



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

This Third Amendment (“Amendment”) is entered into between Broward County, a political subdivision of the State of Florida (“County”), and United Healthcare Services, Inc., a Minnesota corporation registered to transact business in the State of Florida (“Plan Manager”) (each a “Party” and collectively referred to as the “Parties”).

RECITALS

A. The Parties entered into the agreement, dated November 8, 2021 (the “Original Agreement”), to provide administrative management services for self-insured group health insurance coverage and benefits and pharmacy benefit management services for Broward County benefits-eligible individuals.

B. The Original Agreement was amended by a First Amendment, dated September 19, 2024, which exercised the first Renewal Term and modified other terms, and a Second Amendment, dated October 30, 2025, which exercised the second Renewal Term and modified piggyback requirements and other terms of the Agreement. The Original Agreement, as amended by the First Amendment and the Second Amendment, is referred to herein as the “Agreement.”

C. The Parties now desire to further amend the Agreement to extend the Term of the Agreement and to modify certain other terms and conditions as set forth herein.

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

1. The above Recitals are true and correct and are incorporated herein by reference. All capitalized terms not expressly defined within this Amendment shall retain the meaning ascribed to such terms in the Agreement.

2. Unless otherwise expressly stated herein, amendments to the Agreement made pursuant to this Amendment are indicated herein by use of strikethroughs to indicate deletions and bold/underlining to indicate additions. Except as modified herein, all remaining terms and conditions of the Agreement shall remain in full force and effect.

3. Section 4.2 of the Agreement is amended as follows:

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. **In addition to the foregoing Renewal Terms, the Parties may, upon written mutual agreement, renew this Agreement for one (1) additional three (3)-year term commencing January 1, 2027, and ending December 31, 2029 (the "Additional Renewal Term")**. 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. The Parties agree to exercise the Additional Renewal Term as defined in Section 4.2 of the Agreement, beginning January 1, 2027, through 11:59 p.m. on December 31, 2029.

5. Section 8.9 of the Agreement is amended as follows:

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 **and, to the extent required, licensed and certified by all appropriate governmental authorities** to perform such ~~s~~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.

6. Section 12.1 of the Agreement is deleted and replaced in its entirety with the following (bold/underlining omitted):

12.1. Plan Manager and Subcontractors shall not discriminate on the basis of race, color, sex, religion, national origin, disability, age, marital status, political affiliation, pregnancy, or any other basis prohibited by Applicable Law in the performance of this Agreement. Plan Manager shall include the foregoing or similar language in its contracts with all Subcontractors, except that any project assisted by U.S. Department of Transportation funds shall comply with the nondiscrimination requirements in 49 C.F.R. Parts 23 and 26.

7. Section 13.3 of the Agreement is amended as follows:

13.3. **Public Records. Notwithstanding any other provision in this Agreement, any action taken by County in compliance with, or in a good faith attempt to comply with, the requirements of Chapter 119, Florida Statutes, shall not constitute a breach of this Agreement.** ~~To the extent~~ If 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 Applicable 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 Applicable Law for the duration of ~~this Agreement~~ the Term 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 ~~s~~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 of Applicable Law 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~~ If Plan Manager receives a request for public records regarding this Agreement or the Services, Plan Manager must immediately notify the Contract Administrator in writing and provide ~~any~~ all requested records to County to enable County to timely respond to the public records request. County will respond to all such public records requests.

~~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."~~ Plan Manager must separately submit and conspicuously label as

“RESTRICTED MATERIAL – DO NOT PRODUCE” any material (a) the Plan Manager contends constitutes or contains its trade secrets under Chapter 688, Florida Statutes, or (b) for which Plan Manager asserts a right to withhold from public disclosure as confidential or otherwise exempt from production under Florida public records laws (including Chapter 119, Florida Statutes) (collectively, “Restricted Material”). In addition, Plan Manager must, simultaneous with the submission of any ~~Trade Secret~~ **Restricted** Materials, provide a sworn **declaration or affidavit in a form acceptable to County** from a person with personal knowledge attesting that the ~~Trade Secret~~ **Restricted** Materials constitutes trade secrets ~~under Section 688.002, Florida Statutes,~~ **or is otherwise exempt or confidential under Florida public records laws, including citing the applicable Florida statute** and ~~stating~~ **specifying** the factual basis for ~~same~~ **each such claim. Upon request by County, Plan Manager must promptly identify the specific applicable statutory section that protects any particular document.** If a third party submits a request to County for records designated by Plan Manager as ~~Trade Secret~~ **Restricted** Materials, County shall refrain from disclosing ~~the Trade Secret Materials,~~ **such material** unless otherwise ordered by a court of competent jurisdiction, ~~or~~ authorized in writing by Plan Manager, **or the claimed exemption is waived.** **Any failure by Plan Manager to strictly comply with the requirements of this section shall constitute Plan Manager’s waiver of County’s obligation to treat the records as Restricted Material.** 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~~ **Restricted** 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.

8. Section 13.14 of the Agreement is amended as follows:

13.14. **Compliance with Laws.** Plan Manager and the Services must comply with all ~~a~~ **Applicable Law, federal, state, and local laws, codes, ordinances, rules, and regulations** including, without limitation, **the** 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~~ **all deliverables provided for online utilization must meet or exceed the World Wide Web Consortium/Web Content Accessibility Guidelines (WCAG) 2.1 Level AA standard or any higher standard as required by Applicable Law.**

9. Section 13.21 of the Agreement is deleted and replaced in its entirety with the following (bold/underlining omitted):

13.21. 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: (a) fully protect individually identifiable health information as required by HIPAA and/or HITECH; and (b) comply with the Business Associate Agreement attached as Exhibit T. 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 Applicable Law, 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 Subcontractors.

10. Section 13.26 of the Agreement is amended as follows:

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

11. New Sections 13.34 and 13.35 are added to the Agreement as follows (bold/underlining omitted):

13.34. Confidential Information; Generative Artificial Intelligence. Unless expressly authorized in this Agreement or in writing in advance by the Contract Administrator, Plan Manager is strictly prohibited from disclosing, uploading, or otherwise making available to third parties, directly or indirectly, including but not limited to through utilization of generative artificial intelligence tools, any exempt, confidential, sensitive security, or personal information of County. Notwithstanding the foregoing, Plan Manager may use and disclose such information to its Subcontractors solely for the purpose of delivering the Services to County and provided that such Subcontractors are subject to substantially similar terms, conditions, and restrictions as stated within this Agreement. Plan Manager must ensure that any use of generative artificial intelligence tools by Plan Manager or its Subcontractors involving exempt, confidential, sensitive security, or personal information is subject to the following restrictions: (i) confined to systems accessible only by employees of Plan Manager or its Subcontractors, (ii) will not result in the further access, disclosure, or use of such information for any purpose other than providing the Services to County, and (iii) County information will not be used for large language model learning or training any generative artificial intelligence tool. Plan Manager must implement and maintain appropriate technological and operational safeguards to ensure compliance with the obligations of this section.

13.35. Polystyrene Food Service Articles. Plan Manager shall not sell or provide for use on County property expanded polystyrene products or food service articles (e.g., Styrofoam), unencapsulated expanded polystyrene products, or single-use plastic straws or stirrers, as set forth in more detail in Section 27.172, Broward County Administrative Code.

12. Sections 1.3, 1.19, 1.35, 1.66, 1.126, 1.127, and 1.165 of Exhibit A, Definitions, are amended as follows:

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 **based on a billable amount per item or program structure, i.e., on a Per Enrolled Employee Per Month (PEPM) or Per Person Per Month (PPPM)** 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.

1.19. **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.

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

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 **"Y"** ~~"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).

~~1.126. **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 medications designated as preventive according to Internal Revenue Service (IRS) guidelines and guidance from other applicable federal entities.~~

~~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. the list of Preventive Drugs, as defined herein, established and maintained by Plan Manager, which identifies those medications eligible for preventive coverage under the Plan and is developed in accordance with applicable administrative guidance issued by the IRS and other applicable federal entities, as such guidance may be updated from time to time.~~

1.165. **URAC (Utilization Review Accreditation Commission)** 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.

13. New Sections 1.177 through 1.186 are added to Exhibit A, Definitions, as follows (bold/underlining omitted):

1.177. **Applicable Law** means all applicable laws, codes, advisory circulars, rules, regulations, and ordinances of any federal, state, county, municipal, or other governmental entity, as amended.

1.178. **Biosimilar Drug** means a biological product that is highly similar to an FDA-approved reference product, having no clinically meaningful differences in safety, purity, or potency. These medications use living organisms and are designed to provide the same therapeutic benefits, strength, and dosage as the original brand-name product, often at a lower cost.

1.179. **Capitation** means when a Participating Provider receives a periodic payment to perform or coordinate certain health care services. The Participating Provider receives a capitation payment regardless of, (i) the volume of services, or (ii) whether the cost of providing or arranging to provide the Plan Participant's health care is less than or more than the payment.

1.180. **County Specific Provider(s)** means a contracted provider or facility that has entered into or is governed by contractual arrangements with County, either directly or through another entity, other than the Plan Manager, under which the provider agrees to

provide health care services to Plan Participants and accept negotiated fees for such services.

1.181. **Limited Distribution Drugs** means prescription drugs only available through select pharmacy providers as determined by the Pharmaceutical Manufacturer.

1.182. **No Surprises Act** means the federal law enacted under the Consolidated Appropriations Act, 2021 (Public Law 116-260), and its implementing regulations, as may be amended, that establishes protections for patients against certain unexpected or balance billing practices.

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

1.184. **Pharmaceutical Manufacturer Administrative Fees** means the administrative fees paid by drug manufacturers to Plan Manager for Plan Manager's provision of Rebate administration services.

1.185. **Pricing Source** means the Medi-Span Prescription Pricing Guide, with supplements, or another nationally recognized pricing source determined by the pharmacy benefit manager.

1.186. **Single-Source Generic Drug** means a generic drug that has only one generic manufacturer.

14. Exhibit D, Schedule of Fees/Discounts, is hereby deleted in its entirety and replaced with Exhibit D, Schedule of Fees/Discounts, attached hereto. The replaced Exhibit D includes Attachment D-1 and Attachment D-2, each of which is incorporated into and made a part of Exhibit D. All references in the Agreement to Exhibit D shall be deemed to refer to Exhibit D attached hereto, inclusive of all attachments.

15. Exhibit F, Carrier-Specific Medical Discount Guarantee, is hereby deleted in its entirety and replaced with Exhibit F, Carrier-Specific Medical Claims Trend Guarantee, attached hereto. All references in the Agreement to Exhibit F shall be deemed to refer to Exhibit F attached hereto.

