers to measure, track and act on their health data through a nationwide network of FDA-cleared self-service Smart Health Stations. The station network shall be provided at no cost to County Plan Participants.)

ss. Other clinical and/or administrative programs that Plan Manager chooses to provide in excess of the requirements of this Agreement
tt. Transparent Shared Savings (Naviguard) Program in accordance with Exhibit E, in which Plan Manager discloses savings achieved by service and provider
uu. Disclosure and refund to County of any recovery amounts from payment integrity and recovery services in accordance with Exhibit E
vv. All other functions required to fulfill the requirements of this Agreement.

<u>Pharmacy specific:</u>

ww. Online formulary/preferred drug listing
xx. Online preventive drug list for HDHP plans
yy. Network pharmacy audits
zz. Mail service program that automatically substitutes a generic for a brand alternative when prescribing physician has authorized generic substitution
aaa. Prospective specialty drug utilization review
bbb. E-Prescribing connectivity and transactions
ccc. Utilization management and review
ddd. Point of Service (POS) messaging
eee. Generic messaging, which includes notices to the Plan regarding upcoming generic releases and communications to Plan Participants to increase awareness of the value of generic drugs
fff. At a minimum, on a semi-annual basis, communicate via mail, email, alerts, or phone calls to Plan Participants regarding savings opportunities of $50 or more
ggg. Clinical and formulary management, including a County-specific program: Non-Formulary and Excluded Drug Exceptions Program requiring Plan Participant to fail or have contraindications or intolerance to at least one therapeutically equivalent formulary drug
hhh. Clinical initiatives based on national clinical guidelines to assist a physician in optimizing patient care through the identification of potential gaps in care in a patient's treatment
iii. Pricing and cost containment measures

jjj. Quantity Level Limit (QLL) system edits and support, and Prior Authorization (PA) edits and support
kkk. Step Therapy edits and support
lll. Duration of Therapy edits and support
mmm. Concurrent, Prospective, and Retrospective Drug Utilization Review (DUR) that ensures appropriate utilization of drugs based on product choice, quantity dispensed, dosing, and duration of therapy
nnn. Evaluation of the appropriateness of controlled substances and other targeted drugs, ensuring safe and appropriate utilization; and communication to physicians via mail, as necessary
ooo. Rebate management/administration, including rebate aggregation services data processing
ppp. Pharmacy network management
qqq. Manage complete Medicare D Retiree Drug Subsidy (RDS) Program in accordance with Exhibit N, Retiree Drug Subsidy Requirements

Health specific:

rrr. Utilization management and review
sss. Acute case management and case management
ttt. Rules and Gaps in Care messaging

B. Provider and Facility Network Management Requirements

1. Plan Manager shall provide its broadest provider and pharmacy Networks.
2. Plan Manager shall market, develop, organize, implement, operate, and maintain a national Network. While County understands that contracts are between Plan Manager and providers and facilities, Plan Manager must work towards maximizing participation to ensure a successful and robust Network.
3. Plan Manager shall notify County sixty (60) days prior to contract expiration date and communicate the status of negotiations for both facilities and largely utilized provider groups.
4. Plan Manager shall report annually the aggregate number of new and terminated network providers.
5. Plan Manager shall ensure network providers are practicing generally accepted medical standards and practices to guarantee adherence.

C. Customer Service, Communications, and Training Requirements

1. Plan Manager shall provide designated customer service representatives, with training on the specific features of the benefits of the Plan, to respond to written and telephone inquiries from Plan Participants, providers, and agencies; to answer questions; verify eligibility of Plan Participants', provide assistance with accessing benefits; and resolve Claims payment problems. Customer service representatives must be knowledgeable

about all Plans offered by County and be able to assist Plan Participants with questions regardless of the plan in which they are enrolled. In addition, Plan Manager shall make available to Plan Participants on-site designated staff to provide information and status on medical and pharmacy Claims. Plan Manager will be required to demonstrate that it has established and staffed telephone lines before open enrollment.

2. Plan Manager shall make available to Plan Participants a pharmacy help line to provide information and status on prescriptions and to provide Plan Participants with alternative drug options and emergency refill too soon overrides for certain drug classes. Plan Manager shall also:
    a. receive the current pricing information on the prescription drug;
    b. provide purchase approval to the participating pharmacy by means of an online system;
    c. conduct concurrent drug utilization reviews to identify and notify the Plan Participant of any drug treatment that is potentially harmful, unnecessary, non-covered, or requires prior authorization;
    d. receive information on lower cost alternatives from the preferred drug list maintained by Plan Manager or lower cost generic alternatives, if appropriate;
    e. inform the Plan Participant of all information that indicates that the prescription may be inappropriate for the individual; and
    f. receive any information on therapeutic contraindications or potential problems from use of the drug prescribed.
3. Plan Manager agrees to develop and distribute forms and materials, and provide timelines for their development and updates, to Plan Participants and County's Benefits Administration Team. All forms and materials are subject to approval by County's Benefits Administration Team prior to actual use and includes, but is not limited to:
    a. Claim forms;
    b. Explanation of benefits (EOB) forms;
    c. A web-based directory of all providers, facilities, and pharmacies participating in the network (a paper directory shall be provided upon request);
    d. Articles describing features of the Plan and all applicable clinical and wellness programs for County publications;
    e. Brochures, payroll stuffers, posters, or similar materials at the Counties request; and
    f. Plan Participant ID cards.
4. Plan Manager shall develop and assist County with distribution of all communication materials and items approved by the County's Benefits Administration Team.
5. Plan Manager shall maintain enough inventory of all current printed materials for distribution or mailing to Plan Participants upon the request of County and provide on demand service delivery for all printed materials.
6. Plan Manager shall participate in a combined health, dental, and vision annual member satisfaction survey at Plan Manager's expense. Survey tool must be collectively selected

and paid for by all current health, dental, and vision plan managers. Survey content must be approved by County. Results are benchmarked year over year and comprehensive reports are provided to each plan manager and County. Survey shall be conducted in the Fall of the year for the current Plan Year.

7. Plan Manager shall provide its personnel, as needed, to inform providers, County, and Plan Participants of rules, updates, changes, and other features of the Plan, especially during the annual open enrollment period. Training and education sessions may be held at the Governmental Center, as well as various County locations across Broward County, Florida.

D. Claims Processing and Payment Requirements

1. Plan Manager shall be responsible for processing all Claims incurred by Plan Participants on and after January 1, 2022, and during the entire Term of the Agreement, determine whether the Claim is payable, and pay the Claim subject to applicable Plan provisions provided, however, that following termination of this Agreement, Plan Manager shall continue for a period of twelve (12) months to process all Claims for the Plan that were incurred during the Term of the Agreement at no additional charge.
2. Plan Manager, under the HDHP plan options, shall calculate the amount due at the point of sale and inform the provider or pharmacy who would collect the amount owed from the Plan Participant, subject to Plan Year deductible and coinsurance up to Plan Participant's Maximum Out of Pocket (MOOP) costs. Plan Manager shall update Plan Participant Maximum Out of Pocket Accumulator within 48 hours of Claim processing.
3. Plan Manager shall be in compliance with all federal requirements including but not limited to implementing Plan modifications, as required under the Medicare Modernization Act (MMA).
4. Plan Manager shall provide an online data link between each participating network provider, facility, and pharmacy that permits provider administration, prior to the completion of a transaction, to:
    a. verify Plan Participant's eligibility;
    b. verify Plan Participant's Plan benefits; and
    c. verify Deductible and Maximum Out of Pocket Accumulators.
5. Plan Manager shall provide the necessary claim forms that can be submitted directly to Plan Manager by Plan Participants for processing after a network provider, facility, or pharmacy in which the Plan Participant received services was unable to verify the Plan Participant's eligibility. The claim form shall provide a disclaimer statement indicating that reimbursement is not guaranteed, and that Plan Manager will review the Claim, subject to limitations, exclusions, and other provisions of the Plan.
6. Plan Manager shall generate and mail a check, as required, and an explanation of benefits or denial notice for all Plan Participant-submitted Claims, and a remittance advice for provider-submitted Claims.

7. Plan Manager shall maintain online history of all Claims submitted (noting if Claims were paid or denied) for no less than the previous twenty-four (24) months.
8. Plan Manager shall identify areas of potential Claims payment discrepancies and take corrective actions. In the case of a Plan or Plan Participant overpayment, refunds should be issued to the Plan or to the Plan Participant who incurred the overpayment within thirty-one (31) days of discovery. Plan Manager shall notify County if Plan Participant or provider fraud is discovered and shall pursue all legal means available in order to recover fraudulent Claim payments made to a Plan Participant or a provider in accordance with Exhibit E, Shared Savings (Naviguard) Program and Subrogation, Payment Integrity and Recovery Services.
9. Plan Manager shall perform reviews, such as verification of services billed, to identify and report to County improper provider billing practices and take appropriate action.
10. Plan Manager shall identify any instance where Coordination of Benefits applies and take appropriate action to recover claims payments or other costs. Plan Manager shall be responsible for capturing and enforcing Coordination of Benefits. Plan Manager shall report Plan savings as a result of Coordination of Benefits in accordance with Exhibit E.
11. Plan Manager shall provide access to medical advisors, medical literature, medical care standards, and other materials as needed for consideration and determination of Claims, and for review of disputed Claims or appeals of denials in whole or in part.
12. Plan Manager shall provide a formal grievance and appeals process compliant with the Affordable Care Act regulations.
13. Plan Manager shall work with the Human Services Department to implement a separate account structure for County's Arrestees. Plan Manager shall process medical and facility claims approved by the Human Services Department when an Arrestee is qualified to receive medical and facility services under the Plan in accordance with Exhibit O, Claims Processing for Arrestees. Claims shall be processed using the same discounted network rate in the Plan. Arrestee services should be administered and reported to the Human Services Department separately from all other Claim reports and services by the Plan Manager.

E. Reporting Requirements

1. Plan Manager shall submit regular reports detailing financial, Plan Participant services, and administrative data established within the mutually agreed upon Performance Measures in Exhibit H, Performance Measures.
2. Plan Manager shall provide the Performance Measure report to Benefits Consultant and the Contract Administrator, indicating compliance or non-compliance with each performance standard, within forty-five (45) days after the end of every quarter and Plan Year.

3. Plan Manager shall be required to provide, in a format and on a basis acceptable to County and Benefits Consultant, standardized management reports that shall include, at a minimum, the following reports and measures:
    a. Key Financial Performance Metric Reports
        - Medical plan cost components, including high-cost claimants with diagnosis
        - Plan Participant demographic cost components
        - Plan savings as a result of cost savings programs, coordination of benefits and shared savings
        - Prescription drug plan cost components
    b. Utilization Management reports for Claims based on a mutually agreed upon format and timeframe
4. Plan Manager shall be required to provide County and Plan Manager's on-site account representatives access to an online query system for analysis, and, at a minimum, it must contain the following:
    a. Individual claimants (Subscriber Type, Plan Participant Type, Entity Type, etc.)
    b. Accumulator (deductible and out of pocket) reports by plan and status (individual and family)
    c. Medical claim and high-cost claimant information
    d. Network provider, facility, and pharmacy information
    e. Prescription Drug Information
    f. Prescriber Information
5. Plan Manager shall provide, at County's request, ad hoc or customized reports that cannot be generated from the online query system to analyze Plan and benefit options in support of County's decision-making activities.
6. Plan Manager shall be required by County to assist, as needed, with respect to the estimated cost impact of benefit modifications.
7. Plan Manager shall be required by County to provide actuarial premium equivalent rates by plan and tier of coverage 180 days prior to each Plan Year.
8. Plan Manager shall be required to provide to County or its designated representative, at least monthly and within twenty (20) calendar days after the end of the reporting period, a detailed claims transaction file that is transmitted to Benefit Consultant or its designee in a secure fashion, in accordance with the Administrative Simplification provisions of HIPAA and the Health Information Technology For Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 ("HITECH" Act). Plan Manager shall, to the extent it acts in its capacity as a Business Associate to County, adhere to the applicable requirements established in the HIPAA Rules for Business Associates handling Electronic Protected Health Information (EPHI) on County's behalf in connection with services and products provided to County as plan sponsor of the Plan. The file shall include all required data fields as identified by the named third-party data warehouse (Benefit Science Technologies).

F. Financial Requirements

1. Administrative Fees payable to Plan Manager
   The total dollar amount of the monthly Administrative Fee shall be determined by County based upon County enrollment files. Fees payable by County for additional services must be clearly identified in Exhibit D, Schedule of Fees/Discounts, or otherwise agreed to by County in writing. Plan Manager will not be compensated for any additional services unless the service and fee are clearly identified in Exhibit D.

2. Claims Reimbursements to Plan Manager
   County will establish and maintain a Designated Deposit Account (DDA) for Claims payment that will fund medical and pharmacy claims checks and EFT's. See Exhibit P, Banking Arrangement.

3. Pharmacy Financial Benefit Guarantees due to County
   a. Plan Manager shall provide full and complete pass through of all revenue Plan Manager receives from any and all sources related to County's utilization or enrollment of programs, which includes but is not limited to Rebates and Discounts, of any kind.
   b. Along with complete pass through of Rebates, Plan Manager shall provide the Rebate Minimum Guarantee specified in Exhibit D. Plan Manager shall pay Rebates for all plans offered by County including but not limited to HDHP Base, HDHP OON, and CDH.
   c. Plan Manager shall remit quarterly Rebates to County, which shall be paid no later than 90 days after the end of each calendar quarter. Quarterly Rebates shall include no less than the Rebate Minimum Guarantee per prescription totals for the quarter. Plan Manager shall monitor actual Rebates received per Rebate earning period and remit all Rebates in excess of the Rebate Minimum Guarantee with the next scheduled Rebate payment. Plan Manager shall provide reports for all Rebates remitted. Plan Manager shall remit to County all True-up amounts to the Rebate Minimum Guarantee or actual Rebates paid, whichever is higher, for the Plan Year no more than 180 days following the end of the Plan Year. Rebates and True-ups must be forwarded to County via check or ACH/Wire to the financial institution provided by County to Plan Manager.
   d. Plan Manager shall provide County with projected Rebate totals for each Plan Year no less than 30 days prior to the beginning of each Plan Year.

G. Eligibility of Participants and Computer Support Requirements

1. County shall provide Plan Manager an initial electronic membership file containing current enrolled active employees and their dependents for purposes of establishing eligibility.
   Third Party Administrator for COBRA and Retiree members (Benefits Outsource, Inc.) shall provide Plan Manager an initial electronic membership file containing currently enrolled members and their dependents for purposes of establishing eligibility.

2. County shall provide Plan Manager, on a weekly basis, an electronic file of updates or changes including new active employee enrollments, changes in a Plan Participant's

enrollment, reinstatement of a Plan Participant's enrollment, and Plan Participant's termination. Plan Manager shall accept, process, maintain, and update eligibility information from the files provided by County within (48) hours of receipt. Plan Manager shall refer to County, for consideration and County's final decision, any questions with respect to an individual's eligibility for benefits.

Third Party Administrator for COBRA and Retiree members (Benefits Outsource, Inc.) shall provide Plan Manager, on a weekly basis, an electronic membership of updates or changes including new COBRA or Retiree enrollments, changes, reinstatement, or termination.

3. Plan Manager shall provide County, via e-mail, with a weekly file acknowledgement of files received and entered in Plan Manager's system.

4. Plan Manager shall provide County a weekly processing report, in a format acceptable to County, of any transactions that did not update when eligibility data sent from County to Plan Manager was entered into Plan Manager's system.

5. Plan Manager shall maintain in its database occurrences of Plan Participant coverage history, as well as Plan Participant opt out history (including effective dates and termination dates, and enrollment in Medicare A, B, and Part D prescription drug plan) sufficient to adjudicate Claims, reconcile subsidy information, and reconcile eligibility data with County. County staff shall be able to access Plan Participant history in Plan Manager's system.

6. Plan Manager shall provide a secure online connection for all Plan Manager representatives working on site at County locations and the Benefits Administration Team for purposes of permitting personnel access to make online inquiries of Plan Manager's database and the ability to make real-time changes to Plan Manager's records regarding a Plan Participant's eligibility. All changes by the Benefits Administration Team are subject to strict controls, including a limited number of persons with access and use of passwords. Plan Manager shall provide a limited number of the Benefits Administration Team staff the ability to make online prescription overrides for maintenance medications for Plan Participant point of sale emergencies. Plan Manager shall provide County documentation of all direct updates by County staff to Plan Manager's database. Regardless of the level of access, the data for all Plan Participants shall be accessible to the Plan Participant through a single sign-on. Plan Manager shall abide by all data integrity, security requirements, and HIPAA regulations for protecting the transfer of data.

7. Plan Manager shall adhere to the Service Level Agreement as provided in Exhibit U.

H. Implementation Plan

1. Plan Manager shall be responsible for the preparation and execution of a final implementation plan to merge medical and pharmacy together under the Plan.

2. Final implementation plan shall be submitted to County not later than five (5) business days after Board approval of this Agreement.
3. Plan Manager's final implementation plan shall outline, in detail, all the steps necessary to begin full performance of the Agreement on January 1, 2022, and shall specify expected dates of completion of all such steps and identify the person(s) responsible for each step.
4. In the event of any failure by Plan Manager to strictly adhere to the final implementation plan, as agreed upon between Plan Manager and County (and without the express written waiver of County before the date of the agreed upon time for completion), Plan Manager shall pay to County the amount of Seven Hundred Fifty Dollars ($750) per day for each day or partial day during which Plan Manager is not in compliance with the final implementation plan.
5. Plan Manager shall complete, no later than November 30, 2021, a live test demonstration of the processing of test claim scenarios with a one hundred percent (100%) passage rate. The test claim scenarios (approximately fifty (50)) shall be provided by County to Plan Manager with enough detail to support the adjudication process. The demonstration must be performed in the presence of County staff and/or designated representatives or using a mutually agreed upon electronic presentation methodology.

I. Performance Measures

Plan Manager shall strictly adhere to the agreed upon Performance Measures as provided in Exhibit H.

J. Account Management and Personnel Requirements

1. Plan Manager shall provide an Account Management Team, who shall be available during the implementation process until County is satisfied that all transitional issues have been resolved. County reserves the right to recall the Account Management Team onsite in the event of ongoing problems. The Account Manager shall serve as the primary contact to respond to County's needs, questions, and/or issues.
2. Plan Manager's Account Management Team shall meet with County as necessary, but not less than quarterly, to review financial performance and service issues and to take corrective action as directed and approved by County. One of the scheduled meetings shall consist of an annual review at County's office in Fort Lauderdale, Florida, to review and summarize financial and clinical issues regarding the claims experience and financial performance of Plan Manager during the previous Plan Year. Plan Manager's designated Medical Director and Pharmacist shall also attend the annual review in person or virtually and the quarterly reviews by phone. Plan Manager shall also, during these meetings, assist County in its ongoing review of County's health and wellness programs and advise County of the following:
    a. Follow-up to, and status of, any agreed upon corrective action resulting from any preceding meetings.

b. Developments in the medical, wellness, and pharmacy industries including, but not limited to, new programs, techniques, models, and the like that will reduce County's cost while improving upon the Plan Participant's health and satisfaction of the benefit.
c. Legal developments including, but not limited to, regulatory, administrative, statutory, and judicial developments relating to insurance companies and Third-Party Administrators. However, Plan Manager must promptly notify County of any changes in the law or regulations affecting Third-Party Administrators and wellness program activities.

3. Plan Manager must provide sufficient staff to respond to County Audits and allow access to County data in accordance with Section 13.4, Audit Rights and Retention of Records, of this Agreement.

K. Wellness Program

1. Plan Manager shall provide a comprehensive Wellness Program to enrolled Plan Participants, which shall include, at a minimum, the following:
    a. Plan Participant online and mobile platform
    b. Plan Participant reward system
    c. Minimum program requirements
    d. Preventive and gender/age-based screening programs
    e. Plan Participant survey capabilities
    f. Tracking and reporting of Plan Participants' adherence to minimum requirements
    g. Through Plan Manager or a third-party vendor, the ability to accept electronic file or Plan Participant self-reported participation in annual wellness visit, biometrics, smoking cessation, weight loss, and chronic condition management programs, etc.
    h. Coaching
    i. Plan Participant facing communication through all medias: paper, email reminders, posters, and video clips for County TV monitors
    j. Initial Plan Participant enrollment and program highlights
    k. Electronic newsletters for County to post in monthly newsletter distribution
2. Minimum Reporting requirements shall be based on Key Performance Indicators and frequency agreed upon by Plan Manager and County, not to exclude gaps in care analysis, and improved Plan Participant health outcomes.
3. Guidance for program changes, based on the wellness of Plan Participants.

L. Chronic Condition Management

1. Plan Manager shall provide a comprehensive Chronic Condition Management program to Plan Participants. The program shall include, at a minimum, the following:
    a. Evidence based programs that follow disease management protocols

b. Specific Diabetes and Pre-Diabetes programs focused on weight loss and behavioral changes
c. Plan Participant online and mobile platform
d. Engagement of identified Plan Participants by Plan Manager
e. Extensive outreach communication to increase program participation
f. Monthly tracking and reporting of Plan Participants' adherence to the program to Benefits Consultant and Contract Administrator
g. Health Coaching must be provided online, through a mobile app and telephonically
h. Plan Participant-facing communication through all medias: paper, email reminders, posters, and video clips for County TV monitors
i. Initial Plan Participant enrollment and program highlights
j. Electronic health awareness newsletters for County to post in monthly newsletter distribution

2. Minimum reporting requirements shall be based on Key Performance Indicators and reported at the frequency agreed upon by Plan Manager and County, not to exclude gaps in care analysis and improved Plan Participant health outcomes.

3. Guidance for program changes, based on the health and wellness of Plan Participants, as well as recommendations to increase participation.

4. Plan Manager shall conduct quarterly meetings with County and Benefits Consultant to review participation and health outcomes and improvements.