16. Each of the following exhibits to the Agreement is hereby deleted in its entirety and replaced with the corresponding exhibit attached to this Amendment: (i) Exhibit C, Scope of Services; (ii) Exhibit E, Shared Savings (Naviguard) Program, Subrogation, Payment Integrity and Recovery Services; (iii) Exhibit H, Performance Measures; (iv) Exhibit J, Clinical Program Services; (v) Exhibit K, Networks; (vi) Exhibit L, Persons Authorized to Receive Private Health Information; (vii) Exhibit M, Wellness Program; (viii) Exhibit N, Retiree Drug Subsidy Requirements; and (ix) Exhibit P, Banking Arrangement. All references in the Agreement to such exhibits shall be deemed to refer to the corresponding exhibits attached hereto.

17. In the event of any conflict or ambiguity between this Amendment and the Agreement, the Parties agree that this Amendment shall control. The Agreement, as amended herein by this Amendment, incorporates and includes all prior negotiations, correspondence, conversations, agreements, and understandings applicable to the matters contained herein, and the Parties agree that there are no commitments, agreements, or understandings concerning the subject matter hereof that are not contained in the Agreement as amended in this Amendment. Accordingly, the Parties agree that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written.

18. Preparation of this Amendment has been a joint effort of the Parties and the resulting document shall not, solely as a matter of judicial construction, be construed more severely against one of the Parties than any other.

19. Plan Manager acknowledges that through the date this Amendment is executed by Contractor, Plan Manager has no claims or disputes against County relating to the Agreement including as amended herein.

20. The effective date of this Amendment shall be January 1, 2027.

21. This Amendment may be executed in multiple originals or in counterparts, whether signed physically or electronically; each of which shall be deemed to be an original, and all of which, taken together, shall constitute one and the same agreement.

(Remainder of page intentionally left blank.)

IN WITNESS WHEREOF, the Parties hereto have made and executed this Amendment: 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 ____ day of _____, 20__; and United Healthcare Services, Inc., signing by and through its duly authorized representative.

COUNTY


ATTEST:

BROWARD COUNTY, by and through
its Board of County Commissioners

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

By: _____
Mayor
____ day of _____, 20__

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

SANDY
By: STEED  Digitally signed by SANDY
STEED
Date: 2026.05.27 10:30:13
-04'00'
Sandy Steed (Date)
Assistant County Attorney

Danielle W.
By: French  Digitally signed by Danielle
W. French
Date: 2026.05.27 10:35:56
-04'00'
Danielle W. French (Date)
Deputy County Attorney

SS/cv
2026-05-22 Third Amendment to Health and Pharmacy Agreement
#1228961.10

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

PLAN MANAGER

United Healthcare Services, Inc.

By: John S. Aissis Digitally signed by John S.
Aissis
Date: 2026.05.27 09:34:31
-04'00'
Authorized Signer

John S. Aissis, Assistant Secretary
Print Name and Title

27th day of May, 2026

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 electronically or, if requested, by mail
- 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 member and provider steerage
 - 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 for 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
 - 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. Maternity Support Online
- vii. 24/7 Virtual Visits
- viii. Level 2 Type 2 Diabetes Specific Program
- 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 - \$350K allowance per Plan Year for health fairs, on-site biometric screenings, on-site flu shots, Wellness activities, Wellness events, and 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, two (2) Plan Manager representatives, and one (1) Wellness Nutritionist, onsite during County business operation hours
 - 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 Programs in accordance with Exhibit K, in which Plan Manager discloses savings achieved by service and provider
- uu. Disclosure and refund to County of any recovery amounts from advance analytics and recovery services in accordance with Exhibit E
- vv. All other functions required to fulfill the requirements of this Agreement

Pharmacy specific:

- ww. Online formulary/preferred drug listing
- xx. Online preventive drug list
- 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

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 Plan Participants' eligibility, provide assistance with accessing benefits; and to resolve claims payment problems. Customer service representatives must be knowledgeable about all plans offered by County and be able to assist members 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, 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 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 health 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/mailing to Plan Participants upon the request of County or 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 (calendar) 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 calendar 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 patient's eligibility;
 - b. verify patients 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 Plan Participant-submitted Claims, and a remittance advice for provider-submitted Claims.
7. Plan Manager shall maintain online history of all Claims submitted and 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 to a Plan Participant or a provider in accordance with Exhibit E, Shared Savings Program Provider Discounts and Subrogation/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.

E. Reporting Requirements

1. Plan Manager shall submit regular reports detailing financial, member services, and administrative data established within the mutually agreed upon Performance Measures in Exhibit H.
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 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 upon a mutually agreed upon format and timeframe
4. Plan Manager shall provide County and/or 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, Member 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 the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191 ("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.
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 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 under the Health Benefits Plan offered by County.
 - 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 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 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 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. Data integrity, security requirements, and HIPAA regulations require an encrypted connection for 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 County's Benefits Consultant to review participation and health outcomes and improvements.

M. Pharmacy Specific Requirements

1. Pricing and Cost Containment Requirements
 - 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 current year. The PDL must be reviewed and approved by County. Any Formulary changes proposed by the Plan Manager during the Plan Year must be reviewed and accepted 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 and formulary removals are treated, how they are deemed appropriate for coverage.

2. Plan Manager shall provide 100% pass through 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 provide 100% pass through of all medical pharmacy rebate monies.
4. Plan Manager shall disclose: 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.
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 Employee Per Year (PEPY) Pharmacy Management Allowance credit in February of each calendar 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 respects 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. 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.

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 Medicare-eligible retiree enrolled in Plan is not enrolled in Medicare Part D. Plan Manager shall administer all components 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 its Plan and prior authorization requests that are part of 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. In the event 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 at the rates set forth below. 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.

(Remainder of page intentionally left blank.)

**Exhibit D
Schedule of Fees/Discounts**

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

1. ADMINISTRATIVE 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 Employee Per Month (PEPM) basis		
2027	2028	2029
\$48.99	\$48.99	\$48.99

Administrative Fee Credit (in Dollars) - Provided once each year as listed below		
2027	2028	2029
\$150,000	\$150,000	\$150,000

- 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(s) offered and tier of coverage (Employee Only, Employee plus Spouse, Employee plus Domestic Partner, Employee plus Children, Employee plus Family, 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.
- 1.5. Plan Manager shall provide County with an annual Administrative Fee credit in the amount of One Hundred Fifty Thousand Dollars (\$150,000), which shall be applied no later than March 1 of each Plan Year to offset County’s administrative costs.

2. PHARMACY CREDITS, FEES, DISCOUNTS AND REBATE GUARANTEES

2.1. CREDITS AND ALLOWANCES

Plan Manager shall provide to County a Pharmacy Management Allowance (PMA) credit once per calendar year, payable in the second month.

Annual Pharmacy Management Allowance Paid on a Per Employee Per Year (PEPY) basis		
2027	2028	2029
\$15.00	\$15.00	\$15.00

The Pharmacy Management Allowance (PMA) will be credited to County in the 2nd month of each calendar 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 any calendar year during the Term, County shall refund to Plan Manager, within 30 days after the effective date of such termination, the full PMA credit applicable to the calendar year in which the termination occurs. 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 on a monthly basis. 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

	2027	2028	2029
Channel	Per Net Paid Claim	Per Net Paid Claim	Per Net Paid Claim
Retail Brand 30 Day:	\$0.50	\$0.50	\$0.50
Retail Brand 90 Day:	\$0.00	\$0.00	\$0.00
Retail Generic 30 Day:	\$0.50	\$0.50	\$0.50
Retail Generic 90 Day:	\$0.00	\$0.00	\$0.00
Mail Service 90 Day:	\$0.00	\$0.00	\$0.00
Specialty	\$0.00	\$0.00	\$0.00

2.3. PHARMACY REBATES & DISCOUNTS

Plan Manager shall pay County the greater of 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 the minimum guarantees as shown below. Payment of such Rebates or guarantees shall be subject to the requirements specified in Exhibit D, Attachments 1 and 2.

Channel	2027 Per Net Paid Brand Claim	2028 Per Net Paid Brand Claim	2029 Per Net Paid Brand Claim
All Brand Drugs (Preferred & Non-Preferred)			
Rebate Sharing Percentage	100%	100%	100%
Retail 30 Day Minimum:	\$450.00	\$475.00	\$500.00
Retail 90 Day Minimum:	\$1,000.00	\$1,100.00	\$1,200.00
Mail Order Minimum:	\$1,000.00	\$1,100.00	\$1,200.00
Specialty Minimum:	\$2,200.00	\$2,400.00	\$2,600.00
Pharmacy Discount Percentage (% discount from Average Wholesale Price (AWP))			
Retail Brand 30 Day	19.50%	19.50%	19.50%
Retail Generic 30 Day	87.00%	87.25%	87.50%
Retail Brand 90 Day	22.00%	22.00%	22.00%
Retail Generic 90 Day	87.00%	87.25%	87.50%
Mail Order Brand	22.00%	22.00%	22.00%
Mail Order Generic	88.00%	88.25%	88.50%
Specialty Listed	22.50%	22.50%	22.50%
Specialty Unlisted	14.00%	14.00%	14.00%

Note: Due to the constant changes in the pharmaceutical industry, these discounts and guarantees are the minimum and 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 and 90, Mail Service 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, Indian Health Service and/or Tribal Claims, long-term care Claims, home infusion 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 (OVERALL DISCOUNT RECONCILIATION) 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 discount, 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.

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.

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

2.3.6. 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.

2.3.7. "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.

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

2.3.9. 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 (Specialty Unlisted) discount guarantee provided in this exhibit.

2.3.10. 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 Service, 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.

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

2.3.12. 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 charge. 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.

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 Management 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
Level 2 Assured Value Program	
Type 2 Diabetes Management Program	\$210 Per Plan Participant Per Month
Adherence Program	
Program 1: Plan Participant Outreach	Included in Administrative Fee
Program 2: Plan Participant & Prescriber Outreach	Included in Administrative Fee
Fraud Waste & Abuse Program	
Clinical Fraud, Waste & Abuse Program: 5,001 - 10,000 Plan Participants	Fee charge based on savings (see Section 3.1, Shared Savings Chart below)
Comprehensive Fraud, Waste & Abuse Program – Intensive Audit and Investigation: Shared Savings Intensive Audit Arrangement	Fee charge based on savings (see Section 3.1, Shared Savings Chart below)
Hospital Transition Program	Included in Administrative Fee

Custom Formulary & Utilization Management Services	Additional Cost per Unit
<i>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.</i>	Cost will be quoted based on complexity of customization requested.
<i>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.</i>	Cost will be quoted based on complexity of customization requested.
<i>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.</i>	Cost will be quoted based on complexity of customization requested.