M. Pharmacy Specific Requirements

1. <u>Pricing and Cost Containment Requirements</u>
   a. Plan Manager shall establish and maintain a comprehensive drug utilization review program that includes:
      i. concurrent, prospective, and retrospective therapeutic drug monitoring with the objectives of minimizing the risk of adverse drug interactions or drug-induced illness;
      ii. increasing use of drug therapies that are medically necessary and most clinically and cost effective;
      iii. identifying individual prescribers and/or pharmacies that demonstrate patterns of possible misuse; and
      iv. promoting cost effective drug therapies in accordance with national prescribing guidelines.

   b. Plan Manager shall provide a drug Formulary, or Preferred Drug list (PDL), that will be made available to Plan Participants, using the incentive of lower cost if a product is on the preferred drug list and/or a generic alternative can be used with the attending physician's approval. Plan Manager must provide to County, the new PDL, effective January 1st of the upcoming Plan Year, by October 1st of the previous Plan Year. The PDL must be reviewed and approved by County. Formulary deletions may only be made by Plan Manager once a year, effective at the start of the new Plan Year, unless specifically authorized, in writing, by County.

c. Plan Manager shall provide its most aggressive and broadest Maximum Allowable Cost (MAC) pricing for generic drugs that use a MAC price list that is subject to review and modification for inclusion of generic drugs representing the greatest cost savings to the Plan based on Plan Participant's drug utilization.

d. Plan Manager shall propose and implement pricing guarantees for generic, brand and specialty prescription drugs for 30-day retail, 90-day retail, mail-order and specialty pharmacy. Pricing guarantees are to be applied to all chain, institutional, and government-owned pharmacies.

e. Plan Manager shall apply the same Maximum Allowable Cost (MAC) list and pricing at mail-order that is applied at retail.

f. Plan Manager shall disclose to County at the time when New to Market Medications are added, how they are deemed appropriate for coverage.

2. Plan Manager shall provide 100% of all pharmaceutical rebate monies, represented by a system of Rebate Minimum Guarantees, based on a guarantee per branded prescription, with guaranteed rebate amounts remitted to County within ninety (90) days after the end of each quarter. Rebates received by Plan Manager, or any Subcontractor, in excess of the guaranteed amounts shall be remitted along with, and in addition to, the Rebate Minimum Guarantee for the quarter in which the excess rebates are received. There will be an annual True-up to the guarantee no later than one-hundred eighty (180) days after the end of the Plan Year. If Plan Manager utilizes a subcontractor for rebate aggregation services, the cost for that subcontractor shall be included in the fixed Administrative Fee. There shall not be Additional Fees assessed or a portion of the rebates retained for any such services.

3. Plan Manager shall reconcile and report on an annual basis: 1) all sources of revenues derived by relationships with Pharmaceutical Manufacturers, from County's utilization at mail-order, specialty, and retail; and 2) all Pharmaceutical Manufacturer fees that offset costs associated with required clinical applications and/or services conducted by Plan Manager in order to support the dispensing of certain medications. County must receive all Financial Benefits of any kind paid to Plan Manager directly or indirectly from pharmaceutical manufacturers that are attributable to County's utilization. Fees received from pharmaceutical manufacturers resulting from costs for applications and/or services associated with the U.S. Food and Drug Administration (FDA) required clinical applications and/or services, while required to be identified, are not required to be passed to County.

4. Plan Manager shall include any revenues from the above sources in the annual reconciliation process through ad hoc reports included in the Discount & Dispensing Fee reconciliation report and/or with the Rebate reconciliation report, depending upon which area the revenues were generated from.

5. Plan Manager shall provide a system of coverage reviews for selected medications, including the use of step therapy algorithms based on national prescribing guidelines that require trials on less expensive yet equally clinically effective alternatives prior to prescribing more expensive drug therapies.

6. Plan Manager must offer an aggressive Specialty Drug Pharmacy program that includes pricing and clinical applications specific for the specialty program. Pricing shall include discount guarantees per product per retail and specialty channels of distribution.

7. Plan Manager shall, on an annual basis, reconcile the Rebate Minimum Guarantee for each element of the cost proposal, with actual results. Each element will be evaluated independently and surpluses in one pricing element may not be applied to pricing elements in deficit. No Channel or Component offsets are permitted. Plan Manager shall reimburse on a dollar-for-dollar basis to County the calculated financial difference between actual performance for the measure and the guaranteed performance for all components of the pricing guarantee that do not meet or exceed the guarantee. This reconciliation shall occur no more than six (6) months after the end of Plan Year. All branded prescriptions, with the exclusion of reversal and adjustment claims, are considered rebateable and are therefore subject to the rebate reconciliation.

8. Plan Manager shall, on an annual basis, reconcile the discount percentage guarantee for each element of the cost proposal, with actual results. Each element will be evaluated independently and surpluses in one pricing element may not be applied to pricing elements in deficit. No Channel or Component offsets are permitted. Plan Manager shall reimburse on a dollar-for-dollar basis to County the calculated financial difference between actual performance for the measure and the guaranteed performance for all components of the pricing guarantee that do not meet or exceed the guarantee. This reconciliation shall occur no more than six (6) months after the end of Plan Year. With the exclusion of reversal and adjustment claims, all other Claims are subject to the discount guarantee reconciliation. Effective discount is calculated at the contractual ingredient cost divided by the Average Wholesale Price and does not consider patient liability as discount. As such, zero balance claims are to be included in the guarantee analysis.

9. Plan Manager will provide an annual Per Enrolled Employee Per Year Pharmacy Management Allowance credit in February of each Plan Year as detailed in Exhibit D, Schedule of Fees/Discounts.

10. Pharmacy Network Management Requirements
    a. Plan Manager shall provide mail-order and specialty pharmacy services. Any program to encourage use of the mail or specialty pharmacy shall not be implemented by Plan Manager without the express approval of County. Upon request of County, Plan Manager shall accept from the incumbent pharmacy benefits manager, a claims file at no additional charge, which shall be used to transfer Plan Participant's current mail and specialty pharmacy prescriptions and related prior authorizations.
    b. Plan Manager shall offer a retail maintenance pharmacy network, similar in respect to the "Retail Maintenance Network" currently in place, which allows Plan Participants the option to purchase 90-day supplies of prescription drugs at local pharmacies for the same copay (CDH Plan) available through the Mail-Order Pharmacy. The CDH Plan shall also receive the same AWP discount for a 90-day supply dispensed at a retail maintenance pharmacy network as the mail-order pharmacy. Plan Participants in the

HDHP plans will pay based on Plan cost for prescriptions, subject to annual deductible and Maximum Out of Pocket.

c. Plan Manager shall maintain and apply generally accepted medical standards and practices to determine whether prescribed drug treatments provided to Plan Participants are consistent with generally accepted criteria.
d. Plan Manager shall demonstrate, on or before November 1, 2021, that the Network can commence operation on January 1, 2022.

11. Retiree Drug Subsidy (RDS) Program

The RDS Program reimburses County for a portion of the cost for prescription drugs otherwise covered by Medicare Part D, if a Medicare-eligible retiree enrolled in Plan is not enrolled in Medicare Part D. Plan Manager shall administer all components of the Centers for Medicare and Medicaid Services (CMS) Retiree Drug Subsidy (RDS) Program in accordance with Exhibit N.

N. CLINICAL SERVICES

The following programs and associated services are included under the Administrative Fee.

1. MEDICATION MANAGEMENT PROGRAM

1.1. Plan Manager shall provide a medication management program that is consistent with the prior authorization requirements, under the benefit design County currently offers to Plan Participants ("Medication Management Program"). The Medication Management Program is designed to promote appropriate utilization of potentially expensive, misprescribed, and/or abused medications based upon generally accepted current pharmacy practices. Accordingly, pursuant to County's direction, commencing January 1, 2022, and continuing for a mutually agreeable time period, Plan Manager will implement the Medication Management Program on County's behalf and in accordance with the protocols, criteria, forms, and related documents approved by County ("Approved Protocols"). The Approved Protocols are hereby incorporated into this Agreement.

1.2. Upon presentation by a Plan Participant of a prescription that requires prior authorization pursuant to the Medication Management Program, Plan Manager will attempt to have the Plan Participant's prescriber respond to questions specific to the prescription presented ("Physician Form"). Completed Physician Forms will be reviewed by Plan Manager's pharmacist and compared to the Approved Protocols for the applicable medication category. Based upon the results, County hereby authorizes Plan Manager's pharmacists either to authorize or deny coverage of the medication, and Plan Manager shall notify the Plan Participant and prescriber accordingly. A Medication Management Program review will be deemed to have occurred whenever Plan Manager has initiated a prior

authorization following request and attempted to have the Plan Participant's prescriber complete the applicable Physician Form. If after two attempts Plan Manager is unable to obtain a completed Physician Form from the Plan Participant's prescriber, County directs Plan Manager's pharmacists to deny the coverage of the medication and to notify the Plan Participant and prescriber accordingly.

1.3. It is expressly understood that County is solely responsible for construing the terms and conditions of its Plan and the selection of medications that are part of the Medication Management Program. Further, County retains complete discretionary and final authority to make all determinations regarding the Medication Management Program, including, without limitation: (i) payment of claims; (ii) provision of benefits; (iii) review and/or denial of prior authorization claims or requests by Plan Participants; and (iv) resolution of Plan Participant complaints, including the establishment of an appeal and/or grievance process. County will comply with all Federal and State laws, rules, and regulations regarding the denial of benefits.

2. MEDMONITOR RETRODUR PROGRAM

Plan Manager shall provide a MedMonitor RetroDUR Program. The MedMonitor RetroDUR Program consists of Plan Manager (in conjunction with necessary third parties) performing a retrospective review of Plan Participants' prescription claims and medical data (if available and agreed to by the Parties) to evaluate the appropriateness of a Plan Participant's therapy based upon generally accepted current clinical pharmacy practices. If Plan Manager identifies clinical concerns in the judgment of a clinical pharmacist regarding a Plan Participant's drug regimen, Plan Manager will communicate its findings to the Plan Participant's Prescriber in the form of a clinical alert letter.

3. MEDMONITOR MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM

Plan Manager shall provide a MedMonitor® MTM Program that consists of Plan Manager (in conjunction with necessary third parties) performing a medication therapy management review designed to ensure that medications prescribed to Plan Participants are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse medication interactions. Plan Manager will identify Plan Participants and will, if applicable, recommend changes in such Plan Participants' drug regimens to the prescribing physicians and/or the dispensing pharmacists, and if applicable, to the Plan Participants.

EXHIBIT D
Schedule of Fees/Discounts

Plan Manager shall be compensated for all Services provided under this Agreement in accordance with this exhibit.

1. ADMINSTRATIVE SERVICES FEE

County shall pay Plan Manager a monthly Administrative Fee for the Services as specified in Exhibit C, Scope of Services, in accordance with the chart below.

Total Administrative Services Only (ASO) Fee (Health and Pharmacy) Fees paid on a Per Enrolled Employee Per Month basis				
2022	**2023**	**2024**	**2025**	**2026**
$49.49	$49.49	$49.49	$50.48	$51.49

1.1. A monthly Administrative Fee shall be paid to Plan Manager for providing the Services, excluding the services that are paid a separate fee and such fee and service is clearly identified in this exhibit. County shall determine the total dollar amount of the monthly Administrative Fee based upon the County's enrollment records. Administrative Fees shall be remitted to Plan Manager by the 15th calendar day of each month. All disbursements of Administrative Fees shall be processed via Automated Clearing House (ACH) transaction to the financial institution provided by the Plan Manager. If the Plan Manager has not received payment by the due date, payment in full must be made before the end of a thirty (30) day grace period beginning the day after the due date, to ensure Services under this Agreement continue without interruption.

1.2. County shall provide a payment roster to Plan Manager on a monthly basis that includes a breakdown of enrollment by plan (CDH, HDHP Base, HDHP Out-of-Network) and tier of coverage (Enrolled Employee Only, Enrolled Employee plus Spouse, Enrolled Employee plus Domestic Partner, Enrolled Employee plus Children, Enrolled Employee plus Family, Enrolled Employee plus Over Age Dependent, etc.). The payment roster shall be sent via electronic transmission at a time and in a format agreed upon by County and Plan Manager. Plan Manager will take County's payment roster and reconcile with Plan Manager's eligibility records. County and Plan Manager agree to work together to resolve discrepancies in a timely manner and any discrepancies will be handled as a credit or debit when the next payment is due.

1.3. County and Plan Manager will, on at least a quarterly basis, reconcile enrollment data to ensure service is properly administered to Plan Participants and that Administrative Fees have been correctly billed and paid.

1.4. County will establish and maintain a benefits Designated Deposit Account (DDA) for Claim payments that will fund claims checks and Electronic Fund Transfers (EFTs) as detailed in Exhibit P, Banking Arrangement.

2. PHARMACY CREDITS, FEES, DISCOUNTS AND REBATE GUARANTEES

2.1. CREDITS AND ALLOWANCES

County shall receive a PMA credit from Plan Manager once per Plan Year, payable in the second month.

Annual Pharmacy Management Allowance Paid on a Per Enrolled Employee Per Year basis				
2022	**2023**	**2024**	**2025**	**2026**
$15.00	$10.00	$10.00	$10.00	$10.00

The PMA will be credited to County in the 2nd month of each Plan Year based on enrollment in January of the year allowance is credited. If County terminates this Agreement for reason of breach before the end of the Initial Term ending December 31, 2024, County shall refund to Plan Manager within 30 days after the effective date of such termination the full PMA credit applicable to the year of termination. It is the intention of the Parties that, for the purposes of the Federal Anti-Kickback Statute, this PMA credit shall constitute and shall be treated as a discount against the price of drugs within the meaning of 42 U.S.C. § 1320a-7b(b)(3)(A).

2.2. DISPENSING FEES

Plan Manager shall submit an invoice to County for Dispensing Fees monthly. Dispensing Fees shall only be invoiced to County for Dispensed Claims. Plan Manager shall not invoice County for denied, rejected, or reversed Claims, and may invoice only once for adjusted or partially filled Claims. Dispensing Fees shall be based on Pass-Through Pricing.

PASS-THROUGH TRANSPARENCY PRICING SCHEDULE

Channel	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**	**Per Net Paid Claim**
Retail 30 Day:	$0.50	$0.50	$0.50	$0.50	$0.50
Retail 90 Day:	$0.00	$0.00	$0.00	$0.00	$0.00
Mail Service 90 Day:	$0.00	$0.00	$0.00	$0.00	$0.00
Specialty	$0.00	$0.00	$0.00	$0.00	$0.00

2.3. PHARMACY REBATES AND DISCOUNT GUARANTEES

Plan Manager shall pay County the greater of (1) 100% of all Rebates Plan Manager (or any affiliate or subsidiary) directly or indirectly receives that can be attributed to allowable utilization of Plan Participants; or (2) the minimum guarantees as shown below.

Rebates All Brand Drugs (Preferred & Non-Preferred)					
Channel	**2022 Per Net Paid Brand Claim**	**2023 Per Net Paid Brand Claim**	**2024 Per Net Paid Brand Claim**	**2025 Per Net Paid Brand Claim**	**2026 Per Net Paid Brand Claim**
All Brand Drugs (Preferred & Non-Preferred)					
Retail 30 Minimum:	$217.00	$230.00	$240.00	$240.00	$240.00
Retail 90 Minimum:	$800.00	$830.00	$860.00	$860.00	$860.00
Mail Minimum:	$900.00	$930.00	$960.00	$960.00	$960.00
Specialty Minimum:	$2,500.00	$2,750.00	$3,000.00	$3,000.00	$3,000.00

Pharmacy Discount Percentage (% discount from Average Wholesale Price (AWP))					
Channel	**2022 Per Net Paid Claim**	**2023 Per Net Paid Claim**	**2024 Per Net Paid Claim**	**2025 Per Net Paid Claim**	**2026 Per Net Paid Claim**
Brand Formulary Retail 30	18.50%	18.60%	18.70%	18.70%	18.70%
Generic Formulary Retail 30	84.30%	84.40%	84.50%	84.50%	84.50%
Brand Formulary Retail 90	24.75%	24.85%	24.95%	24.95%	24.95%
Generic Formulary Retail 90	84.30%	84.40%	84.50%	84.50%	84.50%
Brand Formulary Mail Service	25.25%	25.35%	25.45%	25.45%	25.45%
Generic Formulary Mail Service	86.80%	86.90%	87.00%	87.00%	87.00%
Brand Specialty Exclusive Network	21.00%	21.10%	21.20%	21.20%	21.20%
Generic Specialty Exclusive Network	21.00%	21.10%	21.20%	21.20%	21.20%

Note: Due to the constant changes in the pharmaceutical industry, these discounts and guarantees are the minimum and the Parties hereby agree that these discounts and guarantees can be negotiated upward each year.

2.3.1. Under the Pass-Through Transparency Pricing, other than for Claims handled via direct Plan Participant reimbursement, County shall pay the actual retail pharmacy rates (drug cost minus the applicable discount shown in the Pharmacy Discount Percentage chart) by Plan Manager plus any applicable Dispensing Fee paid for prescriptions processed and dispensed to a Plan Participant through Plan Manager's retail pharmacy network. For Claims

processed via direct Plan Participant reimbursement, Plan Manager will pass through to County any Rebates actually received in connection with such Claims.

2.3.2. Each Plan Year Plan Manager will perform a reconciliation or "True-Up" of the previous year's mail and retail pharmacy reimbursement rates versus invoiced rates and each such reconciliation or True-Up shall be made no later than 180 days after the close of the Plan Year. Any net positive spread realized by Plan Manager, measuring Brand Drugs in the aggregate and Generic Drugs in the aggregate, will be credited to County within 30 days from Plan Manager's completion and County's acceptance of the True-Up. Notwithstanding the foregoing, County acknowledges that the True-Up will be net of any amounts owed to County under OVERALL DISCOUNT RECONCILIATION below.

2.3.3. OVERALL DISCOUNT RECONCILIATION: Plan Manager will measure all financial guarantees each Plan Year ("Measurement Period") and will report on net performance. Discount calculations are measured using original Ingredient Cost (i.e., MAC, discounted AWP, or usual retail charge, as applicable), which excludes any increases to co-pays or minimum reimbursements. Ingredient Cost also excludes sales taxes and Dispensing Fees, provided that where usual retail charge is adjudicated, the calculation will subtract the contracted Dispensing Fee amount, if any.

a. All results will be measured and reported by Plan Manager to County annually. The annual reconciliation is by Channel (i.e., Retail 30, Retail 90, Mail-Order Pharmacy, and Specialty Drug Pharmacy) and Component within each Channel (i.e., Brand Drugs, Generic Drugs, and Specialty Drugs). No excess discount delivered in one Component may be credited to another Component within that Channel or another Channel (i.e., no offsetting is permitted). Results will include Net Paid Claims with the exception of Over-the-Counter products, Compound Drugs, direct Plan Participant reimbursement Claims, 340B Claims, Indian Health Service and/or Tribal Claims, long-term care Claims, home infusion Claims, Coordination of Benefit Claims, ancillary charges associated with Claims (e.g., fees for the administration of a Covered Drug or vaccines), and Claims filled outside Plan Manager's retail pharmacy network. Specialty Drugs will be included in the annual reconciliation as a separate Channel. Additionally, drugs in short supply, as published within the FDA's Current and Resolved Drug Shortages and Discontinuations Report to FDA index, shall be excluded from all guarantees and, to the extent applicable, for on-site pharmacy Claims, Plan Manager will review Brand Drug and Generic Drug prescription Claims that were filled during the Measurement Period to determine whether financial guarantees were achieved. The overall generic guarantees, brand effective rates, and Dispensing Fees are contingent upon County receiving Plan Manager's services for the entire length of

the applicable Measurement Period. County acknowledges that any amounts owed to County pursuant to this section will be net of any amounts owed to County as a result of the True-Up. Plan Manager will pay County any undisputed amounts due pursuant to this section within thirty (30) days after the reconciliation report date.

b. Notwithstanding the foregoing, County acknowledges that certain factors beyond Plan Manager's control may affect Plan Manager's ability to achieve the guaranteed Discounts including, but not limited to, significant changes in: (i) County's plan design; (ii) the brand/generic status of certain highly utilized drugs; and (iii) applicable law or regulations (collectively, "Changes"). If at any time Plan Manager, in its reasonable discretion, determines that any Changes are likely to materially and negatively affect Plan Manager's ability to meet the guaranteed Discounts, the Parties shall, upon Plan Manager's request, negotiate a mutually acceptable alternative guarantee or other financial arrangement. If the Parties fail to reach any such agreement in writing concerning the aforementioned Changes within forty-five (45) calendar days after the date the Parties begin negotiations, then Plan Manager shall not be required to achieve the applicable guaranteed Discounts affected by such Changes for the Measurement Period in which the renegotiation was requested. Plan Manager shall meet all other guaranteed discounts that are not significantly impacted by such Changes.

2.3.4. The Discounts and the Dispensing Fees set forth above are effective annual average rates. Pricing assumes the continuation of the current plan design and mandatory 90-day supply for maintenance medications. Three (3) retail fills allowed before mandatory 90-day supply requirement.

2.3.5. Plan Manager will not engage in repackaging for pharmaceutical products.

2.3.6. Plan Manager's compensation for its services shall be the Administrative Fee set forth above and other fees in amounts agreed to in writing by the Parties for any additional services authorized by County. Plan Manager and its affiliates disclose that they have entered, and will continue to enter, into agreements with drug manufacturers to receive manufacturer administrative fees of up to five percent (5%) of the Wholesale Acquisition Cost (WAC) of the products dispensed or administered. Plan Manager and County agree that for purposes of this Agreement, all such manufacturer administrative fees are considered Rebates and that Plan Manager will pass such fees through to County in the same manner as any other Rebate. Additionally, Plan Manager discloses that its affiliates, operating as mail service pharmacy, Specialty Drug Pharmacy, and home infusion pharmacy, may purchase covered drugs from drug manufacturers and receive certain discounts and purchase rebates

from drug manufacturers in connection with these purchases. Such discounts and purchase rebates received by these specific affiliates of Plan Manager are not included in the definition of Rebates and are not passed through to County.

Plan Manager may retain any Claims processor or other fees received from Participating Pharmacies in connection with the covered drugs dispensed to Plan Participants under the Plan, including: (a) a per Claim communications charge for on-line electronic Claims processing by point-of-service communication; (b) a charge for each Claim submitted to Plan Manager via paper, tape, or a medium other than point-of-service communication; (c) surcharges for canceled or reversed Claims; (d) a charge if a Participating Pharmacy requests an evidence of benefits report in a tape medium; and (e) charges for marketing and administrative services.

2.3.7. Certain drugs that become available on the market from time to time will not be subject to the mail service pricing rate due to, among other things, a drug's high cost, nominal or negative margin, extraordinary shipping requirements, or generics that have recently come off patent with a six-month exclusivity and may not be available through Plan Manager's mail service pharmacy.

2.3.8. "Single source generics" and/or "Non-MAC generics" include all Generic Drugs that have recently come off patent and do not generate Discounts traditionally delivered by Generic Drugs, in their period of exclusivity or generics with an exclusive pharmaceutical manufacturer. Single source generics will be included in the overall generic drug guarantee.

2.3.9. The effective overall generic discount rate is the only generic rate guaranteed for purposes of retail and mail service pharmacy rates.

2.3.10. Newly available Specialty Drugs approved for coverage as described in the definition of Specialty Drug, will be billed and reimbursed at the default rate of AWP – 14% and will be included for financial reconciliation purposes in the aggregate Specialty Drug discount guarantee provided in this exhibit.

2.3.11. Plan Manager negotiates Rebates based on market share over its aggregate book of business and not solely on behalf of County. Rebates shall be based upon Net Paid Claims submitted on behalf of County. Net Paid Claims means all paid Claims minus reversals or rejections for a single prescription fill. The three-tier rebate guarantees (Retail 30, Retail 90 and Mail-Order, and Specialty Drug) above apply to a qualified three tier plan design with a minimum differential of $15 between preferred and non-preferred Brand Drugs and County's 100% compliance with Plan Manager's Formulary. County's CDHP and HDHP plans as in effect on January 1, 2022, will be included in the Rebate calculations and disbursements. Should

the County implement a different plan design, claims with less than 50% of the total drug cost covered by the plan, or where there is a 100% copay for brands (for example, a discount card plan) will be excluded from Rebate calculations and disbursements. County agrees to discuss any proposed plan design changes or new plan designs with Plan Manager prior to implementation so that Plan Manager can review the proposed changes and advise the County of any impact those changes will have on the pricing structure, Rebates, and any other key terms of the Agreement, including the Scope of Services, Performance Guarantees, Minimum Rebate Guarantees, the Broward County MAC List, and the Formulary and Specialty Pharmacy Drug List.

2.3.12. Effective date of any changes to Rebate arrangements shall be at the beginning of a calendar quarter following the Effective Date of the Agreement.

2.3.13. Except as noted in this section, Plan Manager's affiliated Specialty Drug pharmacy shall be the exclusive specialty providers under this Agreement for Plan Participants.

3. ADDITIONAL SERVICES

In addition to the Services listed in Exhibit C, Scope of Services, the following additional services shall also be included in the monthly Administrative Fee, unless otherwise indicated. Certain services as indicated below are not included in the Administrative Fee and are available for an Additional Fee. This is not an inclusive list. Plan Manager shall not charge for any products or services not specifically represented herein or in Exhibit C unless requested in writing by County, except, the fees set forth herein do not include fees related to the requirements set forth in the Consolidated Appropriations Act, 2021, including the No Surprises Act and the Transparency in Coverage Rule. Proposed additional fees for these new regulatory requirements will be provided to County in writing on a future date once regulatory guidance is received and final compliance requirements are determined. Such additional fees will be subject to negotiation, to the extent permitted by Applicable Law.

Additional Services	**Billable Amount**
Paper Claim Fee:	Included in Administrative Fee
Reports:	
Standard Reporting	Included in Administrative Fee
Ad Hoc Reporting	Reports requiring data within prior two years – Included in Administrative Fee. Reports requiring data prior to two most recent years will be quoted based on complexity of report.
Actuarial Reporting and Associated Fees	Included in Administrative Fee
Standard Format FTP (Billing Transmission)	Included in Administrative Fee

Employer Access to eligibility, claims, reporting (10 users)	Included in Administrative Fee
Online Management Reports	Included in Administrative Fee
ID Cards:	
Welcome Package - ID Cards (2 cards) inclusive of postage with Plan Manager formulary and intro package including mail-order form.	Included in Administrative Fee
Plan Participant/Participant ID Cards – Replacements; inclusive of postage	Included in Administrative Fee
Formulary Management:	
Standard Formulary Management Services	Included in Administrative Fee
Custom Formulary Materials	
Customized Formulary Management Services	
Claim Management:	
Manually submitted paper claims (includes subrogated and direct Plan Participant reimbursement claims), per submitted claim	Included in Administrative Fee
Electronic Claims Processing	Included in Administrative Fee
Prior Authorization Administrative Overrides	Included in Administrative Fee
Coordination of Benefits (COB) per Plan Participant submitted claim	Included in Administrative Fee
Audit Administration (On-site)	Included in Administrative Fee
Eligibility:	
Manual Eligibility Updates	Included in Administrative Fee
Eligibility - Direct Access	Included in Administrative Fee
Group Setup Fees	Included in Administrative Fee
Communications Campaign:	
Customized Letters to Plan Participants Step Therapy or CPA Letters Industry Events Communication Letter	Included in Administrative Fee
Plan Manager Formulary Conversion/Delete Letter	Included in Administrative Fee
Plan Manager New Generic Announcement Letter	Included in Administrative Fee
Plan Participant Communication - Printing	Included in Administrative Fee
Plan Participant Communication - Mailing (e.g. postcards, etc.)	Included in Administrative Fee
Annual Summary of Benefits (ASB)	Included in Administrative Fee
HIPAA-Related Correspondence, per request, per Plan Participant	Included in Administrative Fee
Explanation of Benefits (EOB)	Included in Administrative Fee
Clinical Management:	
Drug Utilization Review Programs	Included in Administrative Fee

Medication Management Clinical Prior Authorization (CPA) Program Bundle	Included in Administrative Fee
Compliance and Persistency (C&P)	Included in Administrative Fee
E-Prescribing Monthly Access	Included in Administrative Fee
E-Prescribing Inquiries	Included in Administrative Fee
E-Prescribing Formulary Inquiries E-Prescribing Claim History Inquiries	Included in Administrative Fee
Outreach Campaigns	
Cost Mgmt Products (e.g. Therapeutic Interchange, Generic Substitution, Dosage Optimization, Mandatory Maintenance, etc.)	Included in Administrative Fee
Medication Therapy Management (MTM) Program	
Medication Therapy Management Program Plan Participants: Includes-Comprehensive Medication Review, Appropriateness of Therapy, High Risk Medications and Compliance & Persistency	Included in Administrative Fee
RetroDUR Program	
RetroDUR Safe & Appropriate Utilization	Included in Administrative Fee
Diabetes Management Program	
$0 Plan Participant copay meter & supplies (specific to Formulary)	Paid through Claims
Adherence Program	
Program 1: Plan Participant Outreach	Included in Administrative Fee
Program 2: Plan Participant & Prescriber Outreach	Included in Administrative Fee
Hospital Transition Program	Included in Administrative Fee
Wellness Program	
Rally Employer Rewards	Shall be invoiced to County monthly based on the dollar amount of gift cards redeemed by Enrollee(s) under the Rally Employer Rewards program.

Custom Formulary & Utilization Management Services	Additional Cost per Unit
A) Full Custom Formulary - Full Custom applies when a client requests a formulary or utilization management program completely different from what Plan Manager offers or when a client requests over 40% customization of an existing Plan Manager formulary or utilization management program (40% of formulary brand and generic drugs). Full Custom also applies to adopting an incumbent's formulary or utilization management program.	Cost will be quoted based on complexity of customization requested.
B) Partial Custom Formulary - Partial Custom applies to when a client requests a customized version of an existing Plan Manager formulary. The range of partial customization is from 5 single drug customizations to 40% of an existing Plan Manager formulary/UM (40% of formulary brand and generic drugs). Requests of over 40% customization become a Full Custom.	Cost will be quoted based on complexity of customization requested.
C) Single/AdHoc Custom Formulary Request - Single/AdHoc Custom applies to when a client requests a single drug change (adding or removing) to an existing Plan Manager formulary. The costs are a multiple of the number of single deviations. If customizations exceed 4 single deviations, the Partial Custom rates will be used.	Cost will be quoted based on complexity of customization requested.

3.1. **SHARED SAVINGS (NAVIGUARD) PROGRAM (See Exhibit E)**

Shared Savings (Naviguard) Program	Fees/% of Savings Achieved/Recovered
Naviguard Program (non-network providers) (New Transparency Laws, replaces prior Facility and Reasonable Charge Program)	25% of savings achieved. The fee per individual claim shall not exceed $15,000.

3.2. **SUBROGATION, PAYMENT INTEGRITY AND RECOVERY SERVICES (See Exhibit E)**

Subrogation, Payment Integrity and Recovery Services	Fees/% of Savings Achieved/Recovered
Third Party Liability (Subrogation Services and Injury Coverage Coordination) (claims incurred by Plan Participant when a third party causes the injury or illness)	30% of gross recovery amount

• Services to prevent the payment of Plan Benefits, or recover Plan Benefits, which should be paid by a third party. • Does not include benefits paid in connection with coordination of benefits, Medicare, or other Overpayments. • Pre-adjudicated claims or post-adjudicated claims. • County will not engage any entity except Plan Manager to provide such services without prior approval from Plan Manager.	
Advance Analytics and Recovery Services (recovery of paid claims for a Plan Participant who was retroactively terminated by County) • Plan Manager's large-scale analytics to identify additional recovery opportunities. • Claims re-examined every month for up to 12 months. • Post-adjudicated Claims.	24% of savings achieved
Focused Orthopedic Health Review (review of claims for orthopedic services)	22% of savings achieved
Focused Claim Review • Review of Claims for inappropriate billing of services not documented in clinical notes. • Board certified, same-specialty medical directors. Pre-adjudicated claims or post-adjudicated claims.	22% of the gross recovery amount
Fraud, Waste and Abuse Management Program (review of claims that may not be legitimate) • Detection and recovery of wasteful, abusive, and/or fraudulent claims. • Search claims for patterns that indicate possible waste or error by identifying specific claims for additional review. • Pre-adjudicated claims or post-adjudicated claims.	32.5% of gross recovery amount
Hospital Bill and Premium Audit Program (retrospective review of paid claims to ensure a correct payment was made based on medical records and codes billed) • In-depth review of hospital medical records or other related documentation compared to claimed amounts to ensure billing accuracy. • Post-adjudicated claims	22% of gross recovery amount

County's assignment of ownership, title, and legal rights and interests in Claims to Plan Manager that are the subject matter of litigation or arbitration (including without limitation a class action) shall not constitute a waiver of County's right to a proportionate share of any recovery resulting

from such litigation or arbitration. This provision shall survive the expiration or termination of this Agreement.

3.3. Plan Manager or its affiliate may provide payment services to the healthcare industry, at no cost to County, and offer medical providers with various payment methods and options, including electronic payments, virtual cards, and checks. Some options are available to medical providers for a fee and may result in the receipt of transaction fees or other compensation (e.g., 1% to 3% of the total transaction amount) by a Plan Manager affiliate.

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EXHIBIT E
Shared Savings (Naviguard) Program, Subrogation, Payment Integrity and Recovery Services

Plan Manager will arrange access for County to receive certain Provider Discounts established by Plan Manager that may be available at the time services are rendered and/or provider fee negotiations occur.

1. SHARED SAVINGS (NAVIGUARD) PROGRAM

1.1. Naviguard – Emergent/Radiology Anesthesia Pathology Labs (RAPL) (Plan Participant Had No Choice). Offers a reimbursement methodology applicable to out-of-network Claims that calculates allowed amounts based on what a healthcare provider generally accepts for the same or similar service. Includes an advocacy component where the Plan Participant can access dedicated resources as well as a dedicated advisor to help Plan Participants stay in-network, and provide assistance in explaining reimbursement methodologies. Plan Participants are held harmless from provider balance billing. Program complies with Applicable Law, including, but not limited to, the Affordable Care Act's minimum reimbursement methodology.

1.2. Naviguard – Non-Emergent (Plan Participant Had a Choice). Offers a reimbursement methodology applicable to out-of-network Claims that calculates allowed amounts based on what a healthcare provider generally accepts for the same or similar service. Includes an advocacy component where the Plan Participant can access dedicated resources as well as a dedicated advisor to help Plan Participants stay in-network, provides assistance in explaining reimbursement methodologies, and helps to avoid and mitigate balance bills. County directs Plan Manager, at Plan Manager's discretion, to increase compensation for a particular Claim if Plan Manager reasonably concludes that the particular facts and circumstances related to a Claim provide justification for reimbursement greater than that which would result from the application of the allowed amount, and Plan Manager believes that it would serve the best interests of the Plan and its Plan Participants (including interests in avoiding costs and expenses of disputes over payment of Claims).

1.3. The "savings" means the amount that would have been payable to a health care provider, including amounts payable by both the Plan Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Plan Participant and the Plan, after the application of the reimbursement calculation.

1.4. County realizes that the Shared Savings (Naviguard) Program and/or fee negotiations are only available with respect to hospital or facility services that are part of the current program structure but that the program structure may change over time.

1.5. Plan Manager may receive recoveries through deducting the amount due from the

next payment to the provider. Recovery is credited back to the benefits DDA within two (2) business days. If recovery is received via check with backup detail, the average time to be credited back to the benefits DDA is seven (7) business days. Checks received without sufficient back up to apply the credit will take longer due to time needed to research.

1.6. Plan Manager will deposit 100% of realized savings from the Shared Savings (Naviguard) Program into benefits DDA bank account and bill County for the agreed upon Fee/% of Savings detailed under Shared Savings (Naviguard) Program as shown in Exhibit D, Schedule of Fees and Discounts, Section 3.1, Shared Savings (Naviguard) Program.

1.7. Plan Manager will report recoveries monthly through Plan Manager's employer billing portal (eServices).

2. SUBROGATION SERVICES

Plan Manager will provide Subrogation services (in addition to routine application of the Coordination of Benefits provisions of the Plan) for identifying and obtaining recovery of Claims payments from all appropriate parties through operation of the subrogation provisions of the Plan.

2.1. Subrogation services will be provided by Plan Manager unless County proposes exceptions that are acceptable to Plan Manager. Such services may only be performed by Plan Manager or by subcontractors and/or counsel selected by Plan Manager.

2.2. Subrogation is typically the recovery of payments for an accident or injury where a third party is responsible. Examples:

- Motor vehicle accident (MVA)
- Animal bites
- Business or premise liability (slip & falls)
- Defective product or equipment
- Workers' compensation
- Medical malpractice from surgical/treatment error

Once identified Claims are investigated for possible sources of recovery, monitored and followed on a regular basis, until appropriate resolution is reached. Claims are typically identified by ICD-10 trauma codes.

2.3. Subrogation services include the following activities:

a. Investigation of Claims and obtaining additional information to determine if a person or entity may be the appropriate party for payment;

b. Presentation of appropriate Claims and demands for payment to parties determined to be liable;

c. Notification to Plan Participants that recovery or subrogation rights will be exercised with respect to a Claim; and

d. Filing and prosecution of legal proceedings against any appropriate party for determination of liability and collection of any payments for which such appropriate party may be liable.

2.4. If this Agreement is terminated, Subrogation services will be continued only with respect to Claims processed under this Agreement and those continued services will be provided by Plan Manager until completion. Subrogation services will cease immediately if the termination of this Agreement results from a material default in the delivery of such subrogation services.

2.5. Subrogation services will be provided by Plan Manager when a group has contracted with a third-party vendor (ex. Stop Loss carrier). Any recoveries are reported to County. County is responsible for any required notifications/reimbursements to its contracted third parties. If Plan Manager is also the contracted Stop-Loss carrier, then County is not responsible for any required notifications/reimbursements to Plan Manager.

2.6. Plan Manager will process recoveries received in the prior month at the beginning of each month. Plan Manager will calculate the appropriate allocations at a Plan Participant claim level, determine fees, create customer reconciliation reporting for employer billing portal (eServices), and apply the debits and credits to the benefits DDA account. This process should typically be completed by the 10th business day of the month.

2.7. Plan Manager shall deposit 100% of realized savings through Subrogation Services into the benefits DDA bank account and bill County for the agreed upon Fee/% of Savings as shown in Exhibit D, Schedule of Fees and Discounts, Section 3.2, Subrogation, Payment Integrity and Recovery Services. However, there will be no cost to County for recovery of Claims payments made in error by Plan Manager. Also, for recovery of Claims payments made in error by Plan Manager, Plan Manager may not be obligated to file and prosecute legal proceedings against persons for determination of liability and collection of any payments. Plan Manager will not be responsible for reimbursement of any unrecovered Overpayment nor attorneys' fees and costs related to litigation or arbitration associated with recoveries except to the extent the Overpayment was due to Plan Manager's failure to meet the Standard of Care or Plan Manager's willful misconduct.

3. PAYMENT INTEGRITY AND RECOVERY SERVICES

3.1. **Overpayments**. Where information about Overpayments is known and available to Plan Manager, Plan Manager will employ appropriate outreach to Plan Participants and/or providers to request reimbursement of Overpayments.

3.2. **Payment Integrity Services**. Plan Manager provides services to help prevent, identify, and resolve irregular claims ("Payment Integrity Services"). Plan Manager's Payment Integrity Services hep guard against potential errors, fraud, waste, and abuse by reviewing claims on a pre- or post-adjudicated basis.

Plan Manager's Payment Integrity Services processes will be based upon Plan Manager's proprietary and confidential procedures, modes of analysis, and investigations. Plan Manager will use these procedures and standards in delivering Payment Integrity Services to County and to Plan Manager's other customers. Services include all work to identify recovery and savings opportunities, research, data analysis, investigation, and initiation of all recovery processes set forth below. Plan Manager does not guarantee or warranty any particular level of prevention, detection, or recovery.

Plan Manager makes available to County an array of standard and optional Payment Integrity Services, as identified in Exhibit D, Schedule of Fees and Discounts, Section 3.2, Subrogation, Payment Integrity and Recovery Services.

3.3. Plan Manager shall deposit 100% of realized savings through Payment Integrity Services into the benefits DDA bank account and bill County for the agreed upon Fee/% of Savings as shown in Exhibit D, Schedule of Fees and Discounts, Section 3.2, Subrogation, Payment Integrity and Recovery Services. However, there will be no cost to County for recovery of Claims payments made in error by Plan Manager. Also, for recovery of Claims payments made in error by Plan Manager, Plan Manager may not be obligated to file and prosecute legal proceedings against persons for determination of liability and collection of any payments. If Plan Manager is unable to recover Claim payments made in error by Plan Manager, Plan Manager shall reimburse County the amount of the Overpayment due to Plan Manager's error.

3.4. **Recovery Process – Non-Class Action Recoveries**. Plan Manager will develop and use standards and procedures for any recovery opportunity, including but not limited to, whether or not to seek recovery, what steps to take if Plan Manager decides to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under which a claim may be compromised or settled for less than the full amount of the potential recovery. In all instances where Plan Manager pursues recovery through litigation or arbitration, Plan Manager will have County, on behalf of its Plan(s), will

be deemed to have granted Plan Manager an assignment of all ownership, title, and legal rights and interests in and to any and all claims that are the subject matter of the litigation or arbitration.

County acknowledges that use of Plan Manager's standards and procedures may not result in full or partial recovery for any particular claim or for any particular customer. Plan Manager will not pursue any recovery if it is not permitted by any Applicable Law, or if recovery would be impractical, as determined in Plan Manager's discretion. While Plan Manager may initiate litigation or arbitration to facilitate a recovery, Plan Manager has no obligation to do so. If Plan Manager initiates litigation or arbitration, County will cooperate with Plan Manager in the litigation or arbitration.

If this Agreement terminates, in whole or in part, Plan Manager can continue recovery activities for any claims paid when the Agreement was in effect pursuant to the terms of this Section 3.

3.5. **Recovery Process – Class Action Recoveries**. Where a class action purports to affect County's (or the Plan(s) it sponsors or administers) right to and interest in any Overpayment, Plan Manager has the right to determine whether to seek recovery of the Overpayment on the County's (or the PlaSan(s) it sponsors or administers) behalf through litigation, arbitration, or settlement. If Plan Manager elects to seek recovery of such an Overpayment that is at issue in a class action, Plan Manager will provide written notice to County of its intention. If County does not want Plan Manager to seek recovery of the Overpayment, County shall notify Plan Manager in writing within thirty (30) days after receiving notice from Plan Manager. If County does not so notify Plan Manager, County, on behalf of the Plan(s) it sponsors and administers, assigns to Plan Manager all ownership, title, and legal rights and interests in and to any and all Overpayments that are the subject matter of the class action. In such cases, County will cooperate with Plan Manager in any resulting litigation or arbitration that Plan Manager may file to pursue the Overpayments.

If County provides Plan Manager with written notice that it does not want Plan Manager to seek recovery of an Overpayment related to a class action (whether putative or certified) then. Pursuant to its standard procedures, Plan Manager will provide County with related Overpayment claims information, at County's request. County is then solely responsible for determining whether it (or the Plan(s) it sponsors or administers) will participate in the class action (whether putative or certified), participate in any class action settlement, pursue recovery of the relevant Overpayment outside of the class action, or take any other action with respect to any cause of action the County (or the Plan(s) it sponsors or administers) might have.

If this Agreement terminates, in whole or in part, Plan Manager can continue recovery activities for any claims paid when the Agreement was in effect pursuant to the terms of this Section 3.

3.6. **Offsetting Process**. Overpayment recoveries may occur by offsetting the Overpayment against future payments to the provider made by the Plan Manager. In effectuating Overpayment recoveries through offset, Plan Manager will follow its established Overpayment recovery rules, which include, among other things, prioritizing Overpayment credits based on: (1) the age of the Overpayment for electronic payments and (2) the funding type and the age of the Overpayment for check payments. Plan Manager may recover the Overpayment by offsetting, in whole or in part, against: (1) future benefits that are payable under the Plan in connection with services provided to any Plan Participants; or (2) future benefits that are payable in connection with services provided to individuals covered under other self-insured or fully-insured plans for which Plan Manager processes payments (a "Cross Plan Offset"). In addition to permitting Plan Manager to recover Overpayments on behalf of the Plan from benefits payable under the Plan through Cross Plan Offsets. County understands and agrees that in doing so, the Plan is participating in a cooperative overpayment recovery effort with other plans for which Plan Manager acts as the claims administrator. Reallocations pursuant to this process do not impact the decision as to whether or not a benefit is payable under the Plan. County represents and warrants that the Plan SPD contains Plan Manager's approved template language authorizing Cross Plan Offsets.

In Plan Manager's application of Overpayment recovery through offset, timing differences may arise in the processing of claims payments, disbursement of provider checks, and the recovery of Overpayments. As a result, the Plan may in some instances receive the benefit of an Overpayment recovery before Plan Manager actually receives the funds from the provider. Conversely, Plan Manager may receive the funds before the Plan receives the credit for the Overpayment. It is hereby understood that the Parties may retain any interest that accrues as a result of these timing differences. Details associated with Overpayment recoveries made on behalf of the Plan through offset will be identified in the monthly reconciliation report provided to the County's Plan. The monthly reconciliation report will contain information relating only to County's Plan and will not contain information relating to other plans for which Plan Manager acts as the claims administrator.

3.7. **Recovery Fees**. County will be charged a fee for the Payment Integrity Services described in this Section 3. That fee is set forth in Exhibit D, Schedule of Fees and Discounts, Section 3.2, Payment Integrity and Recovery Services. No fees will be charged (a) if the Overpayment is solely the result of Plan Manager's acts, or (b) for recoveries obtained through a class action where Plan Manager does not file an opt-out case on behalf of County.