3.1. SHARED SAVINGS PROGRAMS (See Exhibits E and K)

Shared Savings Programs	Fees/% of Savings Achieved/Recovered
Naviguard Program (non-network providers) (New Transparency Laws, replaces prior Facility and Reasonable Charge Program)	25% of savings achieved (max of \$15,000 per claim)
Abuse and Fraud Management Program (review of claims that may not be legitimate)	32.5% of gross recovery amount
Hospital Bill Audit Program (retrospective review of paid claims to ensure a correct payment was made based on medical records and codes billed)	Not to exceed 22% of gross recovery amount

3.2. ADVANCE ANALYTICS AND RECOVERY SERVICES (See Exhibits E and K)

Advance Analytics and Recovery Services	Fees/% of Savings Achieved/Recovered
Subrogation Services (claims incurred by Plan Participant when a third party causes the injury or illness)	30% of gross recovery amount

Advance Analytics and Recovery Services (recovery of paid claims for a Plan Participant who was retroactively terminated by County)	24% of savings achieved
Focused Orthopedic Health Review (review of claims for orthopedic services)	22% of savings achieved
Credit Balance Recovery Program	Not to exceed 10% of gross recovery amount
Injury Coordination Coverage	30% of gross recovery amount
Transplant Resources Services Transplant Cost Negotiations	\$8,333 per negotiation (annual charge at year end reconciliation)

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.

(Remainder of page intentionally left blank.)

Exhibit D – Attachment 1

Broward County Government | Pharmacy Financials
Prepared: 5/21/2026

Unless otherwise specified, these arrangements apply to pharmacy benefits and are effective for the period beginning 01/01/2027 and ending on 12/31/2029 (each twelve month period is a "Guarantee Period"). With respect to the aspects of Plan Manager's performance addressed in this exhibit, these fee adjustments are County's exclusive financial remedies.

The arrangements will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date the Agreement is signed by both parties. In the event these arrangements become effective later than the effective date of the Guarantee Period the arrangements will commence with the Agreement Period during which the Agreement is signed by both parties.

Plan Manager shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent Plan Manager's failure is due to County's actions or inactions or if Plan Manager fails to meet these standards due to fire, embargo, strike, war, accident, pandemic, act of God, acts of terrorism or Plan Manager's required compliance with any law, regulation, or governmental agency mandate or anything beyond Plan Manager's reasonable control.

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, Plan Manager may specify to County in writing new arrangements for the subsequent Guarantee Period. If Plan Manager specifies new arrangements, Plan Manager will also provide County with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Pharmacy Financials				
Definition	Pharmacy rate guarantees.			
Measurement and Criteria	01/01/2027	01/01/2028	01/01/2029	
Component Discount Guarantee - Broad Network				
Retail Brand, Average Wholesale Price (AWP) less	19.50%	19.50%	19.50%	
Retail Brand - 90 Day Supply, AWP less	22.00%	22.00%	22.00%	
Retail Generic - 30 Day Supply, AWP less	87.00%	87.25%	87.50%	
Retail Generic - 90 Day Supply, AWP less	87.00%	87.25%	87.50%	
Mail Order Brand, AWP less	22.00%	22.00%	22.00%	
Mail Order Generic, AWP less	88.00%	88.25%	88.50%	
The Guaranteed Discount amount will be determined by multiplying the AWP by the guaranteed discount off AWP by each component.				
Dispensing Fees - Broad Network				
Retail Brand - 30 Day	\$0.50	\$0.50	\$0.50	
Retail Brand - 90 Day	\$0.00	\$0.00	\$0.00	
Retail Generic - 30 Day	\$0.50	\$0.50	\$0.50	
Retail Generic - 90 Day	\$0.00	\$0.00	\$0.00	
Dispensing fee totals are calculated by multiplying the actual scripts for each type by the contracted rate for that script type.				
Minimum Rebate Guarantee (Flex Base PDL)				
Rebate Sharing Percentage	100.0%	100.0%	100.0%	
Basis, per script	Brand	Brand	Brand	
Retail - 30 Day	\$450.00	\$475.00	\$500.00	
Retail - 90 Day	\$1,000.00	\$1,100.00	\$1,200.00	
Mail Order	\$1,000.00	\$1,100.00	\$1,200.00	
Specialty	\$2,200.00	\$2,400.00	\$2,600.00	
Credits and Allowances				
Pharmacy Management Allowance (once per enrolled employee)	\$15.00	\$15.00	\$15.00	
Fees: Included in the Medical Administration Fee. Not billed Separately				
Pharmacy Administration Fee (PEPM)	\$2.50	\$2.50	\$2.50	
Level	County Specific			
Period	Annually			
Payment Period	Annually			
Payment Amount -- Discounts	The amount the actual discounts are less than the guaranteed discount amount for each individual component.			
Payment Amount -- Dispensing Fees	The amount the combined actual dispensing fee exceeds the combined guaranteed dispensing fee.			
Payment Amount -- Rebates	The amount the combined actual Rebate amount is less than the combined guaranteed Rebate amount.			
Conditions	Discount & Dispense Fee Specific Conditions <ul style="list-style-type: none"> Discounts are based on actual Network Pharmacy brand and generic usage of retail and mail order drugs. The guaranteed discount amount will be determined by multiplying the AWP by the contracted discount rate off AWP by component. Does not apply to items covered under the Plan for which no AWP measure exists. 			

Broward County Government | Pharmacy Financials

Prepared: 5/21/2026

• Discounts calculated based on AWP less the ingredient cost; discount percentages are the discounts divided by the AWP. Discounts for retail and mail order generic prescriptions represent the average AWP based on savings off Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP.

REDACTED

- The 90 day supply Retail guarantee includes drugs dispensed for 84 days or greater; claims with less than 84 days' supply are included with Retail 30.
- The Mail Order guarantee includes drugs dispensed for 46 days or greater; claims with less than 46 days supply are reconciled at retail.
- When a drug is identified as a brand name drug, it will be considered a brand name drug for the calculation of discount guarantees. When a drug is identified as a generic drug, it will be considered a generic drug for the calculation of discount guarantees.

Rebate Specific Conditions

- Assumes implementation of Plan Manager's Flex Base PDL
- Rebate guarantees are contingent upon County's adoption, without deviation, of Plan Manager's PDL and PDL exclusions, as well as any changes Plan Manager makes to its PDL and PDL exclusions; and the implementation of the step therapies required by Plan Manager, as well as any changes Plan Manager makes to its utilization management programs.

REDACTED

• Rebate guarantee payments or reconciliations may be adjusted in the event of a change impacting the level of Rebates due to the utilization of therapeutically equivalent, lower Rebate drugs (e.g. biosimilar, authorized brand alternative, lower cost non-Generic Drug alternative) or the reduction of Wholesale Acquisition Cost on a Brand Drug subject to Rebates. In the event a payment or reconciliation adjustment is required, such adjustment will be based on the difference between a) pharmaceutical manufacturer revenue prior to the introduction of the lower Rebate drugs and b) the actual pharmaceutical manufacturer revenue received after the introduction of the lower Rebate drugs. Such adjustment does not apply to Generic Drugs that launch after the Brand Drug no longer has patent protection.

• The Rebate guarantees account for projected Rebate reductions in the following classes of Prescription Drugs in connection with the elimination of the Average Manufacturer's Price (AMP) Cap pursuant to the American Rescue Plan Act of 2021: Insulin products and Respiratory Medications. Plan Manager reserves the right to modify any Rebate guarantees if there are any additional changes Specific to AMP Cap to Rebates received from pharmaceutical manufacturers.

Broward County Government | Pharmacy Financials

Prepared: 5/21/2026

- The Rebate guarantees assume Stelara is excluded from coverage; Rebate payment or reconciliation adjustments will not apply to utilization of therapeutically equivalent, low WAC Stelara biosimilars.

- The Rebate guarantees assume Humira is excluded from coverage; Rebate payment or reconciliation adjustments will not apply to utilization of therapeutically equivalent, low WAC Humira biosimilars.

Plan Manager reserves the right to modify this arrangement as follows based upon changes in Rebates:

- if changes made to Plan Manager's PDL, for the purpose of achieving a lower net drug cost for County and Plan Manager's other ASO Countys, result in significant reductions to the Rebate level

- in the event that there are material deviations to the anticipated timing of drugs that will come off patent and no longer generate Rebates

- if there is a change impacting the availability or amount of Rebates offered by drug manufacturer(s), including changes related to the elimination or material modification of a drug manufacturer(s) historic models or practices related to the provision of Rebates

- If the average Specialty Brand days' supply declines below 28

- Plan Manager will pay Rebates consistent with the Agreement. A reconciliation of the Rebate amounts will occur after the end of each annual contract period and when Rebate payments are substantially complete. The reconciliation calculates the minimum rebate amount by multiplying the actual number of scripts filled by the applicable rebate amount for that script type.

- The Parties acknowledge and agree that Plan Manager has priced the pharmacy benefit services under this Agreement in reliance on County's commitment to receive such services from Plan Manager for the entire Pharmacy Pricing Term. In the event that County terminates pharmacy benefit services under this Agreement prior to the end of the Pharmacy Pricing Term, the following will apply:

- Plan Manager will retain 100% of all pending and future Rebates payable under the Agreement as of the effective date of the termination of pharmacy benefit services and no reconciliation of minimum rebate guarantees will apply.

Credits and Allowances

- Pharmacy Management Allowance: Plan Manager will provide a credit allowance to help County mitigate costs appropriately associated with the administration of the pharmacy program. This credit allowance is available once the parties have an executed Agreement and the first month of service fees under the Agreement has been received by Plan Manager. Upon request from the County, a credit will be issued in Plan Manager's fee billing system

- If County terminates pharmacy benefit services with Plan Manager prior to the end of the Pharmacy Pricing Term, County will repay Plan Manager a prorated portion of the amount of the Pharmacy Management Allowance, this would only be retroactively prorated for the current year's PMA and not the entire part back to the beginning of the agreement. All unpaid credits are forfeit

Market Check

County may conduct one market check during the Pharmacy Pricing Term to confirm its financial terms are competitive with those currently available in the market for substantially similar Countys. Such analysis shall:

- be initiated after the first anniversary of the Effective Date of the Agreement

- be conducted by a third party

- include no fewer than four substantially similar Countys under active contracts as determined by the following criteria which must be included in the market check report:

- Within 10% of total membership count
- Same County type (carve-in, coalition, etc.)
- Same line of business (commercial, Medicare, Medicaid, etc.)
- Same types of services (retail, home delivery, specialty, etc.)
- Comparison of pricing for same contract year
- Pricing quoted within past six-month period
- A majority of membership located in a comparable geographic region

- The market check will compare the aggregate value of pricing terms including the combined net value of:

- Ingredient cost discounts and dispensing fees from retail pharmacies, home delivery pharmacies, and specialty pharmacies
- Rebates
- Administrative fees
- Client Credits

If the market check report validates an annualized savings of greater than three (3) percent between the median of the financial terms for such substantially similar Countys and County's financial terms for time period that is the subject of the market check, the parties will negotiate in good faith to revise the financial terms. Plan Manager responds to County within 30 days of receipt of the complete market check report containing sufficient information for Plan Manager to validate that the analysis was conducted in accordance with the above criteria. Any revisions to financial terms resulting from the parties' negotiations are effective the first day of the following contract year, subject to the parties having agreed to revisions in writing at least 30 days prior to the effective date.