EXHIBIT F
Carrier-Specific Medical Discount Guarantee

UnitedHealthcare® **BROWARD COUNTY GOVERNMENT** | Network Savings Guarantee

UnitedHealthcare Choice Network Savings Guarantee

The Network Savings Guarantee is effective during the incurred period 1/1/2022 through 12/31/2022 and applies to in-network claims paid within 3 months following the end of the Network Savings Guarantee Period.

Commitment

Actual Discount Range	Fees At Risk
Less Than 65.0%	20.0%
65.0% - 66.0%	16.0%
66.0% - 67.0%	12.0%
67.0% - 68.0%	8.0%
68.0% - 69.0%	4.0%
Greater Than 69.0%	0.0%

Plan Manager agrees to reimburse the applicable percentage of the standard medical fees (excluding optional and non-standard fees) at risk noted in the table above based on the shortfall in network discounts achieved and the defined range the result falls into up to a maximum of 20.0% of the standard medical fees (excluding optional and non-standard fees).

The UnitedHealthcare Choice product and savings as presented in this document are available under the following assumptions and conditions*:

- Plan Participants enrolled in a UnitedHealthcare Choice Network 10,927
- Target Network Savings Percentage (Illustrative) 71.0%
- Risk Free Corridor 2.0%
- For the UnitedHealthcare Choice Network to be accessed, a sufficient benefit differential between in and out of network benefits must exist to promote in-network usage. Whether a sufficient benefit differential exists will be measured by UnitedHealthcare with the measurement based on Coinsurance differentials, Deductible differentials, out of pocket maximum differentials, and combinations of the former, among others.
- Savings are defined as the sum of: (1) savings that result from the application of Claims payment logic that bundles Claims, consistent with provisions in Plan Manager's provider contracts, and (2) the difference between the covered billed charges (excluding ineligible and not covered charges) submitted by the Network provider and the amount based on the negotiated rate with that provider. This may also include specially negotiated

discounts with Network providers in outlier Claim situations. No reasonable and customary (R&C) reductions are taken when a negotiated rate is in place with a Network provider. The calculation is performed before the application of Copayments, Deductibles, or other Coinsurance.

- Plan Manager reserves the right to exclude Claims billed utilizing billing software, showing billed charges (excluding ineligible and not covered charges) at or near the negotiated rate from this guarantee.
- Plan Manager reserves the right to exclude all Claims for claimants with covered charges $300,000 or greater during the guarantee period.
- Claims where UnitedHealthcare is the secondary payor are excluded from the Network Savings and Network Savings Factor determination.
- Mental Health/Substance Abuse Claims are excluded.

The table below contains anticipated enrollment by market. The other category is made up of markets with smaller concentrations of Plan Participants.

Market Name	Employees	Plan Participants
MIAMI	5,341	10,864
Other	43	63
Total/Average*	5,384	10,927

Groups added after the plan's effective date will be factored into this guarantee according to their date, size and enrollment by network.

A minimum of 4,856 total employees enrolled in the UnitedHealthcare plan is required for the Network Savings Guarantee to remain in effect.

Plan Manager reserves the right to revise this quotation under the following circumstances:

- The benefits requested and/or quoted change prior to or after the effective date of this quotation.
- An award is not made within 90 days of the issuance of this quotation.
- Changed in federal, state or other applicable legislation or regulation require changes to this quotation.

Plan Manager reserves the right to adjust the Discount Guarantee should provider charge master increases (the rate by which provider charges increase) vary from assumed levels.

*These numbers are estimates only. Final numbers will depend on actual enrollment by Network.

EXHIBIT G
Claims Administration

1.1. County hereby delegates to Plan Manager authority to make determinations on behalf of County or the Contract Administrator with respect to benefit payments under the Plan and to pay such benefits. This section shall not apply to Claims that involve eligibility issues only; such eligibility-only issues, if known by the Plan Manager, shall be forwarded to the Contract Administrator for resolution in a timely manner.

1.2. Plan Manager will accept Claims for benefits under the Plan that are made in accordance with procedures established in the Plan documents and submitted for payment during the term of this Agreement.

1.3. Plan Manager will process Claims in accordance with the provisions of the Plan that are in effect and that have been communicated to Plan Manager by County at the time the services are provided. However, if County modifies the Plan provisions retroactively, Plan Manager shall adjust the payment of applicable Claims to reflect the respective Plan modifications. There may be an additional cost for Plan modifications upon mutual agreement between County and Plan Manager.

1.4. Claims will be processed using Plan Manager's normal claims processing procedures, practices, and rules unless they are inconsistent with the provisions of the Plan. Plan Manager shall comply with applicable U.S. Department of Labor claims procedures, regulations, and guidance with respect to notice procedures and content of a notice of adverse benefit determinations.

1.5. Plan Manager will timely approve or deny claims submitted for payment in accordance with an initial determination by Plan Manager or an appeal of a denied Claim.

1.6. If a Claim is wholly or partially denied, Plan Manager shall provide the Plan Participant with a written explanation of the reason for the denial, and information as to what steps may be taken if the Plan Participant wishes to appeal the claim denial.

1.7. Appeals of denied claims shall be processed in accordance with the applicable provisions of the Plan. Plan Manager shall have the ultimate responsibility and authority to make final determinations with respect to Claims and is responsible for providing Plan Participants with a written explanation of that decision.

1.8. Plan Manager shall accept requests for external review of appeals. Plan Manager shall comply with applicable U.S. Department of Labor claims procedures regulations and guidance with respect to external review.

1.9. With respect to Claims for which provider discounts are available ("Provider Discounts"), Plan Manager shall process Claims under this Agreement taking the maximum Provider Discounts into account.

1.10. Payment of covered expenses for services rendered by a provider is subject to Plan Manager's claims processing edits. The amount determined to be payable under Plan Manager's claims processing edits depends on the existence and interaction of several factors. Because the mix of these factors may be different for every Claim, the amount paid for a covered expense may vary depending on the circumstances. Accordingly, it is not feasible to provide an exhaustive description of the claims processing edits that will be used to determine the amount payable for a covered expense, but examples of the most commonly used factors are:

(a) The intensity and complexity of a service;

(b) Whether a service is one of multiple services performed at the same service session such that the cost of the service to the provider is less than if the service had been provided in a separate service session. For example:

(i) Two or more surgeries occurring at the same service session that do not require two preparation times; or

(ii) Two or more radiologic imaging views performed on the same body part;

(c) Whether an assistant surgeon, physician assistant, registered nurse, certified operating room technician or any other health care professional who is billing independently is involved;

(d) When a charge includes more than one claim line, whether any service is part of or incidental to the primary service that was provided, or if these services cannot be performed together;

(e) If the service is reasonably expected to be provided for the diagnosis reported;

(f) Whether a service was performed specifically for the Plan Participant;

(g) Whether services can be billed as a complete set of services under one billing code.

1.11. Plan Manager develops claims processing edits based on review of one or more of the following sources, which are considered "industry standards," including but not limited to:

(a) Medicare laws, regulations, manuals and other medical related sources;

(b) Appropriate billing practices;

(c) National Uniform Billing Committee (NUBC)

(d) American Medical Association (AMA)/Current Procedural Technology (CPT);

(e) UB-04 Data Specifications Manual;

(f) International Classification of Diseases of the U.S. Department of Health and Human Services and the Diagnostic and Statistical Manual of Mental Disorders;

(g) Medical and surgical specialty certification boards;

(h) Plan Manager's medical coverage policies; and/or

(i) Generally accepted standards of medical, behavioral health and dental practice based on credible scientific evidence recognized in published peer reviewed medical or dental literature.

1.12. Changes to any one of the sources may or may not lead Plan Manager to modify current or adopt new claims processing edits. Any such modifications or new claims processing edits will be applied consistently throughout Plan Manager's claims processing edits with its other clients, and not solely applied to County.

1.13. Non-participating providers may bill Plan Participants for any amount this Plan does not pay even if such amount exceeds these claims processing edits. Any amount that exceeds the claims processing edits paid by the Plan Participants will not apply to Deductibles, out-of-pocket limits or Plan maximum out-of-pocket limits, if applicable. The Plan Participant will also be responsible for any applicable Deductible, Coinsurance amount, or Copayment.

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EXHIBIT H
Performance Measures

In no event shall the payments to County, as a result of Plan Manager's failure to meet Performance Measures, exceed Two Hundred Fifty Thousand Dollars ($250,000) annually, with the exception of the Financial Guarantees as stated in this exhibit: Medical Network Discount Report, Pharmacy Discount Report, and Rebate Report.

Deductions, if any, shall be paid in accordance with Section 6.3 of the Agreement.

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
1.	ID Card Production & Distribution	99% mailed by Plan Manager within 10 business days after final member eligibility is received, system loaded and quality assurance check.	County results	$4,000 Quarterly
2.	ID Cards: Open Enrollment	99% mailed by Plan Manager within 10 business days after final member eligibility is received, system loaded and quality assurance check – no later than December 15 each year.	County results	$4,000 Quarterly
3.	Medical & Pharmacy Eligibility File Load	99% or greater of Usable Eligibility Files received by Plan Manager on any business day will be loaded and active in the on-line claims adjudication system within 48 hours of Plan Manager's receipt.	County results	$4,000 Quarterly
4.	Medical & Pharmacy Eligibility Processing Accuracy	98% or greater of Usable Eligibility Files received by Plan Manager will be accurately loaded (without error).	County results	$3,000 Quarterly
5.	Annual Update System Readiness	Plan Manager will load the new plan year formulary and plan design changes no later than 30 days prior to the effective date.	County results	$2,000 Annually

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
		COUNTY must be in adherence with Plan Manager's Annual Readiness process.		
6.	Average Speed to Answer	80% or greater of all calls shall be answered by Plan Manager within 30 seconds.	Plan Manager's Book of Business results	$1,000 Monthly, Reported Quarterly
7.	Call Abandonment Rate	4% or less of all calls requesting to speak to a member services representative of Plan Manager are abandoned before the caller is connected.	Plan Manager's Book of Business results	$1,000 Monthly, Reported Quarterly
8.	First Call Resolution	90% or greater of all calls to Plan Manager's help desk will be resolved during the initial call.	Plan Manager's Book of Business results	$1,000 Monthly, Reported Quarterly
9.	System Availability	Except for scheduled maintenance periods, Plan Manager's on-line claims adjudication system will be available at least 99% of the time.	Plan Manager's Book of Business results	$1,500 Quarterly
10.	Processing Timeliness	90% or greater of all claims will be processed by Plan Manager within 15 days; 98% of all claims will be processed by Plan Manager within 30 days of receipt.	County results	$4,000 Quarterly
11.	Processing Accuracy	98% of all claims received by Plan Manager shall be processed accurately and in accordance with the County's defined plan specifications.	County results	$1,000 Monthly, Reported Quarterly

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
12.	Financial Accuracy	98% of all claims processed by Plan Manager shall be paid accurately, without financial error, and in accordance with the County's defined plan specifications.	County results	$1,000 Monthly, Reported Quarterly
13.	Paper Claim Processing Time (clean claims)	95% of clean paper claims not requiring additional review will be processed within 10 business days of receipt.	Plan Manager's Book of Business results	$3,000 Quarterly
14.	Paper Claim Processing Time (claims requiring intervention)	95% of paper claims requiring additional review will be processed within 15 business days of receipt.	Plan Manager's Book of Business results	$3,000 Quarterly
15.	Standard Management Reports (See Attachment 1 – Reporting below)	Plan Manager will produce and distribute the standard quarterly management reporting package no later than forty-five (45) calendar days following the end of the respective quarter.	County results	$1,500 Quarterly
16.	3rd-Party Member Satisfaction Survey	Plan Manager will participate in a combined annual member satisfaction survey for Plan Participants who have utilized health and/or pharmacy services. Survey questions will be the responsibility of Plan Manager with the County's review and will be mutually agreed upon with Plan Manager and the County. The cost of the survey will be shared with the dental and vision vendors, based on the volume of questions by each vendor.	County results	$15,000 Annually

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
		Plan Manager will achieve an overall satisfaction rate of 80% or greater in the County's statistically valid survey for areas over which Plan Manager maintains a significant amount of control and provided that the plan design will not be altered during the measurement period. Specifically, member satisfaction is defined as those responses falling in the range of 7 - 10 based upon a 10-point satisfaction scale, with ratings of 7 - 10 equating to "Satisfied." Plan Manager will not be required to pay any of the failure deduction specified, regardless of the results, if 25% or less of the surveys distributed to members are completed and returned.		
17.	Account Management Satisfaction, Scorecard attached. (See Attachment 2-Account Management Scorecard below.)	Plan Manager Account Management Scorecard completed quarterly. Plan Manager must average score of 3 or greater for all rating components.	County results	$6,000 Quarterly
18.	Annual Formulary Update Notification	Plan Manager will provide new plan year formulary to the County 82 days or less, in advance of the new formulary effective date. If the new formulary is not provided 82 days in advance, Plan Manager will, prior to making any changes to the Formulary and	County results	$2,000 Annually

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
		Preventive Drug List that would result in the removal of specific drugs whether generic or brand name, provide such proposed changes in writing to the County. Thereafter, County shall have the discretion to either approve the proposed removal or, if the County does not agree with the proposed removal, then Plan Manager agrees not to make the proposed removal and shall instead retain the current Formulary and Preventive Drug List for the upcoming year only without the cost of a custom formulary. Financial impact regarding minimum rebate guarantees, and member impact related to not making the recommended change will be provided to the County for consideration.		
19.	Member Communication – Change in Formulary tier, prior auth, etc.	Plan Manager will notify members via mail for changes to coverage within an average of 15 business days, i.e.: a drug moving to a higher cost copay tier, a new prior authorization is added to coverage and point of sale safety edits that would stop a claim from processing at the point of sale.	County results	$3,000 Quarterly
20.	Annual Pharmacy Disruption Report and Notification	Plan Manager will notify members who have a recent prescription within 60 days of a negative formulary change of a maintenance medication if Plan	County results	$2,000 Annually

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
		Manager's standard letter is utilized. Plan Manager will provide County with a list of members and negative formulary change.		
21.	Medical Provider Retention	Plan Manager will have no more than 10% loss in each specialty network, including general practice.	Plan Manager's Book of Business results	$1,500 Quarterly
22.	Hospital and/or Large Specialty Practices	Plan Manager will provide no less than 60 days written notice to County of all hospital and large specialty practices with a contract termination date and include all ongoing and in-process negotiations.	County results	$1,500 Quarterly
23.	Retail Pharmacies	Plan Manager shall solicit specific pharmacies at County's request.	County results	$3,000 Quarterly
24.	Mail-Order Pharmacy	Plan Manager will ensure 95% of mail-order drugs are dispensed at the Plan Manager's mail-order facility within two (2) days of receipt of an electronic prescription submission, which requires no intervention. Plan Manager will ensure 85% of electronic prescription submissions which requires physician intervention will be dispensed within an average of four (4) days.	Plan Manager's Book of Business results	$3,000 Quarterly

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
25.	File Exchange	Plan Manager will provide electronic delivery of data files, in the specifications requested by County's consultant, to the data warehouse used by County in less than 15 days following the close of the prior service month.	County results	$1,500 Quarterly
	Total Annual Performance Measures at Risk: $250,000			

Financial Guarantees				
Medical Network Discount Report	Plan Manager will measure and report overall medical network discount achieved as stated in Exhibit F, Carrier-Specific Medical Discount Guarantee.	County results	Annual	Fees at Risk as stated in Exhibit F, Carrier-Specific Medical Discount Guarantee.
Pharmacy Discount Report	Plan Manager will measure and report the overall discount of all Drugs dispensed as stated in Exhibit D, Schedule of Fees and Discounts.	County results	Annual	Fees at Risk as stated in Exhibit D, Schedule of Fees and Discounts.
Rebate Report	Plan Manager will measure and report rebates for all Brand and Brand Specialty Drugs dispensed. Plan Manager will also report Reconciliation methodology, quarterly rebate payments and reconciliation as stated in Exhibit D, Schedule of Fees and Discounts.	County results	Annual	Fees at Risk as stated in Exhibit D, Schedule of Fees and Discount.

EXHIBIT H – Attachment 1
Reporting and Data Requirements

Reporting: Provide timely and accurate account specific reports

- Monthly Reports – by the 20th of the month following the close of the reporting month:
  - Premium vs Claims
  - High-Cost Claimants
  - Fund Recap
  - Bank Statement
  - Detailed Summary of Claim Payments
  - Claim Adjustment
  - Network Savings
  - Pharmacy Claims
  - Shared Savings (Naviguard)
  - Outstanding Checks
  - Arrestee claims with discount applied

- Quarterly Reports within 45 days following the end of the reporting quarter:
  - Health & WellBeing Roadmap Review (including Telemedicine Utilization reporting and Cost Estimator Utilization)
  - Plan Performance Review (including Key Performance Indicators, Catastrophic Medical Claims, Non-Catastrophic Medical Cost Drivers, Outpatient Care Setting, Plan Participant Outreach, Rally Portal Activity and Gift Card Incentive Activity, Pharmacy Trend, Generic Dispensing Rate, Member Paid Share, Specialty Medications, Plan Paid Per Plan Participant Per Month historical trend, Top Disease Categories by Plan Paid, Top Traditional Drug Classes Plan Per Plan Participant Per Month Cost Drivers, Clinical Program Savings, Pipeline Updates, etc.
  - Appeals Report

- Annual Reports within 45 days following the end of the reporting period:
  - Health Plan Review (demographics, utilization, major diagnostic categories, etc.).
  - Access to: UnitedHealthcare eServices Guided Analytical Pathways to pull drill-down reports
  - Ongoing Employer portal to access/manage eligibility, claims, invoices and reporting (standard and ad-hoc)
  - Florida Office of Insurance Regulation Reports: Assist County and Consultant with annual FLOIR reporting requirements for self-funded health plans.
  - Wellness and Disease Management reporting metrics and cost-effective clinical care, disease management and wellness resources/programs.

Data Requirements: Provide timely and accurate specific data files

- Provide identified data to County's Benefit Consultant and/or Benefits Consultant's contracted designee as agreed upon.
- Monthly claims data to third-party data warehouse
    - In current customized format;
    - Plan Manager's standard format; or
    - Modified ad-hoc format at no charge
- Data extract will be in compliance with HIPAA privacy and security regulations, as amended from time to time, and all other applicable State and Federal law and regulations, until such time as Plan Manager is otherwise notified by County to terminate the data exchange.
- Ongoing data extract will be provided within 15 days after closing of month of service.
- Benefits Consultant or contracted designee must enter into a Business Associate agreement with Plan Manager.
- The data exchange between Plan Manager and Benefits Consultant or their designee will be the medical paid claims extract and prescription drug paid claim extract.
- Plan Manager and Benefits Consultant, or designee, shall not disseminate data without prior consent and approval from County.

(Remainder of page intentionally left blank.)

EXHIBIT H – Attachment 2
Account Management Scorecard

County is expected to provide feedback quarterly to Plan Manager via this scorecard. If feedback is not provided on this measure, the assumption is that the measure was met by Plan Manager.
Each measurement will be scored on a scale of one (1) to four (4):

4 points = Exceeds Expectations
3 points = Meets Expectations
2 points = Less than Expectations
1 point = Significantly less than Expectations

The quarterly goal is a score of three (3) or greater in each item.
Quarterly deduction due to an overall average score of less than three (3) is $6,000, paid to County by Plan Manager.

Measurement	**Rating (1-4)**
Communication: Responds to telephone messages and emails provided within one (1) business day.	
Issue Resolution: Acknowledges issues within one (1) business day and resolves them in a timely manner. Resolution timeframe will be determined jointly between Plan Manager and Contract Administrator on a case-by-case basis.	
Meetings: Conducts status/review meetings at mutually agreed upon appointments. Identify new program opportunities and innovations on the horizon.	
Enrollment and other Employee Meeting Support: Provide adequate staffing for open enrollment and other employee facing meetings.	
Average Score	

EXHIBIT I
COBRA/Retiree Administrative Services

DUTIES OF THE PLAN MANAGER

1.1. Plan Manager will provide Claims processing and other administrative services as described in this Agreement with respect to COBRA/Retiree Continuees as Covered Persons under the Plan.

1.2. Plan Manager will not determine questions of eligibility for COBRA/Retiree continuation under the Plan.

1.3. Plan Manager will record a termination date for each COBRA/Retiree Continuee as designated to Plan Manager by County or the COBRA/Retiree Service Provider (the "Termination Date"). After the Termination Date, such individual will no longer be considered a COBRA/Retiree Continuee and a Covered Person. Plan Manager will not provide services under this Agreement with respect to any COBRA/Retiree Continuee insofar as those services may pertain to time periods occurring after the Termination Date.

DUTIES OF THE COBRA/RETIREE SERVICE PROVIDER

2.1. The COBRA/Retiree Service Provider will notify Plan Manager and County of an individual's election of COBRA/Retiree continuation coverage via secure Electronic File Transmission or other agreed upon electronic transfer of data.

2.2. The COBRA/Retiree Service Provider will, in accordance with its regular practices, bill COBRA/Retiree Continuees for the costs payable by them for COBRA/Retiree continuation coverage under the Plan on a monthly basis.

2.3. The COBRA/Retiree Service Provider will, in accordance with its regular practices, collect the amounts billed in accordance with Section 2.2 of this exhibit on a monthly basis from COBRA/Retiree Continuees. A thirty-one (31) day grace period will be allowed for payment of the amount due.

2.4. The COBRA/Retiree Service Provider will, in accordance with its regular practices, provide monthly payment to Plan Manager.

DUTIES OF THE COUNTY

3.1. County will retain a COBRA/Retiree Service Provider who is responsible for providing all notices required by COBRA to Qualified Beneficiaries.

3.2. County understands and agrees that County is solely responsible for compliance with COBRA and for deciding all questions, including matters of clerical error, arising out of COBRA/Retiree Continuees' eligibility for COBRA/Retiree continuation coverage.

3.3. County understands and agrees that Plan Manager is in no way responsible and does not assume responsibility for compliance with any obligations of the Employer under COBRA/Retiree Continuation Coverage. Performance of Services under this Agreement shall not be construed by County that Plan Manager endorses, warrants, or represents that the COBRA/Retiree continuation coverage provided by County is in compliance with any legal obligation of County.

3.4. Notification to Plan Manager and COBRA/Retiree Service Provider by County, of the termination date, qualifying event, and eligibility of an individual to receive COBRA/Retiree continuation coverage.

3.5. Notification to the COBRA/Retiree Service Provider by County or Plan Manager of the appropriate amounts due for coverage under the Plan.