General Conditions

Broward County Government | Pharmacy Financials

Prepared: 5/21/2026

- All pricing guarantees shall remain in effect for the entire contract period of 01/01/2027 through 12/31/2029 ("Pharmacy Pricing Term"). Each twelve month period is a Guarantee Period.

REDACTED

- For mail order drugs, specialty drugs, and retail pharmacy drugs and services including dispensing fees, the amount Plan Manager reimburses the Network Pharmacy will be equal to the County's payment for a prescription drug product or service.
- Pricing and guarantees assume enrollment of 5,766 Employees and 11,364 Participants; pricing and guarantees may be revised or withdrawn if actual enrollment varies by 10% or more from assumptions.
- The lesser of three logic (non-ZBL) will apply to Participant payments. Participants pay the lesser of the discounted price, the usual and customary charge or the cost share amount.
- All pricing guarantees require the selection of Plan Manager's PBM as exclusive provider of pharmacy benefit services, including but not limited to retail, mail order, and specialty networks.
- Plan Manager's Price Edge program applies
- Plan Manager will have no financial guarantee obligation under the Agreement for any partial Guarantee Period if County terminates with an effective date prior to the end of the Pharmacy Pricing Term.
- In the event any of the terms herein is inconsistent with the requirements of any federal, state or other applicable law or regulation, then the inconsistent term(s) will be null and void and Plan Manager will have the right to revise, reprice or revoke this arrangement.
- Plan Manager reserves the right to revise or revoke this arrangement if: a) changes in federal, state or other applicable law or regulation require modifications; b) there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in these arrangements; c) County makes benefit changes that impact the arrangements; d) there is a material industry change in pricing methodologies resulting in a new source or benchmark; e) it is not accepted within ninety (90) days of the issuance of our quote; f) if County changes their mail service benefit; g) County utilizes a vendor, that facilitates steering members to different drugs or pharmacies to the extent these services impact the financial guarantees under this Agreement.

Brand / Generic Reconciliation Definition

- **Brand Drug:** An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, which is manufactured and distributed by an innovator drug company, or its licensee, set forth in Medi-Span's National Drug Data File as a brand drug identified by all of the products meeting at least one of the following criteria:
 - Medi-Span Multi-Source Code ("MSC") is equal to M, O, or N.
- **Generic Drug:** An FDA approved drug, or a drug that is designated by FDA a DESI (Drug Efficacy Study Implementation) drug, or product, that is therapeutically equivalent to other pharmaceutically equivalent products, as set forth in Medi-Span's National Drug Data File as a generic drug identified by all products meeting at least one of the following criteria:
 - Medi-Span Multi-Source Code ("MSC") is equal to Y.

PTRX (11/2025)

Exhibit D – Attachment 2

Broward County Government

Specialty Pharmacy
Financial Guarantees
Prepared: 5/21/2026

Unless otherwise specified, these arrangements apply to pharmacy benefits and are effective for the period beginning 01/01/2027 and ending on 12/31/2029 (each twelve month period is a "Guarantee Period"). With respect to the aspects of Plan Manager's performance addressed in this exhibit, these fee adjustments are County's exclusive financial remedies.

The arrangements will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date the Agreement is signed by both parties. In the event these arrangements become effective later than the effective date of the Guarantee Period the arrangements will commence with the Agreement Period during which the Agreement is signed by both parties.

Plan Manager shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent Plan Manager's failure is due to County's actions or inactions or if Plan Manager fails to meet these standards due to fire, embargo, strike, war, accident, pandemic, act of God, acts of terrorism or Plan Manager's required compliance with any law, regulation, or governmental agency mandate or anything beyond Plan Manager's reasonable control.

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, Plan Manager may specify to County in writing new arrangements for the subsequent Guarantee Period. If Plan Manager specifies new arrangements, Plan Manager will also provide County with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Specialty Pharmacy Specialty Pharmacy Discount Guarantee							
Definition	REDACTED						
Measurement	Listed		01/01/2027	01/01/2028	01/01/2029		
	All Include LDD		22.50%	22.50%	22.50%		
	Unlisted		01/01/2027	01/01/2028	01/01/2029		
	All Include LDD		14.00%	14.00%	14.00%		
Criteria	REDACTED						
Level	County Specific						
Period	Annual						
Payment Period	Annual						
Payment Amount	The amount the combined actual specialty drug discounts are less than the composite discount drug target.						
Conditions	<ul style="list-style-type: none"> Discounts calculated based on the AWP less the ingredient cost, discount percentages are the discounts divided by the AWP. Discounts for generic prescriptions represent the average savings off AWP based on Maximum Allowable Cost (MAC) pricing for MAC generics and percentage discount savings off AWP for non-MAC generics. All other discounts represent the percentage discount savings off of AWP. 						
	REDACTED						
	<ul style="list-style-type: none"> Limited Distribution (LDD) status is subject to change based on manufacturer decision. 						
	REDACTED						
	<ul style="list-style-type: none"> Plan Manager reserves the right to revise or revoke this guarantee if: <ol style="list-style-type: none"> material changes in federal, state or other applicable law or regulation require modifications; there are material changes to the AWP as published by the pricing agency that establishes the AWP as used in this guarantee; County makes benefit changes that impact the guarantee; there is a material industry change in pricing methodologies resulting in a new source or benchmark; For specialty drugs, the amount Plan Manager reimburses the Network Pharmacy will be equal to the County's payment for a prescription drug product or service. 						
Specialty Drug Category	Drug Name	LDD Indicator	Included/Excluded From Guarantee	Specialty Drug Category	Drug Name	LDD Indicator	Included/Excluded From Guarantee
AMMONIA DETOXICANTS	RAVICI	Yes	Included	INFLAMMATORY CONDITIONS	NEMLUVIO	Yes	Included
ANEMIA	ARANESP	No	Included	INFLAMMATORY CONDITIONS	OLUMIANT	No	Included
ANEMIA	EPOGEN	No	Included	INFLAMMATORY CONDITIONS	OMVOH	No	Included
ANEMIA	PROCRIT	No	Included	INFLAMMATORY CONDITIONS	OPZELURA	No	Included
ANEMIA	RETACRIT	No	Included	INFLAMMATORY CONDITIONS	ORENCIA	No	Included
ANTIBACTERIALS	ARIKAYCE	Yes	Included	INFLAMMATORY CONDITIONS	OTEZLA	No	Included
ANTICONVULSANTS	DIACOMIT	Yes	Included	INFLAMMATORY CONDITIONS	RIDAURA	No	Included
ANTICONVULSANTS	EPIDIOLEX	Yes	Included	INFLAMMATORY CONDITIONS	RINVOQ	No	Included
ANTICONVULSANTS	PINTEPLA	Yes	Included	INFLAMMATORY CONDITIONS	SILIQ	No	Included
ANTICONVULSANTS	ZTALMY	Yes	Included	INFLAMMATORY CONDITIONS	SIMLANDI	No	Included
ANTHYPERLIPIDEMIC	JUXTAPID	Yes	Included	INFLAMMATORY CONDITIONS	SIMPONI	No	Included
ANTHYPERLIPIDEMIC	TRYNGOLZA	Yes	Included	INFLAMMATORY CONDITIONS	SKYRIZI	No	Included
ANTI-INFECTION	DARAPRIM	Yes	Included	INFLAMMATORY CONDITIONS	SOTYKTU	No	Included
ANTI-INFECTION	LIVTEN CITY	Yes	Included	INFLAMMATORY CONDITIONS	SPEVIGO	Yes	Included
ANTI-INFECTION	PRIMEAMINE	No	Included	INFLAMMATORY CONDITIONS	STELARA	No	Included
ASTHMA	FASENRA	Yes	Included	INFLAMMATORY CONDITIONS	STEQUEYMA	No	Included
ASTHMA	NUCALA	Yes	Included	INFLAMMATORY CONDITIONS	TALTZ	No	Included
ASTHMA	TEZSPIRE	Yes	Included	INFLAMMATORY CONDITIONS	TREMFYA	No	Included
ASTHMA	XOLAIR	Yes	Included	INFLAMMATORY CONDITIONS	TYENNE	No	Included
CARDIOVASCULAR	ATTIRUBY	Yes	Included	INFLAMMATORY CONDITIONS	VELSIPITY	No	Included
CARDIOVASCULAR	CAMZYOS	Yes	Included	INFLAMMATORY CONDITIONS	WEZLANA	No	Included
CARDIOVASCULAR	DROXIDOPA	No	Included	INFLAMMATORY CONDITIONS	XELJANZ	No	Included
CARDIOVASCULAR	NORTHERA	Yes	Included	INFLAMMATORY CONDITIONS	XELJANZ XR	No	Included
CARDIOVASCULAR	VYNDAMAX	Yes	Included	INFLAMMATORY CONDITIONS	YESINTEK	No	Included
CARDIOVASCULAR	VYNDAGEL	Yes	Included	INFLAMMATORY CONDITIONS	YUFLYMA	No	Included
CNS AGENTS	AUSTEDO	No	Included	INFLAMMATORY CONDITIONS	YUSIMRY	No	Included
CNS AGENTS	DAYBUE	Yes	Included	INFLAMMATORY CONDITIONS	ZYMFENTRA	No	Included
CNS AGENTS	ENSPRYNG	Yes	Included	IRON OVERLOAD	DEFERASIROX	Yes	Included
CNS AGENTS	EXSERVAN	Yes	Included	IRON OVERLOAD	DEFERIPRONE	No	Included
CNS AGENTS	FIRDAPSE	Yes	Included	IRON OVERLOAD	EXJADE	Yes	Included
CNS AGENTS	HETLIOZ	Yes	Included	IRON OVERLOAD	FERRIPROX	Yes	Included

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CNS AGENTS	INGREZZA	Yes	Included	IRON OVERLOAD	JADENU	No	Included
CNS AGENTS	RADICAVA	Yes	Included	METABOLIC AGENTS	MIPLYFFA	Yes	Included
CNS AGENTS	RELYVRIO	Yes	Included	METABOLIC BONE DISEASE	SOHONOS	Yes	Included
CNS AGENTS	RILUTEK	No	Included	MOOD DISORDER DRUGS	SPRAVATO	No	Included
CNS AGENTS	RILUZOLE	No	Included	MOOD DISORDER DRUGS	ZURZUVAE	Yes	Included
CNS AGENTS	SABRIL	Yes	Included	MULTIPLE SCLEROSIS	AMPHYRA	Yes	Included
CNS AGENTS	SKYCLARYS	Yes	Included	MULTIPLE SCLEROSIS	AUBAGIO	No	Included
CNS AGENTS	TASIMELTEON	Yes	Included	MULTIPLE SCLEROSIS	AVONEX	No	Included
CNS AGENTS	TEGLUTIK	Yes	Included	MULTIPLE SCLEROSIS	BAFIERTAM	Yes	Included
CNS AGENTS	TETRABENAZINE	No	Included	MULTIPLE SCLEROSIS	BETASERON	No	Included
CNS AGENTS	TIGLUTIK	Yes	Included	MULTIPLE SCLEROSIS	COPAXONE	No	Included
CNS AGENTS	VIGABATRIN	No	Included	MULTIPLE SCLEROSIS	DALFAMPRIDIN	No	Included
CNS AGENTS	VIGADRON	Yes	Included	MULTIPLE SCLEROSIS	DIMETHYL FUMARATE	No	Included
CNS AGENTS	VIGPODER	Yes	Included	MULTIPLE SCLEROSIS	EXTAVIA	No	Included
CNS AGENTS	XENAZINE	Yes	Included	MULTIPLE SCLEROSIS	FINGOLIMOD	No	Included
CYSTIC FIBROSIS	ALYFTREK	Yes	Included	MULTIPLE SCLEROSIS	GILENYA	No	Included
CYSTIC FIBROSIS	BETHKIS	No	Included	MULTIPLE SCLEROSIS	GLATIRAMER	No	Included
CYSTIC FIBROSIS	BRONCHITOL	Yes	Included	MULTIPLE SCLEROSIS	GLATOPA	No	Included
CYSTIC FIBROSIS	CAYSTON	Yes	Included	MULTIPLE SCLEROSIS	KESIMPTA	No	Included
CYSTIC FIBROSIS	KALYDECO	Yes	Included	MULTIPLE SCLEROSIS	MAVENCLAD	Yes	Included
CYSTIC FIBROSIS	KITABIS PAK	Yes	Included	MULTIPLE SCLEROSIS	MAYZENT	No	Included
CYSTIC FIBROSIS	ORKAMBI	Yes	Included	MULTIPLE SCLEROSIS	PLEGRIDY	Yes	Included
CYSTIC FIBROSIS	PULMOZYME	No	Included	MULTIPLE SCLEROSIS	PONVORY	Yes	Included
CYSTIC FIBROSIS	SYMDEKO	Yes	Included	MULTIPLE SCLEROSIS	REBIF	No	Included
CYSTIC FIBROSIS	TOBI	No	Included	MULTIPLE SCLEROSIS	REBIF REBIDOSE	No	Included
CYSTIC FIBROSIS	TOBI PODHALER	No	Included	MULTIPLE SCLEROSIS	TASCENSO	Yes	Included
CYSTIC FIBROSIS	TOBRAMYCIN	No	Included	MULTIPLE SCLEROSIS	TECFIDERA	Yes	Included
CYSTIC FIBROSIS	TRIKAFTA	Yes	Included	MULTIPLE SCLEROSIS	TERIFLUNOMIDE	No	Included
DERMATOLOGIC	LITULO	Yes	Included	MULTIPLE SCLEROSIS	VUMERITY	Yes	Included
DU CHENNE MUSCULAR DYSTROPHY	AGAMREE	Yes	Included	MULTIPLE SCLEROSIS	ZEPOSIA	Yes	Included
DU CHENNE MUSCULAR DYSTROPHY	DEFLAZACORT	No	Included	MUSCULOSKELETAL AGENTS	EVRYSDI	Yes	Included
DU CHENNE MUSCULAR DYSTROPHY	DUVYZAT	Yes	Included	MUSCULOSKELETAL AGENTS	VOXZOGO	Yes	Included
DU CHENNE MUSCULAR DYSTROPHY	EMFLAZA	Yes	Included	MUSCULOSKELETAL AGENTS	ZILBRYSQ	Yes	Included
ENDOCRINE	BETAINE	No	Included	MUSCULOSKELETAL DISORDERS	DICHLORPHENAMIDE	No	Included
ENDOCRINE	CHENODAL	Yes	Included	MUSCULOSKELETAL DISORDERS	KEVEYS	Yes	Included
ENDOCRINE	CRENESSITY	Yes	Included	NARCOLEPSY	LUMRYZ	Yes	Included
ENDOCRINE	CTEXTI	Yes	Included	NARCOLEPSY	SODIUM OXYBATE	Yes	Included
ENDOCRINE	CUPRIMINE	No	Included	NARCOLEPSY	WAKIX	Yes	Included
ENDOCRINE	CUVRIOR	Yes	Included	NARCOLEPSY	XYREM	Yes	Included
ENDOCRINE	CYSTADANE	Yes	Included	NARCOLEPSY	XYWAV	Yes	Included
ENDOCRINE	DEPEN TITRATABS	No	Included	NEUTROPENIA	FULPHILA	No	Included
ENDOCRINE	EGRIFTA	Yes	Included	NEUTROPENIA	FYLNETRA	No	Included
ENDOCRINE	FIRMAGON	No	Included	NEUTROPENIA	GRANIX	No	Included
ENDOCRINE	IMCVREE	Yes	Included	NEUTROPENIA	LEUKINE	No	Included
ENDOCRINE	ISTURISA	Yes	Included	NEUTROPENIA	NEULASTA	No	Included
ENDOCRINE	JAVYGTOR	Yes	Included	NEUTROPENIA	NEUPOGEN	No	Included
ENDOCRINE	JYNARGUE	Yes	Included	NEUTROPENIA	NIVESTYM	No	Included
ENDOCRINE	KORLYM	Yes	Included	NEUTROPENIA	NYVEPRIA	No	Included
ENDOCRINE	KUVAN	Yes	Included	NEUTROPENIA	RELEUKO	No	Included
ENDOCRINE	LANREOTIDE	No	Included	NEUTROPENIA	STIMUFEND	No	Included
ENDOCRINE	MIFEPRISTONE	Yes	Included	NEUTROPENIA	UDENYCA	No	Included
ENDOCRINE	MYALEPT	Yes	Included	NEUTROPENIA	ZARXIO	No	Included
ENDOCRINE	MYCAPSSA	Yes	Included	NEUTROPENIA	ZIEXTENZO	No	Included
ENDOCRINE	NATPARA	Yes	Included	ONCOLOGY - INJECTABLE	BESREMI	Yes	Included
ENDOCRINE	NITYR	Yes	Included	ONCOLOGY - INJECTABLE	ELIGARD	No	Included
ENDOCRINE	OCTREOTIDE ACETATE	No	Included	ONCOLOGY - INJECTABLE	INTRON A	Yes	Included
ENDOCRINE	PENICILLAMINE	No	Included	ONCOLOGY - INJECTABLE	LEUPROLIDE	No	Included
ENDOCRINE	PROCYSLI	Yes	Included	ONCOLOGY - INJECTABLE	SYNRIBO	Yes	Included
ENDOCRINE	RECORLEV	Yes	Included	ONCOLOGY - ORAL	ABIRATERONE	No	Included
ENDOCRINE	SAMSCA	Yes	Included	ONCOLOGY - ORAL	ABIRTEGA	No	Included
ENDOCRINE	SANDOSTATIN	No	Included	ONCOLOGY - ORAL	AFINITOR	No	Included
ENDOCRINE	SAPROTERIN	Yes	Included	ONCOLOGY - ORAL	AFINITOR DISPERZ	No	Included
ENDOCRINE	SIGNIFOR	Yes	Included	ONCOLOGY - ORAL	AKEEGA	Yes	Included
ENDOCRINE	SOMATULINE DEPOT	No	Included	ONCOLOGY - ORAL	ALECENSA	Yes	Included
ENDOCRINE	SOMAVERT	Yes	Included	ONCOLOGY - ORAL	ALKERAN	No	Included
ENDOCRINE	SYPRINE	No	Included	ONCOLOGY - ORAL	ALUNBRIG	Yes	Included
ENDOCRINE	THIOLA	Yes	Included	ONCOLOGY - ORAL	AUGTYRO	No	Included
ENDOCRINE	TIOPRONIN	No	Included	ONCOLOGY - ORAL	AYYAKT	Yes	Included
ENDOCRINE	TOLVAPTAN	No	Included	ONCOLOGY - ORAL	BALVERSA	Yes	Included
ENDOCRINE	TRIENTINE	No	Included	ONCOLOGY - ORAL	BEXAROTENE	No	Included
ENDOCRINE	XURIDEN	Yes	Included	ONCOLOGY - ORAL	BOSULIF	Yes	Included
ENDOCRINE	YORVIPATH	Yes	Included	ONCOLOGY - ORAL	BRAFTOVI	Yes	Included
ENZYMES DEFICIENCY	TEGSEDI	Yes	Included	ONCOLOGY - ORAL	BRUKINSA	Yes	Included
ENZYMES THERAPY	BUPHENYL	No	Included	ONCOLOGY - ORAL	CABOMETYX	Yes	Included
ENZYMES THERAPY	CARBAGLU	Yes	Included	ONCOLOGY - ORAL	CALQUENCE	Yes	Included
ENZYMES THERAPY	CARGLUMIC	Yes	Included	ONCOLOGY - ORAL	CAPECITABINE	No	Included
ENZYMES THERAPY	CERDELGA	Yes	Included	ONCOLOGY - ORAL	CAPRELSA	Yes	Included
ENZYMES THERAPY	CHOLBAM	Yes	Included	ONCOLOGY - ORAL	COMETRIQ	Yes	Included
ENZYMES THERAPY	CYSTAGON	Yes	Included	ONCOLOGY - ORAL	COPIKTRA	Yes	Included
ENZYMES THERAPY	GALAFOLD	Yes	Included	ONCOLOGY - ORAL	COTELLIC	Yes	Included
ENZYMES THERAPY	MIGLUSTAT	No	Included	ONCOLOGY - ORAL	DASATINIB	No	Included