NOTICES

4.1 Plan Manager shall be entitled to rely and act based upon documents, letters, electronic communications, or telephone communications that are confirmed in writing and provided to it by County. Reliance will continue until the time County notifies Plan Manager in writing of any change or amendment to those communications.

4.2 Notices provided by County regarding these COBRA/Retiree Administration Services to Plan Manager shall be provided in accordance with Section 13.10, Notices and Payment Address.

(Remainder of page intentionally left blank.)

EXHIBIT J
Clinical Program Services

These Clinical Program services are performed by Plan Manager in connection with Plan provisions aimed at monitoring quality, containing costs, and promoting efficient delivery of Covered Services (see below) in appropriate settings.

In all circumstances, County understands and agrees that these services are performed solely for the purpose of implementing Plan provisions and assisting in utilization management decision-making that results in the delivery of appropriate levels of Plan benefits. The assistance provided through these services does not constitute the practice of medicine.

None of the Clinical Program services performed by Plan Manager under this Agreement constitute a claims review determination or a guarantee of coverage or benefits eligibility. Benefits eligibility will be determined in the normal course of claims processing.

1. CLINICAL PROGRAM SERVICES

1.1. Precertification, Concurrent Review, and Retrospective Review will be performed by Plan Manager, or a consulting health care professional engaged by Plan Manager, which may use criteria and protocols developed with input from health care experts.

1.2. Plan Manager will provide or arrange for the provision of Precertification services, under applicable Plan provisions.

1.2.1. If a proposed treatment cannot be Precertified:

a. Plan Manager, the person requesting Precertification, and the attending Preferred Provider may, if sufficient information is provided, discuss possible treatment alternatives available under the Plan that might be Precertified.

b. If the attending Preferred Provider chooses not to select possible treatment alternatives that might be Precertified or otherwise wishes to pursue Precertification of the proposed treatment as originally proposed, the Precertification process will proceed to resolution on the basis of available information.

1.2.2. Precertification will be completed within the time periods prescribed in the Plan, or if there are none, within a reasonable time after a request is made.

1.3. During the Precertification and Concurrent Review processes, each hospital admission is evaluated for discharge planning needs, home health care and Case Management potential, as appropriate.

1.4. Plan Manager will provide or arrange for the provision of Concurrent Review services, under applicable Plan provisions.

1.5. Plan Manager will provide or arrange for the provision of Retrospective Review services, under applicable Plan provisions.

1.5.1. For Emergency inpatient admissions, Retrospective Review services will not be performed unless they are requested within the earlier of:

a. The period of time following admission specified in the Plan; or

b. If no time is specified in the Plan, 48 hours following admission.

1.5.2. When required notification is not provided so that Precertification is not performed, Retrospective Review services will be performed only if specifically required by the Plan.

1.6. Notices of the results of the Precertification, Concurrent Review, and Retrospective Review processes, provided in accordance with the provisions of the Plan, will include information about the Plan Manager's standard procedures for having those results reconsidered. Results of these processes do not constitute claims determinations, and reconsideration of these results does not constitute an appeal of a disputed claim.

1.7. Plan Manager will provide or arrange for the provision of Case Management services under applicable Plan provisions.

1.8. Plan Manager will provide or arrange for the provision of the following additional services, under applicable Plan provisions, which services are all included in the Administrative Fee:

1.8.1. **NurseLine Services**: A toll-free, 24-hour medical information line, staffed by registered nurses who are available to answer health-related questions and help Plan Participants decide where to best seek treatment.

1.8.2. **Maternity Program**: The Maternity Program provides a maternity program to eligible Plan Participants. This is a maternity wellness program designed to provide Plan Participants with personal guidance and support. This program may include access to: dedicated maternity nurses experienced in high-risk pregnancies and premature births; pregnancy consultations; support for special health care needs; customized maternity education materials and integration with other applicable care management programs Plan Manager provides to County as set forth in this Agreement.

1.8.3. **Neonatal Resource Services**: Neonatal Intensive Care Unit (NICU) Management: Specially trained case managers promote the highest standards of care for NICU infants and work with Plan Participants throughout the NICU stay to help them prepare for a smooth transition home.

1.8.4. **Gaps in Care**: clinical rules engine leverages expert medical opinions to identify gaps in care that address potential medical errors and instances of sub-optimal medical treatment. The established clinical rules compare a patients' pharmacy, laboratory and claims data to industry standard Quality of Care guidelines to identify patients at risk of highly specific patient-centric problems. Examples include: a misdiagnosis, a flawed surgical treatment or medical management, and lack of follow-up care or preventive treatment. In addition, a variety of preventive and pharmacy rules are included such as drug-to-drug interactions and drug-to-disease interactions. When gaps in care, drug to drug interaction, drug to disease interaction or a preventive reminder is identified, an alert and a message, if appropriate, are generated to communicate the findings through physician and member messaging.

1.8.5. **Preventive Reminders**: Proactive, targeted campaigns that deliver messages to Plan Participants of primary prevention care. Messages are delivered in a variety of methods including phone calls (live and voice activated), mail, text message or emails. Topics include mammography screenings, vaccinations, immunizations and more.

1.8.6. **Transplant Management/Transplant Resource Services**: Transplant Management Program Provides hands-on support to covered persons in need of organ and tissue transplants. They guide covered persons to Plan Manager's National Transplant Network (NTN), designed to deliver a superior transplant experience. They review coverage, coordinate benefits, facilitate services, and follow the transplant recipient's progress from initial referral through treatment and recovery.

1.8.7. **Personal Health Support Tier 3.0 (PHS)**: Plan Manager will provide a chronic condition management program utilizing PHS. The PHS program is designed based on a whole-person philosophy and to provide support to Plan Participants through reviewing Plan Participant's health history, behaviors, social factors, and willingness to engage in improving their health.

PHS encompasses more than 100 conditions under one unified service model for chronic care, disease management, complex care, etc. The program uses predictive modeling to identify signals of existing, rising and emergency risk, which produces the highest possible end-to-end engagement and overall Plan savings.

PHS engages identified Plan Participants through technology-driven outreach, a personalized care plan, coaching, and physician engagement.

Physician engagement includes notifying treating physician by mail or fax of the Plan Participant's participation in the program. Treating physician is also notified by phone when an evidence-based gap in care is missing or to obtain

necessary medical information to appropriately manage the condition and improve the Plan Participant's health outcomes.

Plan Manager agrees to provide County and Benefits Consultant with all the necessary reports to monitor progress of PHS including, but not limited to, monthly reports on actual intervention, places of services (outpatient, inpatient, pharmacy) and total dollar spend for each. If Plan Manager cannot provide this information as part of its standard reporting, Plan Manager will work with County and Benefits Consultant to provide this information.

1.8.8. **Behavioral Health Solutions**: Addresses medical and co-morbid behavioral health conditions. Teams of care managers integrate the delivery of care plans and other guidance so that a primary contact will address both physical and behavioral health conditions. Clinical associates screen Plan Participants for behavioral health conditions to proactively identify Plan Participants who might benefit from an integrated care plan.

1.8.9. **Health Fair Facilitation Services**: Help County plan and run a health fair event. A Health Fair Facilitator works with the County to understand their wants and needs, such as what topics to cover and a budget. The Facilitator will connect with local resources and providers for content and fair participation and will provide onsite coordination at the Health Fair. Fees from third party vendors are not included in this service.

1.8.10. **Wellness Coordinator (Nurse) and Wellness Nutritionist**: Provides ongoing support to the County for onsite wellness activities. Both Wellness Coordinator and Wellness Nutritionist serve as resources for the Employees and are trained in a field such as exercise science, nursing, public health or nutrition. They will work with the County to establish a wellness strategy and provide facilitation of events such as workshops and seminars, worksite health screenings, health fairs, employee campaigns, and walking programs.

1.8.11. **Wellness Telephonic Health Coaching and Online Program**: Allows Plan Participants to elect to receive a series of telephone calls from behavioral health specialists, health educator coaches or registered nurses regarding six main wellness topics including: physical activity, nutrition, stress management, weight management, back care and tobacco cessation. Plan Participants can reach out to their "coach" as often as needed. Offered in conjunction with Health Coaching, Plan Participants will receive tailored communication based upon a confidential topic assessment, including a written personalized action plan and a series of newsletters.

1.8.12. **Transition of Care**: Changing health care plans can be stressful, especially for those who are going through intense medical treatment, such as chemotherapy. The transition of care process helps Plan Participants make a

smooth transition to a new Preferred Provider from their current Preferred Provider with the least amount of disruption to their care.

1.8.13. **Continuity of Care**: If a provider is no longer a participating provider, Plan Participants may be able to continue treatment with the same provider for up to 90 calendar days if they are undergoing active treatment for a chronic or acute medical condition after the provider's termination with the participating provider's network. For pregnancy, if the Plan Participant is in the 2nd or 3rd trimester, continuity of care is available through a 6-week postpartum period. Continuity of care is available only if the provider continues to practice in the geographical area of the network and the termination of the participating provider's contract was not due to misconduct on the part of the provider.

1.8.14. **Telemedicine Program**: Allows Plan Participants to access remote medical services via real-time, two-way communications with a contracted network of telemedicine providers.

1.8.15. **Transparency Tool**: Provides access to cost and quality information for procedures and tests allowing Plan Participants to make informed decisions.

1.8.16. **Orthopedic Health Support**: Decision support program that helps inform Plan Participants of less invasive, alternate treatments to surgery. Plan Participants who need surgery will also be able to utilize one of UnitedHealthcare's Centers of Excellence for their procedure.

1.8.17. **Diabetes Health Plan**: Based on a Plan Participant being either diabetic, pre-diabetic or having high blood pressure with high cholesterol, Plan Manager will automatically enroll the Plan Participant in the Diabetes Health Plan. This plan allows the member to have lower costs for medical services and prescriptions for their condition along with more clinical support to help them manage their condition.

1.8.18. **Bariatric Resource Services**: Bariatric Resource Services helps reduce complications associated with weight loss surgery for morbid obesity. This offers a single source for information and support for Plan Participants seeking bariatric surgery. It is a comprehensive solution to help manage obesity-related bariatric surgical costs, ensure the appropriateness of surgery, and improve the quality of life for the Plan Participants. The program also addresses significant health care expenses associated with co-morbid conditions, length of stay, complications, prescription and other related medical costs.

1.8.19. **Quit4Life**: Quit For Life® is a clinically proven tobacco cessation program that combines digital and telephonic tools and resources, along with physical, psychological and behavioral strategies, to provide Plan Participants with a

personalized quit plan to overcome their nicotine addiction, including smoking and vaping.

1.8.20. **Real Appeal**: Real Appeal takes an evidence-based approach to support weight loss. The program helps people make small changes necessary for larger long-term health results, based on weight-loss research studies commissioned by the National Institutes of Health. Real Appeal uses a highly interactive internet show, videos and live online coaching to drive small behavior changes.

1.8.21. **CDH PLAN ONLY Pharmacy Copay Waiver Program**: The Pharmacy Copay Waiver Program is designed to benefit Plan Participants enrolled in the County's Consumer Driven Health Plan (CDH). Once Plan Manager is notified by the Benefits Administration Team that the eligibility requirements are met, the program will waive the cost of generic and preferred formulary medications for the following diseases: Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), Diabetes and Hypertension

Only drugs that are classified in the generic or Tier 1 drug therapeutic class for the eligible disease state will be covered.

2. PREFERRED PROVIDERS

County agrees that Plan Manager shall not be held responsible for the actions of Preferred Providers acting as licensed professionals within the scope of their professional practice, and that in no event shall the indemnity provisions of this Agreement apply against the Plan Manager with respect to any expense caused by the acts or omissions of Preferred Providers.

3. REPORTS

3.1. Plan Manager agrees to provide a monthly report to County on costs, costs by group, product, and other monthly financial statistics.

3.2. Plan Manager agrees to provide quarterly Health Plan Reviews to County on costs, costs by disease state per Plan Participant, and monthly utilization statistics.

3.3. Plan Manager agrees to provide County and Benefits Consultant with all the necessary reports to monitor progress of any of these programs including, but not limited to, monthly reports on actual intervention, places of services (outpatient, inpatient, pharmacy) and total dollar spend for each. If Plan Manager cannot provide this information as part of its standard reporting, Plan Manager will work with the County and Benefits Consultant to provide this information.

4. MISCELLANEOUS

4.1 Plan Manager will provide these Clinical Program services in accordance with the provisions of the Plan that are in effect and have been communicated to the Plan Manager by the County at the time the services are provided.

4.2 If the Contract Administrator directs Plan Manager to make a Clinical Program services determination that is different than the determination that would otherwise be made by Plan Manager, Plan Manager will follow the determination of the Contract Administrator, provided the Contract Administrator's determination is first communicated to Plan Manager in writing.

However, Plan Manager may decide that it will communicate this determination only as directed in special written instructions from the Contract Administrator that are acceptable to Plan Manager.

4.3 County agrees to pay for the incentives provided to Plan Participants who comply with the criteria outlined in this Exhibit.

5. ADDITIONAL TERMS

5.1 CDH Plan Only: Preventative or diagnostic mammogram and/or colonoscopy: Plan Manager agrees that a Plan Participant's first mammogram and first colonoscopy each Plan Year will be at no cost to the Plan Participant when test is performed at an in-network free standing diagnostic facility.

5.2 All HDHP Plans: First Colonoscopy is covered in full if the visit is preventive. In addition, all related services (anesthesiologists, pathologists, etc.) when performed at a participating facility are to be paid at 100% of billed charges even if the anesthesiologist, pathologist etc. is non-participating. If the related services (anesthesiologists, pathologist, etc.) are performed by a participating provider, those services are to be allowed at full member benefit.

5.3 Hearing Testing and Hearing Aids: Plan Manager agrees to provide coverage for hearing testing and hearing aids. Benefits are limited to $1,500 per ear per Plan Year.

5.3.1 All HDHP Plans: $1,500 per ear benefit subject to meeting Annual Deductible first.

5.3.2 CDH Plan: Deductible and copay not applicable to maximum annual benefit.

EXHIBIT K
Networks

Plan Manager shall market, develop, organize, implement, operate, and maintain a national Network for all Plans. While County understands that contracts are between Plan Manager and providers, facilities, and pharmacies, Plan Manager shall maximize participation to ensure a successful and robust Network.

1. Plan Manager shall engage one or more national Networks to provide Covered Services under the Preferred Provider Services provisions of the Plan, within each Service Area served by the Networks. The Plan Manager shall provide a listing of Network locations and Preferred Provider locations within each Service Area.
2. County agrees that Plan Manager shall not be held responsible for the actions of Health Care Providers, including providing health care services, and that in no event shall the hold harmless and indemnity provisions of this Agreement apply against the Plan Manager with respect to any expense caused by the acts or omissions of Health Care Providers.
3. Plan Manager shall provide a national Network of retail pharmacies, a mail-order/home delivery pharmacy for 90-day prescriptions, and a specialty pharmacy to provide personalized support for Plan Participants with complex conditions.
4. Plan Manager represents that provider agreements entered into by Plan Manager in connection with its obligations under this Agreement comply with all of the requirements of applicable law. With respect to its obligations under this Agreement, Plan Manager will exercise due diligence in selecting Health Care Providers, facilities, labs, and pharmacies.
5. Plan Manager acknowledges that providers of professional health care services under contract with a Network maintained by Plan Manager or by companies under Plan Manager's common control comply with credentialing standards no less stringent than those prevailing in the industry.
6. Plan Manager shall notify County sixty (60) days prior to contract expiration date and communicate the status of negotiations for both facilities and largely utilized provider groups.
7. Plan Manager shall report annually the aggregate number of new and terminated Network providers.
8. Plan Manager shall ensure Network providers are practicing generally accepted medical standards and practices to guarantee adherence.
9. Network Identification:

HEALTH PLAN	NETWORK NAME
HDHP Base	Choice
HDHP Out-of Network	Choice Plus
CDH	Choice

Preferred Lab Network (all Health Plans)	• AmeriPath / Dermpath Diagnostics • BioReference Laboratories • GeneDx • Invitae • LabCorp & Subsidiaries • Mayo Clinic Laboratory • Millennium Health • Quest Diagnostics, Inc.
Pharmacy Network	• Large National Network with retail chains (Costco, CVS, Pill Box, Publix, Target, Walgreens, Walmart, Winn Dixie, and more) • Mail-Order/Home Delivery – OptumRx • Specialty – OptumRx Specialty Pharmacy

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EXHIBIT L
Persons Authorized to Receive Private Health Information

Name:	Lisa Morrison
Title:	Human Resources Manager
Company:	Broward County
Address:	115 South Andrews Avenue, Room 514 Ft. Lauderdale, FL 33301
Telephone:	954-357-6720
Fax:	954-728-2777
Email:	lmorrison@broward.org

Name:	Jahan Garassino
Title:	Administrative Officer
Company:	Broward County
Address:	115 South Andrews Avenue, Room 514 Ft. Lauderdale, FL 33301
Telephone:	954-357-6739
Fax:	954-728-2777
Email:	jgarassino@broward.org

Name:	Paul Raikes
Title:	Accountant
Company:	Broward County
Address:	115 South Andrews Avenue, Room 514 Ft. Lauderdale, FL 33301
Telephone:	954-357-6732
Fax:	954-728-2777
Email:	praikes@broward.org

Name:	Jennifer DiBono
Title:	ADA Administrator/HIPAA Privacy Officer
Company:	Broward County
Address:	115 South Andrews Avenue, Room 427 Ft. Lauderdale, FL 33301
Telephone:	954-357-6581
Email:	jdibono@broward.org

Name:	Susan White
Company:	USI Insurance Services, LLC
Address:	2400 E. Commercial Blvd., Suite 600 Ft. Lauderdale, FL 33308
Telephone:	954-607-5252
Email:	susan.white@usi.com

EXHIBIT M
Wellness Program

Plan Manager agrees to provide a comprehensive Wellness Program for the benefit of Employees.

1. Wellness Program Administration and Resources

1.1. Fees for the Wellness Program are included in the Administrative Fee; except for Rally Employer Rewards, which are invoiced to County monthly based on the dollar amount of gift cards redeemed by Enrollee(s) under the Rally Employer Rewards program. Enrollees must redeem gift cards no later than June 30th of the following Plan Year or rewards earned under the Rally Employer Rewards program will be forfeited.

1.2. Plan Manager agrees to support wellness and the County's Wellness Resource Centers during the Term with a guaranteed annual wellness budget of $300,000 that includes health fairs, on-site flu shot, incentives, marketing promotion materials, printing expenses, and other direct costs associated with all wellness activities for this purpose. The annual wellness budget is included in the Administrative Fee. Any balance remaining at the end of the Plan Year will be paid to County by March 31st of the following contract Plan Year.

1.3. The wellness account will be reconciled each month by Plan Manager with monthly reporting to the County. County shall discuss with Plan Manager and approve of all expenses paid out of the wellness account prior to such expenses being incurred.

1.4. Plan Manager agrees to provide a Wellness Coordinator (registered nurse) five (5) days a week and a Nutritionist five (5) days a week for Employee consultation and wellness activities programs at various locations throughout the County, as mutually agreed to by the Parties.

1.5. Plan Manager agrees to meet with County once per month to review wellness activities. The meetings will include personnel including but not limited to Account Manager, Wellness Coordinator, nutritionist, and representatives from Benefits Administration Team.

1.6. Plan Manager will report to County the Biometric Screening and Health Risk Assessment compliance of the Enrollees.

1.7. Plan Manager agrees to assist in the logistics and problem solving to report data regarding Biometric Screening and Health Risk Assessment compliance.

1.8. Plan Manager shall provide eleven (11) HIGI Health Stations to County at locations specified by County.

2. Rally Digital Health Experience

Rally employs industry-leading technologies, gaming, and social media to help engage Enrollees enrolled in a County Health Benefits Plan in new ways. Interactive capabilities challenge Enrollees and their families to take greater daily ownership of their health. The Rally platform offers an experience designed to help Enrollees feel empowered and motivated through simple, fun interactions and personalization.

The Rally experience includes:

2.1. **The Rally Health Survey:** Easy-to-use across multiple devices—including smartphones, tablets and computers—the survey goes beyond physical health risks to ask members about emotional and financial well-being, and social and community connections. Based on the responses, plus claims and biometric data (when available), Rally creates personalized recommendations for Enrollees.

2.2. **Rally Age:** Survey answers generate a "Rally Age," compared to the Enrollee's actual age, to reveal how lifestyle affects an Enrollee's health and to give a basis for engagement in simple activities to improve health, called Missions.

2.3. **Missions:** Personalized actions in four categories—Move, Eat, Feel and Care: Actions are presented in order of priority for the Enrollee. Missions may include weight training, eating more whole grains, walking 2,000 steps a day, de-cluttering for 10 minutes, stretching or other activities. As Enrollee engages, they receive in-the-moment behavior reinforcement via email and the Rally mobile app. The immediate feedback encourages sustained engagement.

2.4. **Challenges:** Challenges are another integral part of the Rally experience, designed to engage through friendly competition. Enrollees can traverse virtually through city-specific locations to monitor activity and track progress.

2.5. **Communities:** Communities leverage social media and connectivity with Enrollees with similar health concerns and interests. Communities are recommended based on survey results and may include fitness and exercise, heart health, sleeping better, cold and flu, and more. These social networking groups are anonymous and drive motivation and compassion.

2.6. **Rewards:** Enrollees can earn Rally coins from Plan Manager's proprietary virtual coin economy for completing activities on Rally (e.g., completing the Survey, checking in to a Challenge and/or Mission, etc.) and can then use their coins to enter bi-weekly sweepstakes sponsored by Plan Manager.

2.7. **Tools:** A key tool provided by Rally is the Personal Health Record (PHR). The PHR is a personal health hub containing each Enrollee's health information, including allergies, conditions, surgeries and procedures, medications, and clinical tests and healthcare professionals. The health care professional's category features an ability to add information that may be provided by an Enrollee's primary care physician or other provider. Enrollees can print their Rally PHR and take it with

them to provider appointments. Rally also enables providers to see PHR through a provider portal.

2.8. **Device Integration:** Rally easily integrates with fitness devices including Fitbit, Jawbone and BodyMedia, and the data can populate information into Missions and Challenges. Enrollees can sync multiple devices to their Rally account, making it a one-stop solution for data and progress tracking.

2.9. **Evidence-based Health Content:** Rally supports online content (RSS, blogs) and on-site licensed content. In addition, Rally has a growing library of custom original content, including exclusive infographics. Rally's dynamic content management system recommends articles to Enrollees based on their interaction and progression through the site.