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ENZYMES THERAPY	NITISINONE	No	Included	ONCOLOGY - ORAL	DAURISMO	Yes	Included
ENZYMES THERAPY	OLPRUVA	Yes	Included	ONCOLOGY - ORAL	ERIVEDGE	Yes	Included
ENZYMES THERAPY	OPFOLDA	Yes	Included	ONCOLOGY - ORAL	ERLEADA	No	Included
ENZYMES THERAPY	ORFADIN	Yes	Included	ONCOLOGY - ORAL	ERLOTINIB	Yes	Included
ENZYMES THERAPY	PALYNZIQ	Yes	Included	ONCOLOGY - ORAL	ETOPOSIDE	No	Included
ENZYMES THERAPY	PHEBURANE	Yes	Included	ONCOLOGY - ORAL	EVEROLIMUS	No	Included
ENZYMES THERAPY	SODIUM PHENYLBU TYRATE	No	Included	ONCOLOGY - ORAL	EXKIVITY	Yes	Included
ENZYMES THERAPY	STRENSIQ	Yes	Included	ONCOLOGY - ORAL	FARYDAK	Yes	Included
ENZYMES THERAPY	SUCRAID	Yes	Included	ONCOLOGY - ORAL	FOTIVDA	Yes	Included
ENZYMES THERAPY	WAINUA	Yes	Included	ONCOLOGY - ORAL	FRUZAOLA	Yes	Included
ENZYMES THERAPY	YARGESA	Yes	Included	ONCOLOGY - ORAL	GAVRETO	Yes	Included
ENZYMES THERAPY	ZAVESCA	Yes	Included	ONCOLOGY - ORAL	GEFITINIB	No	Included
GASTROINTESTINAL AGENTS	GATTEX	Yes	Included	ONCOLOGY - ORAL	GILOTRIF	Yes	Included
GASTROINTESTINAL AGENTS	IQIRVO	Yes	Included	ONCOLOGY - ORAL	GLEEVEC	No	Included
GASTROINTESTINAL AGENTS	LIVDELZI	Yes	Included	ONCOLOGY - ORAL	GLEOSTINE	No	Included
GASTROINTESTINAL AGENTS	OCALIVA	Yes	Included	ONCOLOGY - ORAL	HYCAMTIN	No	Included
GASTROINTESTINAL AGENTS	YOWST	Yes	Included	ONCOLOGY - ORAL	IBRANCE	Yes	Included
GASTROINTESTINAL AGENTS	XERMELO	Yes	Included	ONCOLOGY - ORAL	ICLUSIG	Yes	Included
GENETIC DISORDER	DOJOLVI	Yes	Included	ONCOLOGY - ORAL	IDHIFA	No	Included
GENETIC DISORDER	RIVFLOZA	Yes	Included	ONCOLOGY - ORAL	IMATINIB MESYLATE	No	Included
GENETIC DISORDER	VJOICE	No	Included	ONCOLOGY - ORAL	IMBRUVICA	Yes	Included
GENETIC DISORDER	ZOKINYY	Yes	Included	ONCOLOGY - ORAL	INKELDI	No	Included
GROWTH HORMONE DEFICIENCY	GENOTROPIN	No	Included	ONCOLOGY - ORAL	INLYTA	Yes	Included
GROWTH HORMONE DEFICIENCY	HUMATROPE	No	Included	ONCOLOGY - ORAL	INQOVI	Yes	Included
GROWTH HORMONE DEFICIENCY	INCARELEX	Yes	Included	ONCOLOGY - ORAL	INREBIC	Yes	Included
GROWTH HORMONE DEFICIENCY	INGENLA	No	Included	ONCOLOGY - ORAL	IPRESSA	Yes	Included
GROWTH HORMONE DEFICIENCY	NORDITROPIN	No	Included	ONCOLOGY - ORAL	ITOVEBI	Yes	Included
GROWTH HORMONE DEFICIENCY	NU TROPIN AQ	No	Included	ONCOLOGY - ORAL	IWILFIN	Yes	Included
GROWTH HORMONE DEFICIENCY	OMNITROPE	No	Included	ONCOLOGY - ORAL	JAKAFI	Yes	Included
GROWTH HORMONE DEFICIENCY	SAIZEN	No	Included	ONCOLOGY - ORAL	JAYPIRCA	Yes	Included
GROWTH HORMONE DEFICIENCY	SEROSTIM	No	Included	ONCOLOGY - ORAL	KISQALI	No	Included
GROWTH HORMONE DEFICIENCY	SKYTROFA	No	Included	ONCOLOGY - ORAL	KISQALI FEMARA	No	Included
GROWTH HORMONE DEFICIENCY	SOGROYA	No	Included	ONCOLOGY - ORAL	KOSELUGO	Yes	Included
GROWTH HORMONE DEFICIENCY	ZOMACTON	No	Included	ONCOLOGY - ORAL	KRAZATI	Yes	Included
GROWTH HORMONE DEFICIENCY	ZORBTIVE	Yes	Included	ONCOLOGY - ORAL	LAPATINIB	No	Included
HEMATOLOGICAL AGENTS	OXBRYTA	Yes	Included	ONCOLOGY - ORAL	LENALIDOMIDE	Yes	Included
HEMATOLOGICAL AGENTS	ALVAIZ	No	Included	ONCOLOGY - ORAL	LENVIMA	Yes	Included
HEMATOLOGICAL AGENTS	CABLVI	Yes	Included	ONCOLOGY - ORAL	LONSURF	Yes	Included
HEMATOLOGICAL AGENTS	DOPTLEET	Yes	Included	ONCOLOGY - ORAL	LORBRENA	Yes	Included
HEMATOLOGICAL AGENTS	EMPAVEU	Yes	Included	ONCOLOGY - ORAL	LUMAKRAS	Yes	Included
HEMATOLOGICAL AGENTS	FABHALTA	Yes	Included	ONCOLOGY - ORAL	LYNPARZA	Yes	Included
HEMATOLOGICAL AGENTS	MOZOBIL	No	Included	ONCOLOGY - ORAL	LYTGOBI	Yes	Included
HEMATOLOGICAL AGENTS	MUPLLETA	No	Included	ONCOLOGY - ORAL	MATULANE	Yes	Included
HEMATOLOGICAL AGENTS	PLERIXAFOR	No	Included	ONCOLOGY - ORAL	MEKINIST	No	Included
HEMATOLOGICAL AGENTS	PRONACTA	No	Included	ONCOLOGY - ORAL	MEKTOVI	Yes	Included
HEMATOLOGICAL AGENTS	PYRUKYND	Yes	Included	ONCOLOGY - ORAL	MELPHALAN	No	Included
HEMATOLOGICAL AGENTS	REZUROCK	Yes	Included	ONCOLOGY - ORAL	MERCAPTOPURINE	No	Included
HEMATOLOGICAL AGENTS	TAVALISSE	Yes	Included	ONCOLOGY - ORAL	MESNA	No	Included
HEMOPHILIA - INFUSED	ADVATE	No	Included	ONCOLOGY - ORAL	MESNEX	No	Included
HEMOPHILIA - INFUSED	ADYNOVATE	No	Included	ONCOLOGY - ORAL	NERLYNX	Yes	Included
HEMOPHILIA - INFUSED	AFSTYLA	No	Included	ONCOLOGY - ORAL	NEXAVAR	Yes	Included
HEMOPHILIA - INFUSED	ALPHANATE/VON WILLEBRAND	No	Included	ONCOLOGY - ORAL	NILANDRON	No	Included
HEMOPHILIA - INFUSED	ALPHANINE SD	No	Included	ONCOLOGY - ORAL	NILUTAMIDE	No	Included
HEMOPHILIA - INFUSED	ALPROLIX	No	Included	ONCOLOGY - ORAL	NINLARO	No	Included
HEMOPHILIA - INFUSED	ALTUVIIIO	No	Included	ONCOLOGY - ORAL	NUBEQA	Yes	Included
HEMOPHILIA - INFUSED	BENEFIX	No	Included	ONCOLOGY - ORAL	ODOMZO	No	Included
HEMOPHILIA - INFUSED	COAGADEX	Yes	Included	ONCOLOGY - ORAL	OGSIVEO	Yes	Included
HEMOPHILIA - INFUSED	CORIFACT	No	Included	ONCOLOGY - ORAL	OUEMDA	Yes	Included
HEMOPHILIA - INFUSED	ELOC TATE	No	Included	ONCOLOGY - ORAL	OJJAARA	Yes	Included
HEMOPHILIA - INFUSED	ESPEROCT	No	Included	ONCOLOGY - ORAL	ONUREG	No	Included
HEMOPHILIA - INFUSED	FEIBA	No	Included	ONCOLOGY - ORAL	ORGOVYX	Yes	Included
HEMOPHILIA - INFUSED	HEMOFIL M	No	Included	ONCOLOGY - ORAL	ORSERDU	Yes	Included
HEMOPHILIA - INFUSED	HUMATE-P	No	Included	ONCOLOGY - ORAL	PAZOPANIB	Yes	Included
HEMOPHILIA - INFUSED	IDELVION	No	Included	ONCOLOGY - ORAL	PEMAZYRE	Yes	Included
HEMOPHILIA - INFUSED	IXINITY	No	Included	ONCOLOGY - ORAL	PIGRAY	No	Included
HEMOPHILIA - INFUSED	JIVI	No	Included	ONCOLOGY - ORAL	POMALYST	Yes	Included
HEMOPHILIA - INFUSED	KOATE	No	Included	ONCOLOGY - ORAL	PURIXAN	No	Included
HEMOPHILIA - INFUSED	KOATE-DVI	No	Included	ONCOLOGY - ORAL	QINLOCK	Yes	Included
HEMOPHILIA - INFUSED	KOGENATE FS	No	Included	ONCOLOGY - ORAL	RETEVMO	Yes	Included
HEMOPHILIA - INFUSED	KOVALTRY	No	Included	ONCOLOGY - ORAL	REVLIMID	Yes	Included
HEMOPHILIA - INFUSED	MONONINE	No	Included	ONCOLOGY - ORAL	REZLIDHIA	Yes	Included
HEMOPHILIA - INFUSED	NOVOEIGHT	No	Included	ONCOLOGY - ORAL	ROZLYTREK	No	Included
HEMOPHILIA - INFUSED	NOVOSEVEN RT	No	Included	ONCOLOGY - ORAL	RUBRACA	Yes	Included
HEMOPHILIA - INFUSED	NUWUQ	No	Included	ONCOLOGY - ORAL	RYDAPT	No	Included
HEMOPHILIA - INFUSED	OBIZUR	No	Included	ONCOLOGY - ORAL	SCEMBLIX	Yes	Included
HEMOPHILIA - INFUSED	PROFLININE	No	Included	ONCOLOGY - ORAL	SORAFENIB	No	Included
HEMOPHILIA - INFUSED	REBINYN	No	Included	ONCOLOGY - ORAL	SPRYCEL	No	Included
HEMOPHILIA - INFUSED	RECOMBINATE	No	Included	ONCOLOGY - ORAL	STIVARGA	Yes	Included
HEMOPHILIA - INFUSED	RIXUBIS	No	Included	ONCOLOGY - ORAL	SUNITINIB	Yes	Included
HEMOPHILIA - INFUSED	SEVENFACT	No	Included	ONCOLOGY - ORAL	SUTENT	Yes	Included
HEMOPHILIA - INFUSED	TRETEN	Yes	Included	ONCOLOGY - ORAL	TABLOID	No	Included
HEMOPHILIA - INFUSED	VONYENDI	Yes	Included	ONCOLOGY - ORAL	TABRECTA	No	Included
HEMOPHILIA - INFUSED	WILATE	No	Included	ONCOLOGY - ORAL	TAFINLAR	No	Included
HEMOPHILIA - INFUSED	XYNTHA	No	Included	ONCOLOGY - ORAL	TAGRISSO	Yes	Included

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HEMOPHILIA - INJECTABLE	ALHEMO	No	Included	ONCOLOGY - ORAL	TALZENNA	Yes	Included
HEMOPHILIA - INJECTABLE	HEMLIBRA	Yes	Included	ONCOLOGY - ORAL	TARCEVA	Yes	Included
HEMOPHILIA - INJECTABLE	HYPMPAVZI	No	Included	ONCOLOGY - ORAL	TARGETIN	No	Included
HEPATITIS C	EPCLUSA	No	Included	ONCOLOGY - ORAL	TASIGNA	Yes	Included
HEPATITIS C	HARVONI	No	Included	ONCOLOGY - ORAL	TAZVERIK	Yes	Included
HEPATITIS C	LEDIPASVIR/SOFOSBUVIR	No	Included	ONCOLOGY - ORAL	TEMODAR	No	Included
HEPATITIS C	MAVYRET	No	Included	ONCOLOGY - ORAL	TEMOZOLOMIDE	No	Included
HEPATITIS C	PEGASYS	No	Included	ONCOLOGY - ORAL	TEPMETKO	Yes	Included
HEPATITIS C	SOFOSBUVIR/VELPATASVIR	No	Included	ONCOLOGY - ORAL	THALOMID	Yes	Included
HEPATITIS C	SOVALDI	No	Included	ONCOLOGY - ORAL	TIBSOVO	Yes	Included
HEPATITIS C	VIEKIRA PAK	No	Included	ONCOLOGY - ORAL	TORPENZ	Yes	Included
HEPATITIS C	VOSEVI	No	Included	ONCOLOGY - ORAL	TRETINOIN	No	Included
HEPATITIS C	ZEPATIER	No	Included	ONCOLOGY - ORAL	TRUQAP	Yes	Included
HEPATOLOGY	BYLVAY	Yes	Included	ONCOLOGY - ORAL	TRUSELTIQ	Yes	Included
HEPATOLOGY	LIVMARU	Yes	Included	ONCOLOGY - ORAL	TUKYSA	Yes	Included
HEREDITARY ANGIOEDEMA	BERINERT	Yes	Included	ONCOLOGY - ORAL	TURALIO	Yes	Included
HEREDITARY ANGIOEDEMA	CINRYZE	Yes	Included	ONCOLOGY - ORAL	TYKERB	No	Included
HEREDITARY ANGIOEDEMA	FIRAZYR	Yes	Included	ONCOLOGY - ORAL	VANFLYTA	Yes	Included
HEREDITARY ANGIOEDEMA	HAEGARDA	Yes	Included	ONCOLOGY - ORAL	VENCLEXTA	Yes	Included
HEREDITARY ANGIOEDEMA	ICATIBANT	No	Included	ONCOLOGY - ORAL	VERZENIO	Yes	Included
HEREDITARY ANGIOEDEMA	ORLADEYO	Yes	Included	ONCOLOGY - ORAL	VITRAKVI	Yes	Included
HEREDITARY ANGIOEDEMA	RUCONEST	Yes	Included	ONCOLOGY - ORAL	VIZIMPRO	Yes	Included
HEREDITARY ANGIOEDEMA	SAJAZIR	Yes	Included	ONCOLOGY - ORAL	VONJO	Yes	Included
HEREDITARY ANGIOEDEMA	TAKHZYRO	Yes	Included	ONCOLOGY - ORAL	VOTRIENT	Yes	Included
IGA NEPHROPATHY	FILSPARI	Yes	Included	ONCOLOGY - ORAL	WELIREG	Yes	Included
IGA NEPHROPATHY	TARPEYO	Yes	Included	ONCOLOGY - ORAL	XALKORI	Yes	Included
IMMUNOLOGICAL AGENTS	ACTIMMUNE	Yes	Included	ONCOLOGY - ORAL	XELODA	No	Included
IMMUNOLOGICAL AGENTS	ARCALYST	Yes	Included	ONCOLOGY - ORAL	XOSPATA	Yes	Included
IMMUNOLOGICAL AGENTS	BENLYSTA	Yes	Included	ONCOLOGY - ORAL	XPOVIO	Yes	Included
IMMUNOLOGICAL AGENTS	JOENJA	Yes	Included	ONCOLOGY - ORAL	XTANDI	Yes	Included
IMMUNOLOGICAL AGENTS	LUPKYNIS	Yes	Included	ONCOLOGY - ORAL	YONSA	No	Included
IMMUNOLOGICAL AGENTS	TAVNEOS	Yes	Included	ONCOLOGY - ORAL	ZEJULA	Yes	Included
IMMUNOLOGICAL AGENTS	XOLREMDI	Yes	Included	ONCOLOGY - ORAL	ZELBORAF	Yes	Included
INFERTILITY	CETRORELIX	No	Included	ONCOLOGY - ORAL	ZOLINZA	No	Included
INFERTILITY	CETROTIDE	No	Included	ONCOLOGY - ORAL	ZYDELIG	Yes	Included
INFERTILITY	CHORIONIC GONADOTROPIN	No	Included	ONCOLOGY - ORAL	ZYKADIA	Yes	Included
INFERTILITY	FOLLISTIM AQ	No	Included	ONCOLOGY - ORAL	ZYTIGA	No	Included
INFERTILITY	FYREMADEL	No	Included	ONCOLOGY - TOPICAL	BEXAROTENE	No	Included
INFERTILITY	GANIRELIX ACETATE	No	Included	ONCOLOGY - TOPICAL	TARGRETIN	No	Included
INFERTILITY	GNAL-F	No	Included	ONCOLOGY - TOPICAL	VALCHLOR	Yes	Included
INFERTILITY	GNAL-F RFF	No	Included	OPHTHALMIC AGENTS	CYSTADROPS	Yes	Included
INFERTILITY	MENOPUR	No	Included	OPHTHALMIC AGENTS	CYSTARAN	Yes	Included
INFERTILITY	NOVAREL	No	Included	OPHTHALMIC AGENTS	OXERVATE	Yes	Included
INFERTILITY	OXDREL	No	Included	OSTEOPOROSIS	FORTEO	No	Included
INFERTILITY	PREGNYL	No	Included	OSTEOPOROSIS	TERIPARATIDE	No	Included
INFLAMMATORY CONDITIONS	ABRIADA	No	Included	OSTEOPOROSIS	TYMLOS	No	Included
INFLAMMATORY CONDITIONS	ACTEMRA	No	Included	PARKINSON'S DISEASE	KYNMOBI	No	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-AACF	No	Included	PARKINSON'S DISEASE	APOKYN	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-AATY	No	Included	PARKINSON'S DISEASE	APOMORPHINE	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-ADAZ	No	Included	PARKINSON'S DISEASE	INBRIA	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-ADBM	No	Included	PULMONARY FIBROSIS	ESBRIET	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-FKJP	No	Included	PULMONARY FIBROSIS	OFEV	Yes	Included
INFLAMMATORY CONDITIONS	ADALIMUMAB-RYVK	No	Included	PULMONARY FIBROSIS	PIRFENIDONE	No	Included
INFLAMMATORY CONDITIONS	ADBRY	Yes	Included	PULMONARY HYPERTENSION	ADCIRCA	No	Included
INFLAMMATORY CONDITIONS	AMJEVITA	No	Included	PULMONARY HYPERTENSION	ADEMPAS	Yes	Included
INFLAMMATORY CONDITIONS	BIMZELX	No	Included	PULMONARY HYPERTENSION	ALYO	No	Included
INFLAMMATORY CONDITIONS	CIBINGO	No	Included	PULMONARY HYPERTENSION	AMBRISENTAN	Yes	Included
INFLAMMATORY CONDITIONS	CIMZIA	No	Included	PULMONARY HYPERTENSION	BOSENTAN	Yes	Included
INFLAMMATORY CONDITIONS	CORTROPHIN	Yes	Included	PULMONARY HYPERTENSION	LETAIRIS	Yes	Included
INFLAMMATORY CONDITIONS	COSENTYX	No	Included	PULMONARY HYPERTENSION	LIOREV	Yes	Included
INFLAMMATORY CONDITIONS	CYLTEZO	No	Included	PULMONARY HYPERTENSION	OPSUMIT	Yes	Included
INFLAMMATORY CONDITIONS	DUPIKENT	No	Included	PULMONARY HYPERTENSION	OPSYNVI	Yes	Included
INFLAMMATORY CONDITIONS	EBGLYSS	No	Included	PULMONARY HYPERTENSION	ORENITRAM	Yes	Included
INFLAMMATORY CONDITIONS	ENBREL	No	Included	PULMONARY HYPERTENSION	REVAATIO	No	Included
INFLAMMATORY CONDITIONS	ENTYVIO	No	Included	PULMONARY HYPERTENSION	SILDENAFIL	No	Included
INFLAMMATORY CONDITIONS	H.P. ACTHAR	Yes	Included	PULMONARY HYPERTENSION	TADALAFIL	No	Included
INFLAMMATORY CONDITIONS	HADLIMA	No	Included	PULMONARY HYPERTENSION	TADLIQ	Yes	Included
INFLAMMATORY CONDITIONS	HULIO	No	Included	PULMONARY HYPERTENSION	TRACLEER	Yes	Included
INFLAMMATORY CONDITIONS	HUMIRA	No	Included	PULMONARY HYPERTENSION	TYVASO	Yes	Included
INFLAMMATORY CONDITIONS	HYRIMOZ	No	Included	PULMONARY HYPERTENSION	UPTRAVI	Yes	Included
INFLAMMATORY CONDITIONS	IDACIO	No	Included	PULMONARY HYPERTENSION	VENTAVIS*	Yes	Included
INFLAMMATORY CONDITIONS	ILUMYA	No	Included	PULMONARY HYPERTENSION	WINREVAIR	Yes	Included
INFLAMMATORY CONDITIONS	KEVZARA	No	Included	WOUND MANAGEMENT	FILSUVZ	Yes	Included
INFLAMMATORY CONDITIONS	KINERET	Yes	Included				

*Includes Nebulizer
2Q 2025

Generic equivalents may be dispensed in lieu of brands.