3. Wellness Coaching

Wellness Coaching programs help Enrollees take a proactive and long-lasting approach to health and wellness through lifestyle changes that decrease or prevent chronic disease and increase productivity. Wellness coaches use evidence-based practices based on stages of change to achieve healthier outcomes. Wellness coaches engage, guide and coach toward a healthier lifestyle using market-leading, Enrollee identification methods, broad stratification criteria, the expertise and insight of the population health consultants, and Plan Manager's comprehensive communication and reporting capabilities. Wellness Coaching synchronizes with programs across the care management portfolio to improve the health of each Enrollee, regardless of status—whether Enrollee is in good health, living with a chronic condition or trying to live a healthier lifestyle. Our Wellness Coaching programs include the following:

- Tobacco Cessation
- Weight Management
- Diabetes Lifestyle
- Heart Health Lifestyle
- Stress Management
- Exercise
- Nutrition

4. Biometric Screenings

Biometric Screenings measure total cholesterol, high-density lipoprotein (HDL) and ratio cholesterol screening, glucose screening, blood pressure and Body Mass Index (BMI). Know Your Numbers is a turnkey operation with end-to-end program coordination, configurable flyers for promotion and communication, and online registration. It integrates with other solutions offered by Plan Manager and serves as a valuable tool for referring Enrollees to available programs, such as Wellness Coaching and condition management, to address identified health risks.

Enrollees who are unable to attend a biometric screening event or are in remote locations can schedule a biometric screening at participating Quest Patient Service Center locations.

5. Wellness Coordinator and Wellness Nutritionist/Health Coach

The Wellness Coordinator (a registered nurse) and Wellness Nutritionist play a key role in activating and engaging Employees in the health and wellness programs available to them. The Wellness Coordinator and Wellness Nutritionist serves as a key resource in educating and empowering Employees to improve care access and enhance health care decision-making.
The Wellness Coordinator will educate Employees on the importance of preventive care as well as chronic disease management and encourage Employees to take advantage of screenings that can prevent serious illness.

To evaluate engagement and outcomes, Plan Manager utilizes a customer-specific dashboard that provides Enrollee-level information tracking including: primary physician engagement, eligibility for condition management programs, emergency room utilization, and wellness and mammography screening utilization. The Wellness Coordinator will use this dashboard to guide Enrollees to health and well-being by promoting care management programs and providing on-site health education to manage chronic conditions.

The Wellness Coordinator's responsibilities typically include:

- Educating Employees on appropriate care settings
- Providing referrals to condition management programs
- Educating Enrollees on proper medication compliance
- Promoting the value of generic medications, when appropriate
- Explaining and educating Enrollees on biometric screening results and actions to improve
- Planning on-site condition management programs and support and implementing wellness programming
- Providing ongoing support and encouragement to build trusting relationships
- Educating Enrollees on evidence-based medical compliance with chronic condition management

Additionally, the Wellness Coordinator facilitates Plan Manager's United At Work series of preventive care and wellness seminars that can be delivered in a group setting, WebEx or podcast format. United At Work includes topics on general health and wellness, nutrition and exercise, how to get the most out of health benefits, preventive care, managing and preventing health conditions and more.

The Wellness Nutritionist's responsibilities typically include:

- Providing healthy lifestyle coaching
- Educating Employees on healthy eating options to maximize health and manage chronic conditions and disease states
- Personalizing meal plans and recipes
- Providing healthy cooking sessions (virtually or in-person)
- Attending health fairs and other on-site events

Plan Manager will report Wellness Coordinator's and Wellness Nutritionist's activities and

outcomes to the County by providing a quarterly, activity-based scorecard demonstrating the penetration and activities of the Wellness Coordinator. Plan Manager will provide an annual performance review that captures outcomes and decisions made by Employees who were engaged with the nurse versus Employees not engaged.

EXPECTED OUTCOMES

Overall goals of the Wellness Coordinator and Wellness Nutritionist program is as follows:

- Improve Enrollee engagement with: **myuhc.com** registration and utilization, Health Survey completion, online Missions and Challenges participation and completion, and Advocate4me utilization
- Increase referrals to premium-designated providers
- Increase referrals and enrollment to clinical programs
- Increase physician referrals as a result of on-site biometric risk screenings
- Increase participation in on-site educational classes
- Increase appropriate consumer decision making

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EXHIBIT N
Retiree Drug Subsidy Requirements

Medicare Part D Subsidy – Retiree Drug Subsidy (RDS) program falls under the Centers for Medicare and Medicaid Services (CMS) which continues to refine and clarify rules for the RDS program. The Medicare Part D RDS provides employers with a tax-free subsidy payment of up to 28 percent of allowable retiree prescription drug costs attributable to gross prescription costs between $250 and $5,000 per qualifying covered retiree.

A qualifying covered retiree is a Part D eligible individual who is not enrolled in a Part D plan, but is a Plan Participant, or the spouse or dependent of a Plan Participant, covered under employment-based retiree health coverage that meets the criteria for a qualified retiree prescription drug plan. The Plan determines if an individual is covered under employment-based retiree health coverage in accordance with the plan rules. An individual is presumed not to be covered under employment-based retiree health coverage if, under the Medicare Secondary Payer (MSP) rules, the person is considered to be receiving coverage by reason of current employment status. The presumption applies whether or not the MSP rules actually apply to the employer.

Plan Manager shall continue to develop reports that County may use to meet the Part D reporting requirements as they have been communicated by CMS. Reports currently available or in development status are subject to modification as CMS continues to refine their requirements.

Plan Manager, through OptumInsight, shall provide the following RDS services:

1. Interim Cost Report Monthly Submission to CMS
2. Annual Reconciliation File to CMS
3. RDS Actuarial Attestation
4. Subsidy Enrollment Updates to CMS
5. Creditable Coverage determination (pass/fail).

Plan Manager shall, subject to County approval, draft, finalize, and mail an annual Creditable Coverage Disclosure Notice to all Plan Participants who will be age 65 in the following Plan Year on or before the deadline of October 15 of each Plan Year.

EXHIBIT O
Claims Processing for Arrestees

1. For purposes of this Agreement, "Arrestee" means an individual that is ill, wounded, or otherwise injured during or at the time of arrest in Broward County for any violation of a state law or a Broward County ordinance, and for which Broward County is responsible for the costs of medical care, treatment, hospitalization, and transportation pursuant to Section 901.35, Florida Statutes.

2. A division, "Human Services Group," will be created under the primary Broward County Government group. Plan Manager will process and adjudicate claims for Arrestees of the Human Services Group at the negotiated, discounted rates under the HDHP Base plan. Claims are not subject to deductible or maximum out of pocket. There will be no other services such as pharmacy, wellness, HSA, case management, stop loss coverage, etc. provided related to claims under the Human Services Group. The Human Services Group is only for claims processing purposes.

3. Process for arrestee claim payment:
   i. Medical provider/facility bills the Broward County Human Services Department for Arrestee medical services.
   ii. Human Services Department reviews claims for accuracy.
   iii. Plan Manager receives Arrestee claim from provider/facility.
   iv. Human Services Department notifies Plan Manager of approval or denial of Arrestee claim.
   v. Plan Manager pays provider/facility for approved claim.
   vi. Plan Manager draws from a demand deposit bank account (DDA) maintained by the Human Services Department solely for arrestee claims. The DDA maintains a minimum required balance as determined by Plan Manager, not to exceed $55,000.
   vii. Human Services Department reconciles DDA and audits paid claims.

4. Arrestee claims do not apply to Stop Loss, pharmacy, wellness, HSA, or case management. This exhibit is only for processing and adjudication of Arrestee claims. Arrestee claims are not included in any actuarial calculations or rates. The Affordable Care Act (ACA) maximum annual out of pocket amount does not apply to Arrestee claims.

EXHIBIT P
Banking Arrangement

County and Plan Manager have entered into the Agreement whereby Plan Manager administers benefits pursuant to the provisions of the Plan. In connection with the Agreement, County has requested that, as to the Plan, Plan Manager establish a benefits demand deposit bank account ("benefits DDA") at a banking institution named by County (currently Bank of America) to draw from to pay Claims, expenses, and other fees, and into which County will deposit and maintain funds from the County's Concentration Account. County is solely responsible for any and all federal, state, local or other governmental demand, charge or tax (by whatever named called) assessed against or imposed upon Plan Manager arising out of Plan Manager's establishing a bank account for County and/or making such aforementioned payments.

The benefits DDA account will be known as:
UnitedHealthcare Administered Plan for Broward County

The benefits DDA will be used to pay benefits, fees, and other charges for Plan Participants covered under the County's Plan. Drafts in payment of these benefits will be drawn by Plan Manager. Expenses paid through the benefits DDA will be those fees and other charges County authorizes Plan Manager to collect through this account. The benefits DDA will maintain a minimum required balance as determined by Plan Manager.

County will make an advanced claim funding payment to the benefits DDA in the amount of One Million Seven Hundred Forty-six Thousand Dollars (**$1,746,000.00**). This amount represents an estimated six (6) days of claims expense activity with respect to the Plan.

No Claims payments will be made until the advanced claim funding amount is received by the Plan Manager no later than one (1) business day before the effective date of the Plan.

The advanced claim funding amount will be increased if the benefits DDA incurs overdrafts due to an inadequate advanced claim funding amount. If it is later determined that an increase in the amount of the advanced claim funding is necessary due to increased Claims activity, or an increase in the amount of electronic Claims payments to providers, the Plan Manager will present the proposed new advanced claim funding amount to the County. If County does not deposit these additional funds into the benefits DDA within ten (10) business days, Plan Manager has the right to hold Claim processing, but not services to Plan Participants, until the additional advanced claim funding has been received into the benefits DDA.

Plan Manager will inform County two (2) days in advance of the amount of the electronic payment that must be paid from the benefits DDA for checks and EFT's issued the previous week.

County will fund the benefits DDA weekly on Mondays, or the next business day if Monday is a holiday, via ACH initiated by Plan Manager.
Plan Manager will provide a monthly itemized financial reconciliation statement that reports

benefits DDA activity. The reconciliation statement will include a breakdown of medical and pharmacy expenses.

County will reimburse Plan Manager for any bank fees related to overdrafts caused by County, after notice from Plan Manager of insufficient funds, in the benefits DDA.

Upon termination of the Agreement, the benefits DDA will remain open for an additional twelve (12) months ("Run-out Period") to fund run-out Claims incurred prior to the Agreement termination date. After the Run-out Period, all remaining money in the benefits DDA will be returned to County after all Claims and fees, if any, have been paid.

For the Term of the Agreement, County and Plan Manager may agree in writing to change this Banking Arrangement. However, any such change shall not affect continuing obligations under the Agreement or liability of the County for checks and EFT's authorized for payment, fees incurred as provided in this Banking Arrangement, and/or any due and agreed upon balance requirements in effect prior to the effective date of the change.

Persons to contact at the County's location regarding banking issues:

Administrative Officer
Human Resources Division
Phone Number: 954-357-6700

Funding for the benefits DDA will be from the bank account shown below:

Bank Name:	Bank of America
Bank City/State:	Tampa, FL
ACH Transit Routing Number:	011900445
Wire Transit Routing Number:	011900445
Name of Account:	UHC Admin Plan for Broward County
Account Number:	xxx5608

Banking Statements shall be provided electronically to:

Jahan Garassino, jgarassino@broward.org
Paul Raikes, praikes@broward.org

This Banking Arrangement is effective on January 1, 2022.

EXHIBIT Q
Insurance Requirements

Project: Health and Pharmacy Benefits Program
Agency: Human Resources Division

TYPE OF INSURANCE	ADDL INSD	SUBR WVD	MINIMUM LIABILITY LIMITS		
				Each Occurrence	Aggregate
GENERAL LIABILITY - Broad form ☑ Commercial General Liability ☑ Premises–Operations ☐ XCU Explosion/Collapse/Underground ☑ Products/Completed Operations Hazard ☑ Contractual Insurance ☑ Broad Form Property Damage ☑ Independent Contractors ☑ Personal Injury **Per Occurrence or Claims-Made:** ☑ Per Occurrence ☐ Claims-Made **Gen'l Aggregate Limit Applies per:** ☐ Project ☐ Policy ☐ Loc. ☐ Other _____	☑	☑	Bodily Injury		
			Property Damage		
			Combined Bodily Injury and Property Damage	**$1,000,000**	**$2,000,000**
			Personal Injury		
			Products & Completed Operations		
AUTO LIABILITY ☑ Comprehensive Form ☑ Owned ☑ Hired ☑ Non-owned ☑ Any Auto, If applicable ***Note: May be waived if no driving will be done in performance of services/project.***			Bodily Injury (each person)		
			Bodily Injury (each accident)		
			Property Damage		
			Combined Bodily Injury and Property Damage	**$500,000**	
☐ **EXCESS LIABILITY / UMBRELLA** **Per Occurrence or Claims-Made:** ☑ Per Occurrence ☐ Claims-Made *Note: May be used to supplement minimum liability coverage requirements.*					
☑ **WORKER'S COMPENSATION**	N/A	☑	Each Accident	**STATUTORY LIMITS**	
☑ **EMPLOYER'S LIABILITY**			Each Accident	**$100,000**	
☑ **CYBER LIABILITY**	N/A		Each Claim:	**$2,000,000**	
			*Maximum Deductible:	$100,000	
☑ **PROFESSIONAL LIABILITY (ERRORS & OMISSIONS)**	N/A		Each Claim:	**$2,000,000**	
			*Maximum Deductible:	$100,000	
☑ **CRIME AND FIDELITY** Broward County must be a Loss Payee.			Each Claim:	**$1,000,000**	

Description of Operations: "Broward County" shall be listed as Certificate Holder and endorsed as an additional insured for liability, except as to Professional Liability. County shall be provided 30 days written notice of cancellation, 10 days' notice of cancellation for non-payment. Contractors insurance shall provide primary coverage and shall not require contribution from the County, self-insurance or otherwise. Any self-insured retention (SIR) higher than the amount permitted in this Agreement must be declared to and approved by County and may require proof of financial ability to meet losses. Contractor is responsible for all coverage deductibles unless otherwise specified in the agreement.

CERTIFICATE HOLDER:

Broward County
115 South Andrews Avenue
Fort Lauderdale, Florida 33301

Digitally signed by COLLEEN A. POUNALL
Date: 2021.01.20 14:22:11 -05'00'

Risk Management Division

EXHIBIT R
Work Authorization

Agreement Title: _____
Agreement Date: _____
Contract Number: _____
Work Authorization No. _____
Plan Manager: _____

This Work Authorization is between Broward County and Plan Manager pursuant to the Agreement. Plan Manager affirms that the representations and warranties in the Agreement are true and correct as of the date this Work Authorization is executed by Plan Manager. In the event of any inconsistency between this Work Authorization and the Agreement, the provisions of the Agreement shall govern and control.

The time period for this Work Authorization will be from the date of County's Notice to Proceed until [____ (___)] days after the Notice to Proceed, unless otherwise extended or terminated by the Contract Administrator.

Services to be provided:

[COMPOSE SIMPLE SUMMARY]

The applicable not-to-exceed amount stated in the Agreement for the work at issue is: $[_____].

The total fee for goods and services under this Work Authorization is: $[_____] ("Total Fee").

The Total Fee shall be invoiced by Plan Manager upon written acceptance by County of all goods and services provided under this Work Authorization.

(*Signatures appear on the following page.*)

IN WITNESS WHEREOF, the Parties hereto have made and executed this Work Authorization, effective as of the date the last party signs this Work Authorization.

County

Project Manager Date

Approved as to form by Office of the Broward County Attorney:

Assistant County Attorney Date

Contract Administrator Date

Board or Designee Date

Plan Manager

[Name of Plan Manager]

WITNESSES

Signature

Print/Type Name

Signature

Print/Type Name

ATTEST

Signed Date

(Print/Type Name of Secretary)

CORPORATE SEAL

Signed Date

Print/Type Name

Title

EXHIBIT S
Certification of Payments to Subcontractors and Suppliers

RLI/Bid/Contract No. _____
Project Title _____

The undersigned Plan Manager hereby swears under penalty of perjury that:

1. Plan Manager has paid all Subcontractors and suppliers all undisputed contract obligations for labor, services, or materials provided on this project in accordance with the "Compensation" article of this Agreement, except as provided in paragraph 2 below.

2. The following Subcontractors and suppliers have not been paid because of disputed contractual obligations; a copy of the notification sent to each, explaining in reasonably specific detail the good cause why payment has not been made, is attached to this form:

Subcontractor or supplier's name and address	Date of disputed invoice	Amount in dispute

3. The undersigned is authorized to execute this Certification on behalf of Plan Manager.

Dated _____, 20__

_____
Plan Manager Name
By_____
(Signature)
By_____
(Name and Title)

STATE OF)
)
COUNTY OF)

The foregoing instrument was acknowledged before me, by means of ☐ physical presence or ☐ online notarization, this _____ day of _____, 20__, by _____, who is personally known to me or who has produced _____ as identification and who did (did not) take an oath.

NOTARY PUBLIC:
Signature: _____
Print Name: _____
State of Florida at Large (Seal)
My commission expires:

EXHIBIT T
BUSINESS ASSOCIATE AGREEMENT BETWEEN BROWARD COUNTY, FLORIDA AND BUSINESS ASSOCIATE, UNITED HEALTHCARE SERVICES, INC.

This Business Associate Agreement ("BAA") is entered into by and between Broward County, Florida ("County") and United Healthcare Services, Inc., with its principal office located at UnitedHealth Group Center, 9900 Bren Road East, Minnetonka, Minnesota 55343 ("Business Associate") (each a "Party," and collectively the "Parties"), in connection with the Agreement for Administrative Management Services for Self-Insured Group Health Insurance Coverage and Benefits and Pharmacy Benefit Management Services for Broward County Benefits-Eligible Individuals (the "Agreement").

RECITALS

A. Business Associate provides services related to the operation of certain activities/programs that involve the use or disclosure of Protected Health Information ("PHI").

B. The operation of such activities/programs is subject to the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the American Recovery and Reinvestment Act of 2009 ("ARRA"), and the Health Information Technology for Economic and Clinical Health Act ("HITECH").

C. HIPAA, ARRA, and HITECH mandate that certain responsibilities of contractors with access to PHI be documented through a written agreement.

D. County and Business Associate desire to comply with the requirements of HIPAA, ARRA, and HITECH and acknowledge their respective responsibilities.

Now, therefore, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

Section 1: Definitions

1.1 All terms used in this BAA not otherwise defined herein shall have the meanings stated in the Privacy and Security Rules, 45 C.F.R. Parts 160, 162, 164, and 42 U.S.C. § 17921.

1.2 "HIPAA Laws" means collectively HIPAA, ARRA, HITECH, 42 C.F.R. Part 2 (if applicable), and the related regulations and amendments.

1.3 When the term "PHI" is used in this BAA, it includes electronic Protected Health Information (also known as "EPHI").

1.4 "Penalties" as used in Section 4.21 below is defined as civil penalties that may be applied to the Business Associate and its workforce members by the Secretary ("Secretary") of Health

and Human Services ("HHS"). The amount of the penalties range depending on the type of violation. In determining penalties, the Secretary may take into account:

a. the nature and extent of the violation;
b. the nature and extent of harm resulting from such violation;
c. the degree of culpability of the covered entity or business associate;
d. the history of prior compliance with the administrative simplification provision including violations by the covered entity or business associate;
e. the financial condition of the covered entity or business associate; and
f. such other matters as justice may require.

Section 2: Effective Dates

This Agreement shall become effective the earlier of the date the Agreement is executed by the Parties or the date Business Associate begins to receive PHI for purposes of this Agreement (the "Effective Date").

Section 3: Confidentiality

3.1 County and Business Associate shall comply with all federal and state laws governing the privacy and security of PHI.

3.2 ☐ If this box is checked, County and Business Associate are required to comply with 42 C.F.R. Part 2 with respect to patient identifying information concerning alcohol and substance abuse treatment.

Section 4: Obligations and Activities of Business Associate

<u>Use and Disclosure of PHI</u>

4.1 Business Associate shall not use or disclose PHI other than as permitted or required by this BAA or as required by law. Business Associate may:

a. Use and disclose PHI only as necessary to perform its obligations under the Agreement, provided that such use or disclosure would not violate HIPAA Laws if done by County;

b. Use the PHI received in its capacity as a Business Associate of County for its proper management and administration and to fulfill any legal responsibilities of Business Associate;

c. Disclose PHI in its possession to a third party for the proper management and administration of Business Associate, or to fulfill any legal responsibilities of Business Associate, provided that the disclosure would not violate HIPAA Laws if made by County, or is required by law, and Business Associate has received from the third party written

assurances that (i) the information will be kept confidential and used or further disclosed only for the purposes for which it was disclosed to the third party or as required by law; (ii) the third party will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information may have been breached; and (iii) the third party has agreed to implement reasonable and appropriate steps to safeguard the information;

d. Use PHI to provide data aggregation activities relating to the operations of County; and

e. De-identify any and all PHI created or received by Business Associate under the Agreement, provided that the de-identification conforms to the requirements of the HIPAA Laws.

4.2 Business Associate is prohibited from selling PHI, using PHI for marketing purposes, or attempting to re-identify any PHI information in violation of HIPAA Laws. Business Associate agrees to comply with the "Prohibition on Sale of Electronic Health Records or Protected Health Information," as provided in Section 13405(d) of Subtitle D (Privacy) of ARRA, the "Conditions on Certain Contracts as Part of Health Care Operations," as provided in Section 13406 of Subtitle D (Privacy) of ARRA, and related guidance issued by the Secretary from time to time.

4.3 Business Associate acknowledges that, effective on the Effective Date of this BAA, it shall be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. § 1320d-5 and 1320d-6, as amended, for failure to comply with any of the use and disclosure requirements of this BAA and any guidance issued by the Secretary from time to time with respect to such use and disclosure requirements.

Administrative, Physical, and Technical Safeguards

4.4 Business Associate shall implement the administrative safeguards set forth at 45 C.F.R. § 164.308, the physical safeguards set forth at 45 C.F.R. § 164.310, the technical safeguards set forth at 45 C.F.R. § 164.312, and the policies and procedures set forth at 45 C.F.R. § 164.316, to reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI that it creates, receives, maintains, or transmits on behalf of County. Business Associate acknowledges that, effective on the Effective Date of this BAA, (a) the foregoing safeguards, policies, procedures, and requirements shall apply to Business Associate in the same manner that such requirements apply to County, and (b) Business Associate shall be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. § 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the safeguards, policies, and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements.

4.5 Business Associate shall require all of its subcontractors, agents, and other third parties that receive, use, transmit, maintain, store, or have access to PHI to agree, in writing, to the same

restrictions, conditions, and requirements that apply to Business Associate pursuant to this BAA and the HIPAA Laws.

Access of Information; Amendment of Information; Accounting of Disclosures

4.6 Business Associate shall make available to County all PHI in designated record sets within ten (10) days of County's request for County to meet the requirements under 45 C.F.R. § 164.524.

4.7 Business Associate shall make any amendments to PHI in a designated record set as directed or agreed to by County pursuant to 45 C.F.R. § 164.526, and in the time and manner reasonably designated by County.

4.8 Business Associate agrees to comply with an individual's request to restrict the disclosure of their personal PHI in a manner consistent with 45 C.F.R. § 164.522, except where such use, disclosure, or request is required or permitted under applicable law.

4.9 Business Associate agrees that, when requesting, using, or disclosing PHI in accordance with 45 C.F.R. § 164.502(b)(1), such request, use, or disclosure shall be to the minimum extent necessary, including the use of a "limited data set" as defined in 45 C.F.R. § 164.514(e)(2), to accomplish the intended purpose of such request, use, or disclosure, as interpreted under related guidance issued by the Secretary from time to time.

4.10 Business Associate shall timely document and maintain such disclosures of PHI and information related to such disclosures as would be required for County to respond to an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. Further, Business Associate shall provide to County an accounting of all disclosure of PHI during the term of this BAA within ten (10) days after termination of this BAA, or sooner if reasonably requested by County for purposes of any monitoring/auditing of County for compliance with HIPAA Laws.

4.11 Business Associate shall provide County, or an individual under procedures approved by County, information and documentation collected in accordance with the preceding section to respond to an individual requesting an accounting for disclosures as provided under 45 C.F.R. § 164.528 or HIPAA Laws.

Notification of Breach

4.12 Business Associate shall notify County's HIPAA Privacy Official at (954) 357-6500 of any impermissible access, acquisition, use, or disclosure (collectively and individually, a "Breach") of any Unsecured PHI within twenty-four (24) hours of Business Associate discovering such Breach. "Unsecured PHI" shall refer to such PHI that is not secured through use of a technology or methodology specified by the Secretary that renders such PHI unusable, unreadable, or indecipherable to unauthorized individuals. A Breach of Unsecured PHI shall be treated as discovered by Business Associate as of the first day on which such Breach is known to the Business Associate or, by exercising reasonable diligence, would have been known to Business Associate,

including any employee, officer, contractor, subcontractor, or other agent of Business Associate. In addition, Business Associate's notification under this section shall comply in all respects with each applicable provision the HIPAA Rules and all related guidance issued by the Secretary or the delegate of the Secretary from time to time.

4.13 Business Associate shall submit a written report of a Breach to County within ten (10) business days after initial notification, which shall document the following:

a. The identification of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate, to have been accessed, acquired, used, or disclosed during the Breach;

b. A brief description of what occurred, including the date of the Breach and the date of the discovery of the breach, if known;

c. A description of the types of Unsecured PHI that are involved in the Breach (such as full name, social security number, date of birth, home address, account number, diagnosis, etc.);

d. A description of what is being done to investigate the Breach, to mitigate harm to individuals, and the reasonable and appropriate safeguards being taken to protect against future breaches;

e. Any steps County or the individual impacted by the Breach should take to protect himself or herself from potential harm resulting from the Breach;

f. Contact procedures for the Business Associate to enable individuals to ask questions or learn additional information, which may include, in the discretion of County, a toll-free telephone number, e-mail address, website, or postal address, depending upon the available contact information that Business Associate has for the affected individuals; and

g. Any other reasonable information requested by County.

4.14 County, in its sole discretion, will determine whether County or Business Associate shall be responsible to provide notification to individuals whose Unsecured PHI has been impermissibly accessed, acquired, used, or disclosed, as well as to the Secretary and the media. Such notification shall be provided as follows:

a. Notification will be by first-class mail, or by electronic mail, if the individual has specified notice in the manner as a preference.

b. Information may be posted on County's and Business Associate's website(s) where the Business Associate experienced, or is reasonably believed to have experienced, an

impermissible access, acquisition, use, or disclosure of Unsecured PHI that compromised the security or privacy of more than ten (10) individuals when no other current information is available to inform such individuals.

c. Notice shall be provided to prominent media outlets with information on an incident where the Business Associate experienced an impermissible access, acquisition, use or disclosure of Unsecured PHI that compromised the security or privacy of more than five hundred (500) individuals within the same state or jurisdiction during the incident.

4.15 In the event of the impermissible access, acquisition, use, or disclosure of Unsecured PHI in violation of the HIPAA Laws, Business Associate bears the burden of demonstrating that all notification(s) required by Sections 3.10 – 3.12 (as applicable) was made, including evidence demonstrating the necessity of any delay, or that the use or disclosure did not constitute a Breach of Unsecured PHI.

4.16 Business Associate shall pay the costs of providing all notification(s) required by Sections 4.12 – 4.14 (as applicable) of this BAA.

Mitigation of Breach

4.17 Business Associate shall mitigate to the extent possible, at its own expense, any harmful effect that is known to Business Associate of any access, use, or disclosure of Unsecured PHI in violation of the requirements of this BAA or applicable law.

4.18 Business Associate shall take appropriate disciplinary action against any members of its workforce who use or disclose Unsecured PHI in any manner not authorized by this BAA or applicable law.

4.19 Business Associate shall have established procedures to investigate a Breach, mitigate losses, and protect against any future breaches, and shall provide such procedures and any specific findings of the investigation to County in the time and manner reasonably requested by County.

4.20 In the event of a Breach, Business Associate shall, in consultation with and at the direction of County, assist County in conducting a risk assessment of the Breach and mitigate, to the extent practicable, any harmful effect of such breach known to Business Associate. Business Associate shall pay the costs for mitigating damages, including, but not limited to, the expenses for credit monitoring, if County determines that the Breach warrants such measures.

4.21 Business Associate is liable to County for any civil penalties imposed on County under the HIPAA Laws in the event of a violation of the HIPAA Laws as a result of any practice, behavior, or conduct of Business Associate or its agents or employees.

Available Books and Records

4.22 Business Associate shall make its internal practices and books, related to the Agreement or the BAA, including all policies and procedures required by HIPAA Laws, available to the County Contract Administrator within five (5) business days after execution of the Agreement.

4.23 Business Associate shall make its internal practices, books, and records, including all policies and procedures required by HIPAA Laws, relating to the use and disclosure of PHI received from County or created or received on behalf of County, available to County or to the Secretary or its designee within five (5) business days after request for the purposes of determining the Business Associate's compliance with HIPAA Laws.

Section 5: Obligations of County

5.1 County shall notify Business Associate of any limitations in its notice of privacy practices in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Business Associate's use of PHI.

5.2 County shall notify Business Associate of any changes in, or revocation of, permission by an individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use of PHI.

5.3 County shall notify Business Associate of any restriction to the use or disclosure of PHI to which County has agreed in accordance with 45 C.F.R. § 164.522, to the extent that such changes may affect Business Associate's use of PHI.

5.4 County shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA Laws if done by County.

5.5 County may report, at least annually, any impermissible access, use, or disclosure of unsecured PHI by Business Associate to the Secretary as required by HIPAA Laws.

Section 6: Term and Termination

6.1 The term of this BAA shall be effective the earlier of the date the Agreement is fully executed by the Parties or the date Business Associate begins to receive PHI for purposes of this Agreement, and shall terminate upon the later of (a) expiration or earlier termination of the Agreement, or (b) return or destruction of all PHI within the possession or control of the Business Associate as a result of the Agreement.

6.2 Upon County's knowledge of a material breach of this BAA by Business Associate, County may:

a. Provide an opportunity for Business Associate to cure the breach within the time

for cure set forth in County's written notice to Business Associate and terminate if Business Associate does not cure the breach within the time specified by County; or

b. Immediately terminate this BAA and the Agreement if Business Associate has breached a material term of this BAA and a cure is not possible; or

c. If neither termination nor cure is feasible, County's HIPAA Privacy Official shall report the violation to the Secretary of HHS.

6.3 Upon expiration or termination of the Agreement, Business Associate agrees, at County's option, to return to County or destroy all PHI gathered, created, received, or processed pursuant to the Agreement. No PHI related to the Agreement will be retained by Business Associate, or a contractor, subcontractor, or other agent of Business Associate, unless retention is required by law and specifically permitted in writing by County.

6.4 If returning or destroying PHI is infeasible, Business Associate shall provide to County a written statement that it is infeasible to return or destroy the PHI and describe the conditions that make return or destruction of the PHI infeasible. Under that circumstance, Business Associate shall extend the protections of this BAA to the PHI retained and limit further uses and disclosures of such PHI to those purposes that make return or destruction infeasible, for so long as Business Associate maintains the PHI. Business Associate's obligations under this section shall survive termination of this BAA.

Section 7: Miscellaneous

7.1 Amendment. County and Business Associate shall take such action as is necessary to amend this BAA for County to comply with the requirements of HIPAA Laws or other applicable law.

7.2 Interpretation. Any ambiguity in this BAA shall be resolved to permit County to comply with HIPAA Laws. Any inconsistency between the HIPAA Laws, as interpreted by the HHS, a court, or another regulatory agency with authority over the Parties, and this BAA shall be interpreted in favor of the HIPAA Laws as interpreted by the HHS, the court, or the regulatory agency. Any provision of this BAA that differs from the requirements of the HIPAA Laws, but is nonetheless permitted by the HIPAA Laws, shall be adhered to as stated in this BAA.

7.3 Successors and Assignment. This BAA will be binding on the successors and assigns of County and Business Associate. However, this BAA may not be assigned, in whole or in part, without the written consent of the other Party. Any attempted assignment in violation of this provision shall be null and void.

BUSINESS ASSOCIATE AGREEMENT BETWEEN BROWARD COUNTY, FLORIDA, AND BUSINESS ASSOCIATE, UNITED HEALTHCARE SERVICES, INC.

WHEREAS, the Parties have made and executed this Business Associate Agreement on the respective dates under each signature: BROWARD COUNTY, through its Board of County Commissioners, signing by its County Administrator, authorized to execute same, and BUSINESS ASSOCIATE, signing by and through its _____, duly authorized to execute same.

BROWARD COUNTY

WITNESS:

_____
(Signature)

_____
(Print Name of Witness)

BROWARD COUNTY, by and through
its County Administrator

By:_____
Bertha Henry, County Administrator

____ day of _____, 2021

_____
(Signature)

_____
(Print Name of Witness)

Approved as to form by
Andrew J. Meyers
Broward County Attorney
Governmental Center, Suite 423
115 South Andrews Avenue
Fort Lauderdale, Florida 33301
Telephone: (954) 357-7600

By:_____
Sandy Steed (Date)
Assistant County Attorney

BUSINESS ASSOCIATE AGREEMENT BETWEEN BROWARD COUNTY, FLORIDA, AND BUSINESS ASSOCIATE, UNITED HEALTHCARE SERVICES, INC.

BUSINESS ASSOCIATE

UNITED HEALTHCARE SERVICES, INC.

Signature:_____

Name:_____

Title:_____

____ day of _____, 2021

STATE OF _____

COUNTY OF _____

The foregoing instrument was acknowledged before me by means of □ physical presence or □ online notification this ___ day of _____, 20___, by _____, as _____, of the _____.

Personally Known OR Produced Identification
Type of Identification Produced

_____
Print Name:
Notary Public, State of
Commission No.

Commission Expires:

EXHIBIT U

Service Level Agreement

For purposes of this Service Level Agreement ("SLA"), Plan Manager is referred to as "Contractor."

In connection with all Services provided to County under the applicable contract (the "Agreement"), Contractor shall, at no additional cost to County, meet or exceed the requirements set forth in this SLA for the duration of the Agreement. The standards set forth herein are intended to reflect the current industry best practices for the Contractor Platform provided by Contractor under this Agreement. If and to the extent industry best practices evolve to impose higher standards than set forth herein, this SLA shall be deemed to impose the new, higher standards upon Contractor. Contractor shall promptly notify County in writing of any material change to its compliance with these standards. Any approval required by County under this SLA may be issued in writing by the Contract Administrator or the Broward County Chief Information Officer ("CIO").

Sections 1-5 of this SLA apply to all aspects of the Contractor Platform. In addition, Sections 6 and 7 of this SLA apply to any Software as a Service ("SaaS") or web hosting services provided to County under the Contractor Platform.

1. Definitions

1.1. "Contractor Platform" means any and all SaaS or web hosting to be provided by Contractor under the Agreement, including any system or other solution that stores, hosts, or transmits County Data. Contractor shall maintain the same standards set forth herein for its data centers and facilities that store or host County Data.

1.2. "County Data" means the data and information (including text, pictures, sound, graphics, video and other medium) relating to County or its employees or agents, or made available or provided by County or its agents to Contractor, for or in the performance of this Agreement, including all derivative data and results derived therefrom, whether or not derived through the use of the Contractor's services, whether or not electronically retained, and regardless of the retention media.

1.3. Any other capitalized terms not defined herein refer to those terms as defined in the Agreement, if so defined; if not defined in the Agreement, any other capitalized terms shall have their plain language meaning as used in the applicable context.

2. Security

2.1. General

2.1.1. Contractor will ensure that County can authenticate all access by username and password or two-factor authentication.

2.1.2. Contractor shall ensure that separation of duties and least privilege access are enforced for privileged or administrative access to County Data and the Contractor Platform.

2.1.3. Contractor's procedures for the following must be documented and made available upon request by County, including:

2.1.3.1. Evaluating security alerts and vulnerabilities;
2.1.3.2. Installing security patches and service packs;
2.1.3.3. Intrusion detection, incident response, and incident escalation or investigation;
2.1.3.4. Access and authorization procedures and resetting access controls (e.g., password policy);
2.1.3.5. Risk analysis and assessment procedures;
2.1.3.6. User access and termination procedures;
2.1.3.7. Security log policy;
2.1.3.8. Physical facility access controls; and
2.1.3.9. Change control procedures.

2.1.4. Contractor shall ensure that its service providers, subcontractors, and any third parties, including any data hosting providers, performing any services related to this Agreement shall comply with all terms and conditions specified in this SLA unless County, in writing, excuses specific compliance with any such term or condition. Contractor shall provide County with a list of any such service providers, subcontractors or other third parties on an annual basis, upon County's request, and promptly upon a material change in the composition of such entities.

2.1.5. If new or unanticipated threats or hazards to the Contractor Platform are discovered by either County or Contractor, or if existing safeguards have ceased to function properly, the discovering party shall immediately bring the situation to the attention of the other party.

2.1.6. When technically feasible, for all software used, furnished, or supported under the Agreement, Contractor shall review such software to find and remediate security vulnerabilities during initial implementation and upon any significant modifications and updates to same.

2.1.7. Contractor must mitigate critical or high-severe risk vulnerabilities (as defined by Common Vulnerability and Exposures scoring system) to the Contractor Platform within 30 days after patch release. If Contractor is unable to apply a patch to remedy the vulnerability, Contractor must promptly notify County of proposed mitigation steps to be taken and develop and implement an appropriate timeline for resolution.

2.2. Controls

2.2.1. Prior to the Effective Date of the Agreement, and at least once annually for the duration of this Agreement, Contractor shall provide County with a copy of a current unqualified System and Organization Controls (SOC) 1 Type II and a certification letter from Health Information Trust Alliance (HITRUST). If the audit opinion in the SOC 1, Type II report is qualified in any way or if Corrective Action Plans are identified in HITRUST, Contractor shall provide sufficient documentation to demonstrate remediation or mitigation of the issue(s) to the satisfaction of the CIO.

2.2.2. Contractor shall maintain industry best practices for data privacy, security, and recovery measures, including, but not limited to, disaster recovery programs, physical facilities security, server firewalls, virus scanning software, current security patches, user authentication, and intrusion detection and prevention. Upon request by County, Contractor shall provide documentation of such procedures and practices to County.

2.2.3. Contractor shall utilize industry standard security measures to safeguard against unauthorized access to the Contractor Platform.

2.2.4. Contractor shall utilize antivirus protection software, updated and currently supported operating systems, firmware, third party and open source application patches, and firewalls to protect against unauthorized access to the Contractor Platform.

2.2.5. Contractor shall conduct penetration testing internally and externally at least annually and after any significant infrastructure or application upgrade or modification to the Contractor Platform.

2.3. Network Architecture/Security

2.3.1. Contractor shall protect any Internet interfaces or web services provided under this Agreement using a security certificate from a certification authority (“CA”) that meets or exceeds the CA/Browser Forum’s latest Secure Sockets Layer (“SSL”) baseline requirements and network and certificate systems security requirements.

2.3.2. Contractor will support encryption using at a minimum Advanced Encryption Standard 256-bit encryption keys (“AES-256”) or current industry security standards, whichever is higher, for the connection between any user or County network to the Contractor Platform.

2.4. Physical Architecture/Security

2.4.1. Contractor shall ensure the facilities that house the network infrastructure for the Contractor Platform are physically secure against threats such as

unauthorized access and natural and environmental hazards, and entry controls are in place to limit and monitor physical access to the Contractor Platform.

2.4.2. Contractor shall ensure adequate background checks are routinely performed on any personnel with access to County Data. Contractor shall not knowingly allow convicted felons or other persons deemed by Contractor to be a security risk to access County Data. Contractor shall provide privacy and information security training to its employees upon hire and at least once annually.

2.5. Incident Response

2.5.1. If any unauthorized party is successful in accessing any information technology component related to the Contractor Platform, including, but not limited to, servers or fail-over servers where County Data exists or is stored, Contractor shall report to County within twenty-four (24) hours after Contractor becoming aware of such breach. Contractor shall provide County with a detailed incident report, including remedial measures instituted and any law enforcement involvement, within five (5) days after the breach, unless a longer time period is approved in writing by the CIO. Contractor shall fully cooperate with County on incident response, forensics, and investigations that involve the Contractor's infrastructure relating to any County Data or County applications. Contractor shall not release County Data without the advance written consent of County.

2.5.2. Prior to the Effective Date of this Agreement, Contractor shall provide County with the names and contact information for a security point of contact and a backup security point of contact to assist County with security incidents.

2.5.3. Upon request by County, Contractor shall deliver to County, in electronic form, the website application activity such as logs of visits and user logins and logoffs by or on behalf of County on the Contractor Platform.

2.5.4. In the event the Contractor Platform has been compromised, Contractor shall promptly notify County of the security breach. County may, at its sole discretion, terminate all access to the Contractor Platform.

2.6. County Data

2.6.1. Contractor shall maintain controls that ensure logical separation of County Data from non-County data. Contractor agrees to provide at a minimum Advanced Encryption Standard 256-bit encryption ("AES-256") or current industry security standards (or whichever is higher) for all County Data that includes any social security numbers, bank account numbers, username with passwords or security questions, cardholder data, or any other protected data such as Protected Health Information ("PHI") and Personally Identifiable Information ("PII"), and any other data as may be directed by County, and on all copies of such data stored, transmitted, or processed,

at no additional charge to County, and shall classify such data internally at its highest confidentiality level. Contractor shall also ensure that the encryption key(s) are not stored with the encrypted data. Contractor shall immediately notify County of any compromise of any encryption key. Contractor shall prohibit the use of unencrypted protocols such as FTP and Telnet for the data identified in this paragraph.

2.6.2. Upon termination or expiration of this Agreement or end of serviceable life of any media used in connection with this Agreement, and upon written notification from County that the applicable County Data is currently maintained by County or otherwise securely stored, Contractor shall, at County's option, (a) securely destroy all media (including media used for backups) containing any County Data on all decommissioned hard drives or storage media to National Institute of Standards and Technology ("NIST") standards and provide to County a signed certificate of destruction within ten (10) business days, or (b) return to County all County Data and provide a signed certification within two (2) business days thereafter documenting that no County Data is retained by Contractor in any format or media.

2.6.3. County Data is the property solely of County and may not be reproduced or used by Contractor with the prior written consent of County. Contractor and its Subcontractors will not publish, transmit, release, sell, or disclose any County Data to any third party without County's prior written consent.

2.6.4. County shall have the right to use the Products and Services to provide public access to County Data as County deems appropriate or as otherwise required by law.

2.6.5. In the event of any impermissible disclosure, loss, or destruction of County Data caused in whole or in part by any action or omission of Contractor, Contractor must immediately notify County and take all reasonable and necessary steps to mitigate any potential harm, further disclosure, loss, and destruction.

2.6.6. County shall have sole control over County Data unless otherwise expressly stated in the Agreement and required for Contractor to provide the Services required under the Agreement.

2.6.7. Contractor shall not supplement, modify, or alter any deliverable previously accepted by County or any County Data (other than modifications strictly necessary to upload the County Data to the Contactor Platform) without County's prior written consent.

3. Compliance

3.1. Contractor shall cooperate and provide any information requested by County relating to compliance and regulatory requirements, and will, upon request:

3.1.1. Provide a letter attesting that Contractor performed vulnerability scans of authenticated and unauthenticated operating systems/networks, web applications, database applications, and the Contractor Platform;

3.1.2. Permit County or its contractors to conduct automated and manual scans and penetration ("Pen") tests at mutually agreed upon times;

3.1.3. Provide Contractor's architecture documents, information security policies and procedures (redacted, if necessary), and general network security controls documentation such as firewalls, Intrusion Detection System ("IDS"); and

3.1.4. Permit County to conduct a physical inspection of Contractor's facilities but only to the extent such inspection is related to the security of and access to County Data or the Contractor Platform.

3.2. Contractor shall provide County with the ability to generate account reports consisting of the account holder's name and application access rights.

3.3. Contractor shall provide County with the ability to generate account management reports showing new users, access rights changes, and account termination with the associated time stamp information.

3.4. Contractor shall provide County with the ability to generate time-stamped user and administrator access (login/logout) and a list of activities performed by administrators, privileged users, or third-party contractors while using the System.

3.5. Upon request by County, Contractor shall promptly provide County with access to time-stamped data transfer logs (including the account, a description of the data transferred and its size, and the user and account names for forensic purposes), time-stamped application and platform environment change control logs, and time-stamped data backup logs indicating the backup type (e.g., full, incremental, etc.).

3.6. Upon County's request, Contractor shall make available to County proof of Contractor's compliance with all applicable federal, state, and local laws, codes, ordinances, rules, and regulations in performing under this Agreement, including, but not limited to: HIPAA compliance; Contractor's latest compliance reports (e.g., PCI Compliance report, SSAE 16 report, International Organization for Standardization 27001 (ISO 27001) certification); and any other proof of compliance as may be required from time to time.

4. Infrastructure Management

Contractor shall ensure that an unlimited number of transactions may be processed to the County production database. Subject to County approval, Contractor may recommend that non-routine reports and queries be limited to certain timeframes, quantities, or other specifications if Contractor determines that such reports and queries cause degradation to response times affecting performance levels established in this SLA. Contractor shall routinely apply upgrades, new releases, and enhancements to the Contractor Platform as they become available and shall ensure that these changes will not adversely affect the Contractor Platform or County Data. A test system, which shall mirror the production system, shall be made available for use by County for testing or training purposes, including, without limitation, for County's testing of application upgrades and fixes prior to installation in the production environment. County may control data that is populated on the demonstration and training system by requesting that Contractor perform any or all of the following: periodically refresh data from production; perform an ad-hoc refresh of data from production; not refresh data from production until further notice from County; or refresh data on an ad hoc basis with training data supplied by County.

5. Transition/Disentanglement

5.1. Contractor will complete the transition of any terminated Services or Support and Maintenance to County and any replacement provider(s) that County designates (collectively, the "Transferee"), without causing any unnecessary interruption of, or adverse impact on, the Services, County Data, or the ongoing business operation of County ("Disentanglement"). Contractor will work in good faith (including, upon request, with the Transferee) at no additional cost to County to develop an orderly Disentanglement plan that documents the tasks required to accomplish an orderly transition with minimal business interruption or expense for County. Upon request by County, Contractor shall cooperate, take any necessary additional action, and perform such additional tasks that County may reasonably request to ensure timely and orderly Disentanglement, which shall be provided at the rate(s) specified in the Agreement or, if no applicable rate is specified, at a reasonable additional fee upon written approval by County. Specifically, and without limiting the foregoing, Contractor shall:

5.1.1. Promptly provide the Transferee with all nonproprietary information needed to perform the Disentanglement, including, without limitation, data conversions, interface specifications, data about related professional services, and complete documentation of all relevant software and equipment configurations;

5.1.2. Promptly and orderly conclude all work in progress or provide documentation of work in progress to Transferee, as County may direct;

5.1.3. Not, without County's prior written consent, transfer, reassign, or otherwise redeploy any of Contractor's personnel during the Disentanglement period to the extent such action would impede performance of Contractor's obligations under the Agreement;

5.1.4. If applicable, with reasonable prior written notice to County, remove its assets and equipment from County facilities;

5.1.5. If County requests, and to the extent permitted under the applicable agreements, assign to the Transferee (or use its best efforts to obtain consent to such assignment where required) all contracts including third-party licenses and maintenance and support agreements, used by Contractor exclusively in connection with the Services or Support and Maintenance. Contractor shall perform all of its obligations under such contracts at all times prior to the date of assignment, and Contractor shall reimburse County for any losses resulting from any failure to perform any such obligations;

5.1.6. Deliver to Transferee all current, nonproprietary documentation and data related to County-owned assets and infrastructure. After confirming in writing with County that the applicable County Data is received intact or otherwise securely stored by County, Contractor shall securely erase all County Data, including on any hard drives and backup media, in accordance with NIST standards. Upon written consent from County, Contractor may retain one copy of documentation to the extent required for Contractor's archival purposes or warranty support; and

5.1.7. To the extent requested by County, provide County a list with current valuation based on net book value of any Contractor-owned tangible assets required to make the Contractor Platform available to County. County shall have the right to acquire any or all such assets for net book value. If County elects to acquire such assets for the net book value, Contractor shall use best efforts to ensure that any and all related warranties will transfer along with those assets.

6. Network Architecture/Security

6.1. Network Architecture

6.1.1. The Contractor Platform shall be protected behind a layer of firewalls.

6.1.2. At County's request, Contractor shall submit a network architecture diagram of County's stored and transmitted data, including the location of the data center and details of connectivity for all third parties who have access to County Data. Any network security changes implemented by Contractor must not compromise the security of County Data. Contractor shall ensure that all database servers are protected behind a second set of internal firewalls.

6.1.3. Contractor shall restrict inbound and outbound traffic to County's network to "deny all, permit by exception" configuration.

6.1.4. Contractor's wireless networks connected to the Contractor Platform shall at a minimum, be configured for Wi-Fi Protected Access 2 (WPA2)-Enterprise using

Advanced Encryption Standard (AES) and Protected Extensible Authentication Protocol (PEAP), or current industry security standards (whichever is higher) to secure and protect County data.

6.2. Physical Architecture/Security. Contractor shall connect its hosting site for the Contractor Platform through at least two (2) independent Internet Service Contractors ("ISPs") with different Internet points of presence.

6.3. Disaster Recovery

6.3.1. Contractor shall maintain a disaster recovery plan for the Contractor Platform with mirrored sites geographically separated by at least 50 miles, with a Recovery Time Objective ("RTO") of a maximum of eight (8) hours and a Recovery Point Objective ("RPO") of a maximum of four (4) hours from the incident.

6.3.2. Contractor shall conduct a disaster recovery test of the hosted or SaaS system that is utilized by or comprises the Contractor Platform on at least an annual basis, and shall notify County at least ten (10) days in advance of Contractor's annual disaster recovery test.

6.4. County Data. Contractor shall make any County Data available to County upon request within one (1) business day and in any format reasonably requested by County, including, without limitation, Extensible Markup Language ("XML") and Structured Query Language ("SQL"), or in another format as may be mutually agreed by County and Contractor.

7. Service Availability

7.1. System Availability

7.1.1. Contractor guarantees that the Network Uptime (as defined herein) will be 99.99% of Prime Time (defined as County business days from 7 a.m. – 7 p.m. Eastern Time) and 98.00% of non-Prime Time for each calendar month during the term of the Agreement, excluding Scheduled Maintenance as defined herein (collectively, the "Network Uptime Guarantee"). Network Uptime is the time that the Contractor Platform and System are functioning optimally and fully operational, and requires proper functioning of all network infrastructure, including routers, switches, and cabling, affecting a user's ability to reliably transmit or receive data; Network Downtime is the remainder of time that is not included in Network Uptime, and is measured from the time the trouble ticket is opened to the time the Contractor Platform and System are fully restored. As long as the System is available over the Internet to at least two other comparable non-County customers (i.e., the System is functioning properly and there are no technical issues with Contractor or the Contractor Platform), any inability on the part of County to access the System as a result of a general Internet outage will not be counted toward Network Downtime.

System unavailability for the purpose of building redundancy or other recovery systems that is approved by County in advance shall not be charged as downtime in computing the Network Downtime. Contractor Platform or System unavailability due to Contractor's equipment failure constitutes Network Downtime.

7.1.2. Contractor will refund to County five percent (5%) of the monthly fees (or monthly pro rata equivalent, if recurring fees under the Agreement are charged other than monthly) under the Agreement for each thirty (30) minutes of Network Downtime in excess of that permitted under the Network Uptime Guarantee (up to 100% of County's monthly or pro rata fee), measured on a calendar month basis. Such refunds will be paid within ten (10) days after the applicable monthly report or, at County's option, may be credited against amounts due under any unpaid invoice or future invoice. If the Agreement provides for other credit or compensation due to County for an event that also constitutes Network Downtime, the greater of the two amounts shall apply.

7.1.3. Normal availability of the Contractor Platform and System shall be twenty-four (24) hours per day, seven (7) days per week. Planned downtime (i.e., taking the System offline such that it is not accessible to County) ("Scheduled Maintenance") shall occur during non-Prime Time and with at least five (5) business days' advance written notice to County. Contractor may conduct Scheduled Maintenance at other times without advance notice only with written consent from County, which consent will not be unreasonably withheld. During non-Prime Time, Contractor may perform routine maintenance operations that do not require the Contractor Platform or System to be taken offline but may have immaterial effects on performance and response time without any notice to County. Such immaterial degradation in performance and response time shall not be deemed Network Downtime. All changes that are expected to take more than four (4) hours to implement or are likely to impact user workflow require County's prior written approval, which will not be unreasonably withheld.

7.1.4. By the tenth day of each calendar month, Contractor shall provide County a report detailing Contractor's performance under this SLA for the prior calendar month. To the extent the performance fails to meet the Network Uptime Guarantee, the report shall calculate: the total number of minutes of uptime for each of Prime Time and non-Prime Time; the total number of minutes for each of Prime Time and non-Prime Time minus any applicable Scheduled Maintenance, respectively; and the percentage of uptime versus total time minus Scheduled Maintenance for each (e.g., monthly minutes of non-Prime Time network uptime / (Total minutes of non-Prime Time – Minutes of Scheduled Maintenance) = __%).

7.2. Infrastructure Management

7.2.1. During Prime Time, Contractor shall ensure packet loss of less than one percent (1%) and less than sixty (60) milliseconds domestic latency within the

Contractor Platform. Contractor shall maintain sufficient bandwidth to the Contractor Platform and ensure the server processing time (or CPU processing capacity) to provide millisecond response times from the server. County and Contractor recognize that end user response times are dependent on intermittent ISP network connectivity, and in the case of County's users, dependent on County's internal network health.

7.2.2. To the extent the Contractor Platform provides or supports public access to users in Broward County or through the County's web pages, the Contractor Platform shall support up to 500,000 site hits per calendar day and capture the number of site hits by page for performance to standards reporting.

7.2.3. Contractor will retain all County-related database records regardless of number or size.

7.2.4. To the extent the Contractor Platform includes an ad-hoc reporting tool or standard reports, Contractor agrees to provide unlimited access to such functionality to County. Contractor agrees to support an unlimited number of queries and reports against County Data. County agrees that Contractor may put reasonable size limits on queries and reports to maintain System performance, provided such limits do not materially impact County's regular business operations.

7.2.5. Contractor shall conduct full, encrypted backups (including System and user data) weekly and shall conduct incremental, encrypted backups daily. Encrypted backups will be written to a backup device with sufficient capacity to handle the data. Contractor shall maintain a complete current set of encrypted backups for County's System, including County Data, at a remote, off-site "hardened" facility from which data can be retrieved within one (1) business day at any point in time. Full System restoration performed as a recovery procedure after a natural disaster is included as part of the required performance by Contractor under this Agreement. Upon County's request, Contractor shall also provide restoration of individual file(s).

7.3. Performance Monitoring and Hosting Capacity Increases

7.3.1. If requested by County, Contractor shall provide standard reporting metrics of the Contractor Platform to County on a monthly basis which shall include: traffic patterns by user and by time; server load, including central processing unit load, virtual memory, disk and input/output channel utilization; transmission control protocol load for each server allocated in part or in full to County System; and system errors in the System, database, operating system, and each server allocated in part or in full to the System.

7.3.2. In the event County anticipates an increase in transaction volume or seeks to expand capacity beyond the limitations, if any, provided under the Agreement, Contractor will provide timeline and cost estimates to upgrade existing servers or

deploy additional servers dedicated to County's System within fifteen (15) calendar days after written notice by County.

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EXHIBIT V
Enterprise Technology Services Security Requirements – High Risk

Definitions.

"Agreement" means the written contract executed between Contractor and County, if any; the terms and conditions stated in the applicable competitive solicitation, if no mutually executed contract; or, if none of the above, the applicable purchase order issued by County.

"Contractor" means the Plan Manager providing the Services pursuant to the Agreement.

"County Confidential Information" means any County Data that includes employee information, financial information, or personally identifiable information for individuals or entities interacting with County (including, without limitation, social security numbers, birth dates, banking and financial information, and other information deemed exempt or confidential under state or federal law or applicable regulatory body).

"County Data" means the data and information (including text, pictures, sound, graphics, video and other data) relating to County or its employees or agents, or made available or provided by County or its agents to Contractor, for or in the performance of this Agreement, including all derivative data and results derived therefrom, whether or not derived through the use of Contractor's services, whether or not electronically retained, and regardless of the retention media.

"Equipment" means the hardware being provided by Contractor under the Agreement.

"Software" means software provided or licensed by Contractor pursuant to the Agreement.

All other capitalized terms not expressly defined within this exhibit shall retain the meaning ascribed to such terms in the Agreement (and if not so defined, then the plain language meaning appropriate to the context in which it is used).

Security and Access. If Contractor will have access to any aspect of County's network via an Active Directory account, onsite access, remote access, or otherwise, Contractor must:

(a) comply at all times with all applicable County access and security standards, policies, and procedures related to County's network, as well as any other or additional restrictions or standards for which County provides written notice to Contractor;
(b) provide any and all information that County may reasonably request in order to determine appropriate security and network access restrictions and verify Contractor's compliance with County security standards;
(c) provide privacy and information security training to its employees with access to County's network upon hire and at least once annually; and
(d) notify County of any terminations or separations of Contractor's employees who had access to County's network.

In addition, for any remote access to County's network, Contractor must:

(a) utilize secure, strictly-controlled industry standards for encryption (e.g., Virtual Private Networks) and passphrases and safeguard County Data that resides in or transits through Contractor's internal network from unauthorized access and disclosure;

(b) ensure the remote host device used for access is not connected to any other network, including an unencrypted third party public WiFi network, while connected to County's network, with the exception of networks that are under Contractor's complete control or under the complete control of a person or entity authorized in advance by County in writing;
(c) enforce automatic disconnect of sessions for remote access technologies after a specific period of inactivity with regard to connectivity into County infrastructure;
(d) utilize equipment that contains antivirus protection software, an updated operating system, firmware, and third party-application patches, and that is configured for least privileged access;
(e) utilize, at a minimum, industry standard security measures, as determined in County's sole discretion, to safeguard County Data that resides in or transits through Contractor's internal network from unauthorized access and disclosure; and
(f) activate remote access from Contractor and its approved subcontractors into the County network only to the extent necessary to perform services under this Agreement, deactivating such access immediately after use.

If at any point in time County, in the sole discretion of its Chief Information Officer ("CIO"), determines that Contractor's access to any aspect of County's network presents an unacceptable security risk, or if Contractor exceeds the scope of access required to perform the required services under the Agreement, County may immediately suspend or terminate Contractor's access and, if the risk is not promptly resolved to the reasonable satisfaction of the County's CIO, may terminate this Agreement or any applicable Work Authorization upon ten (10) business days' notice (including, without limitation, without restoring any access to County network to Contractor).

Data and Privacy. To the extent applicable to the Services being provided by Contractor under the Agreement, Contractor shall comply with all applicable data and privacy laws and regulations, including without limitation Florida Statutes Section 501.171, and shall ensure that County Data processed, transmitted, or stored by Contractor or in Contractor's system is not accessed, transmitted or stored outside the United States. Contractor shall not sell, market, publicize, distribute, or otherwise make available to any third party any personal identification information (as defined by Florida Statutes Section 501.171, Section 817.568, or Section 817.5685, as amended) that Contractor may receive or otherwise have access to in connection with this Agreement, unless expressly authorized in advance by County. If applicable and requested by County, Contractor shall ensure that all hard drives or other storage devices and media that contained County Data have been wiped in accordance with the then-current best industry practices, including without limitation DOD 5220.22-M, and that an appropriate data wipe certification is provided to the satisfaction of the Contract Administrator.

Managed or Professional Services. Contractor shall immediately notify County of any terminations or separations of Contractor's employees who performed services under the Agreement and who had access to County Confidential Information or the County network. If any unauthorized party is successful in accessing any information technology component related to Contractor (including but not limited to servers or fail-over servers) where County Data or files exist or are housed, Contractor shall notify County within twenty-four (24) hours after becoming

aware of such breach, unless an extension is granted by County's CIO. Contractor shall provide County with a detailed incident report within five (5) days after becoming aware of the breach, including remedial measures instituted and any law enforcement involvement. Contractor shall fully cooperate with County on incident response, forensics, and investigations into Contractor's infrastructure as it relates to any County Data or County applications. Contractor shall not release County Data or copies of County Data without the advance written consent of County. If Contractor will be transmitting County Data, Contractor agrees that it will only transmit or exchange County Data via a secure method, including HTTPS, SFTP, or another method approved by County's CIO. Contractor shall ensure adequate background checks have been performed on any personnel having access to County Confidential Information. To the extent permitted by such checks, Contractor shall not knowingly allow convicted felons or other persons deemed by Contractor to be a security risk to access County Data. Contractor shall ensure the use of any open source or third-party software or hardware does not undermine the security posture of Contractor or County.

System and Organization Controls (SOC) Report. In lieu of an unqualified SOC 2 Type II Report, Contractor must provide County with a copy of a current Health Information Trust Alliance (HITRUST) certification letter and a SOC 1 Type II Report, prior to commencement of the Agreement, unless this requirement is waived in writing by the County's CIO or designee.

Software Installed in County's Network. To the extent Contractor provides any Software to be installed in County's network, Contractor must:

(a) advise County of all versions of any third-party software (e.g., Java, Adobe Reader/Flash, Silverlight) to be installed and support updates for critical vulnerabilities discovered in applicable third-party or open source software;
(b) ensure that the Software is developed based on industry standards and best practices, including following secure programming techniques and incorporating security throughout the Software-development life cycle;
(c) develop and maintain the Software to operate on County-supported and approved operating systems and firmware versions;
(d) mitigate critical or high risk vulnerabilities (as defined by Common Vulnerability and Exposures ("CVE") scoring system) to the Software or Contractor platform within 30 days after patch release, notifying County of proposed mitigation steps to be taken and timeline for resolution if Contractor is unable to apply a patch to remedy the vulnerability;
(e) ensure the Software provides for role-based access controls and runs with least privilege access, enables auditing by default for any privileged access or changes, and supports electronic delivery of digitally signed upgrades from Contractor's or the third-party licensor's website;
(f) ensure the Software is not within three (3) years from its end of life date and provide County with end-of-life-schedules for all applicable Software;
(g) support encryption using at a minimum Advanced Encryption Standard 256-bit encryption keys ("AES-256") or current industry security standards, whichever is higher, for confidential data at rest and use transport layer security ("TLS") 1.2 or current industry standards, whichever is higher, for data in motion; and

(h) upon request by County, provide an attestation letter identifying date of the most recent security vulnerability testing performed and any vulnerabilities identified and mitigated (must be dated within six (6) months after any major release).

Equipment Leased or Purchased from Contractor. To the extent Contractor is the Original Equipment Manufacturer ("OEM") or an authorized reseller for the OEM for any Equipment provided under this Agreement, Contractor must:

(a) ensure that physical security features to prevent tampering are included in any Equipment provided to County and ensure, at a minimum, industry-standard security measures are followed during the manufacture of the Equipment;
(b) ensure any Equipment provided does not contain any embedded remote-control features unless approved in writing by County's Contract Administrator, and disclose any default accounts or backdoors that exist for access to County's network;
(c) shall supply a patch, firmware update, or workaround approved in writing by County's Contract Administrator within thirty (30) days after identification of a new critical or high security vulnerability and notify County of proposed mitigation steps taken;
(d) develop and maintain Equipment to interface with County-supported and approved operating systems and firmware versions;
(e) upon request by County, make available any required certifications as may be applicable per compliance and regulatory requirements (e.g., Common Criteria, Federal Information Processing Standard 140);
(f) ensure the Equipment is not within three (3) years from its end of life date at the time of delivery and provide County with end-of-life-schedules for all applicable Equipment;
(g) (for OEMs only) support electronic delivery of digitally signed upgrades of any applicable Equipment firmware from Contractor's or the original Equipment manufacturer's website; and
(i) (for OEMs only) upon request by County, provide an attestation letter identifying date of the most recent security vulnerability testing performed and any vulnerabilities identified and mitigated (must be dated within six (6) months after any major release).

Payment Card Industry ("PCI") Compliance. If and to the extent at any point during the Agreement the Software accepts, transmits, or stores any credit cardholder data or is reasonably determined by County to potentially impact the security of County's cardholder data environment ("CDE"), Contractor must:

(a) comply with the most recent version of VISA Cardholder Information Security Program ("CISP") Payment Application Best Practices and Audit Procedures including Security Standards Council's PCI Data Security Standard ("DSS"), including the functions relating to storing, processing, and transmitting of the cardholder data;
(b) maintain PCI DSS validation throughout the Term of the Agreement;
(c) prior to commencement of the Agreement (or at such time the Software will process cardholder data), prior to final acceptance (if applicable), after any significant change to the CDE, and annually, provide to County: (i) a copy of Contractor's Annual PCI DSS Attestation of Compliance ("AOC"); and (ii) a written acknowledgement of responsibility for the security of cardholder data Contractor possesses or otherwise stores, processes, or transmits and for any service Contractor provides that could impact the security of

County's CDE (if Contractor subcontracts or in any way outsources the credit card processing, or provides an API that redirects or transmits cardholder to a payment gateway, Contractor is responsible for maintaining PCI compliance for the API and providing the AOC for the subcontractor or payment gateway to County);

(d) maintain and provide to County a PCI DSS responsibility matrix that outlines the exact PCI DSS controls that are the responsibility of either party and the PCI DSS controls that are the shared responsibility of Contractor and County;

(e) follow Open Web Application Security Project ("OWASP") for secure coding and transmission of payment card data only to the extent Contractor provides a payment application;

(f) immediately notify County if Contractor learns or suspects that Contractor, its Software, or its platform is no longer PCI DSS compliant and provide County the steps being taken to remediate the noncompliant status no later than seven (7) calendar days after Contractor learns or suspects it is no longer PCI DSS compliant;

(g) activate remote access from Contractor and its approved subcontractors into County's network only to the extent necessary to perform services under this Agreement, deactivating such access immediately after use; and

(h) maintain all inbound and outbound connections to County's CDE using Transport Layer Security (TLS) 1.2 or current industry standard (whichever is higher).

Application Development Services. Contractor shall develop, implement, and comply with industry-standard secure coding best practices as outlined by the County's Service Provider Application Secure Coding Standard. In addition, if application development services are performed by Contractor augmented staff on behalf of County, staff must strictly follow and adhere to County's established application development policies, process, procedures, practices and standards.

Upon request by County, Contractor shall provide an attestation letter to certify that security testing as specified above was performed along with security scan test results and tests performed. Any exceptions must be documented with the delivery of the attestation letter for acceptance by County.

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EXHIBIT W
FLEX Formulary Prescriptive Drug List and Preventative Drug List

Plan Manager shall provide the final FLEX Formulary Prescriptive Drug List and Preventative Drug List to County eighty-two (82) days in advance of the formulary effective date.

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EXHIBIT X
FLEX Formulary Key Exclusions and Alternatives

Plan Manager shall provide the final FLEX Formulary Key Exclusions and Alternatives to County eighty-two (82) days in advance of the formulary effective date.

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EXHIBIT Y
Identification of the Plans/Summary Plan Descriptions

Plan Manager shall provide draft Summary Plan Descriptions ("SPDs") to County within thirty (30) days after execution of this Agreement. County will review and comment, and Plan Manager shall revise accordingly. Upon written approval by the Contract Administrator of the final or revised SPDs, such approved SPDs shall be automatically deemed incorporated herein.

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