Exhibit E

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

The Shared Savings Program does not extend to services rendered by Participating Providers or County Specific Providers.

1. SHARED SAVINGS

- 1.1. **Out of Network Programs.** Plan Manager offers out of network programs that intend to increase savings to County by accessing discounts or negotiating reductions on out-of-network claims. Plan Manager offers a mix of out-of-net network programs that offer varying degrees of discounts, consumer advocacy, and cost controls.
- 1.2. Naviguard is the primary out of network, shared savings program for the County and program fees are identified in Exhibit D, Schedule of Fees/Discounts.
- 1.3. Naviguard is designed to assist County members manage and reduce out-of-network medical bills by providing advisory support, negotiation with healthcare providers to lower costs, offering educational resources, and advocating for protections under the No Surprises Act.
- 1.4. Plan Manager will report recoveries monthly through Plan Manager's employer billing portal (eServices).
- 1.5. The Shared Savings Program does not include discounts with respect to (a) Participating Providers, or (b) County Specific Providers.
- 1.6. After application of the Shared Savings Program, Plan benefits will be determined as if the services were provided in an out-of-network setting, unless it is appropriate that they be considered as in-network due to the application of the urgent/emergency benefits provision of the Plan.
- 1.7. Plan Manager may receive recoveries through deducting the amount due from the next payment to the provider. Recovery is credited back to the benefits Demand Deposit Account (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.
- 1.8. Plan Manager will deposit 100% of realized savings from the Shared Savings Program into benefits DDA bank account and bill County for the agreed upon Fee/% of Savings detailed under Shared Savings Program as shown in Exhibit D, Schedule of Fees/Discounts, Section 3.1, Shared Savings Programs.
- 1.9. Plan Manager will report recoveries monthly through Plan Manager's employer billing portal (eServices).

2. SUBROGATION/RECOVERY SERVICES

Plan Manager will provide Subrogation/Recovery 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 or recovery provisions of the Plan.

- 2.1. Subrogation/Recovery 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 reflects the legal right of County to recover medical expenses paid according to defined plan benefit guidelines from a third party who was responsible for injuries. Examples may include:
 - 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 claims are identified, they are investigated for potential sources of recovery and monitored on a regular basis until appropriate resolution is reached. Claims may be identified by ICD-10 trauma codes.

- 2.3. Subrogation/Recovery 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/Recovery 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/Recovery 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/Recovery 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 the Advanced Analytics and Recovery 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/Discounts, Section 3.2, Advance Analytics and Recovery Services. However, there will be no cost to County for recovery of claims payments made in error by Plan Manager exclusive of any other cause. 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.

(Remainder of page intentionally left blank.)

Exhibit F Carrier-Specific Medical Claims Trend Guarantee

Definitions

- i. **Allowed charges** means the portion of submitted charges considered for payment. This amount is before Plan Participant contributions (e.g., copays, deductibles, coinsurance) and after discounts, savings, benefits limits, and reduction amounts due to duplicates.
- ii. **Allowed charge trend guarantee** means a maximum increase in year-over-year medical claims committed to by Plan Manager. The medical claims are based on allowed charges for medical services and treatments rendered to covered enrollees of County's self-funded medical plan. This is typically expressed as a percentage.
- iii. **Guaranteed trend factor** means the percentage year-over-year change in medical claims cost (based on allowed charges) utilized by Plan Manager as the target percentage change in medical claims for the allowed charge trend guarantee.
- iv. **Plan relativity adjustments** means the factors used in medical underwriting to account for the expected differences in claim costs among different medical plan design options offered by County.
- v. **Trend** means the year over year (increase/decrease) in the cost of medical care, including services and treatments. This is typically expressed as a percentage.

Trend Development Guarantee

Plan Manager and Neighborhood Health Partnership (NHP) will provide a 2027 allowed charge trend guarantee, which will be developed by reviewing County's full year 2026 allowed charge experience and applying an adjustment based on a combination of trend and the application of Plan Manager and NHP programs designed to lower County's claim costs. Plan Manager and NHP will develop a combined guaranteed trend factor that will apply against the actual 2026 allowed charges to develop a 2027 allowed charge trend projection (incurred in Plan Year 2027 and paid within Plan Year 2027 plus three (3) months following the end of the Plan Year) will be the basis of Plan Manager and NHP's guarantee.

Required Claim Data

Plan Manager and NHP will base the allowed charge trend guarantee calculation on full year 2026 allowed charges. Plan Manager and NHP will require 2026 monthly incurred allowed charges and Capitation charges by Plan, processed through March 31, 2027, with corresponding monthly Employee and Plan Participant enrollment by Plan. Plan Manager and NHP will also require a 2026 Plan Participant-level census file containing Plan election, coverage tier, age, gender, and 3-digit ZIP code information. The Plan designs must be provided for all 2026 Plans, and Plan Manager and NHP will require an aggregated-level migration matrix showing Plan Participant counts for 2026 Plan elections versus 2027 Plan elections, with 2027 new Plan entrants separately itemized.

Trend Factor Programs

Plan Manager and NHP's trend projection is based upon current clinical, medical management, cost containment, and utilization management programs offered to County. If County removes or changes currently offered programs, the trend projection may need to be adjusted.

NOTE: This guarantee assumes selection of current programs and implementation of the NHP's Flex plan. Plan relativity adjustments will be applied, depending on the final Plan designs and configuration, relative to the Plan designs in force in 2026 to the extent Plan design changes will impact allowed charges.

Plan Manager and NHP's Trend Commitment:

Guarantee	Plan Manager / NHP will beat the below Published Trend by 1% (please see guarantee calculation below)
Plan Manager trend target	9% (Trend to be used a 50/50 Blend between Published 2027 AON / Siegel Trend)
NHP trend target	4.5% (Trend to be used a 50/50 Blend between Published 2027 AON / Siegel Trend)
Total Guaranteed Trend	Weighted Average Based on Claims

Plan Manager and NHP will apply an adjustment to the Plan Manager or NHP ASO fees based upon Plan Manager and NHP's performance in achieving the 2027 allowed charge trend developed by applying the guaranteed trend factor shown above to the 2026 PMPM incurred allowed charge experience. The guarantee will include a 1.0% risk-free corridor. The allowed charge trend development is illustrated in the table shown below.

Please note that if NHP is not selected, the trend target will be 9%. NHP implementation is not required in order for the Plan Manager's trend guarantee to hold.

Basis of Plan Manager and NHP's Guarantee (Illustrative 2027 Allowed Charge Development)

	UHC Choice Plus Development	NHP-Flex Development	Combined
2026 PMPM Incurred Allowed Charges (Allowed Charges Incurred from January 1, 2026, through December 31, 2026, and Paid through March 31, 2027)	\$600.00	\$600.00	\$600.00
Plan Weight (based on claims)	90.0%	10.0%	100.0%
Application of the Unadjusted Allowed Charge Trend	9.0%	4.5%	8.6%

Application of Claim Adjustment	0.0%	0.0%	0.0%
Guaranteed Allowed Charge Trend Factor	9.0%	4.5%	8.6%
Risk Free Corridor	1.0%	1.0%	1.0%
Guaranteed Allowed Charge Trend Factor (including Risk Free Corridor)	10.1%	5.5%	9.6%
Guaranteed Composite Allowed Charge PMPM for the Incurral Period January 1, 2027, through December 31, 2027, and Paid through March 31, 2028 (12/15 Basis) [Threshold for Penalty]	\$660.54	\$633.27	\$657.81

The combined guaranteed trend factor shown above is illustrative. The final combined trend factor in 2027 will be based upon a weighted average of the Plan Manager and NHP trend factors using actual 2027 enrollment and base plan costs, as well as client-specific savings factors for NHP. For new enrollees to the Plan in 2027, Plan Manager reserves the right to apply adjustments to the trend factors, given the unknown baseline cost for this subgroup.

Penalties:

The table below provides a schedule of penalties based on Plan Manager and NHP's performance relative to achieving the 2027 trend commitment. The maximum penalty is up to 25.0% of the 2027 Administrative Services Only fees for the assumed subscribership payable by County under this Agreement.

The fees at risk do not include County-elected optional and non-standard programs fees, payment integrity programs fees, out-of-network programs fees, and ancillary products. Any County credits will reduce the total fees at risk.

Actual 2027 Trend	Adjustment to 2027 Plan Manager ASO Fee	Adjustment to 2027 NHP ASO Fee	Annual Adjustment \$\$ Value
9.6% or less	No Penalty	No Penalty	No Penalty
9.7% to 10.6%	-5.0%	-5.0%	-\$186,100
10.7% to 11.6%	-10.0%	-10.0%	-\$372,200
11.7% to 12.6%	-15.0%	-15.0%	-\$558,301
12.7% to 13.6%	-20.0%	-20.0%	-\$744,401
13.7% or greater	-25.0%	-25.0%	-\$930,501

Timeline Illustration for setting of Plan Year 2027 Target:

Allowed Charges incurred in 2026 with 3 months runout under current arrangement	Q2-Q3 of 2027. Actual target set based on review of Allowed Charges incurred in 2026 and paid through March 31, 2027.	Q2-Q3 of 2028. Reconciliation is completed to determine Allowed Charge Trend Guarantee results.
↓	↓	↓
Prior Year - 2026	Year 1 with Plan Manager & NHP	Year Claims Trend Guarantee is Reconciled

Plan Manager and NHP's Allowed Charge Trend Guarantee is subject to the following requirements:

- Medical coverage awarded to Plan Manager and NHP on a full-replacement basis in sites where offered.
- Plan includes Naviguard for OON. NHP plan includes the SSP for OON.
- Plan includes all available payment integrity programs.
- Incurred in 12/Paid in 15 Contract Basis.
- Guarantee applies 2027 Plan Year.
- If County does not renew for the 2028 Plan Year, the allowed charge trend guarantee will not apply.
- Current carrier data used to set the baseline year must be provided within 9 months of the initial effective date of the guarantee period, otherwise the guarantee will be void.
- A demographic factor will be used to adjust for changes in the demographic distribution of Employees from the base period and the claims guarantee period. Actuarial factors will be shared and included as part of the final guarantee document.

The following are the assumptions used to develop this guarantee. Plan Manager and NHP reserve the right to revise (or revoke) this guarantee if there are changes in these assumptions:

- No changes in the proposed benefits included in this Agreement that would influence the value of the allowed charges relative to the baseline period of the 2026 incurred allowed charges.
- Allowed charges in excess of \$200,000 per Plan Participant will be excluded.
- Pharmacy Claims are excluded.
- GLP-1 drugs for weight loss or conditions other than diabetes are excluded from both the base period and measurement period calculations.
- Mental Health/Substance Abuse claims are excluded.
- COBRA enrollees are Included, provided it is included in the prior year used to reconcile the guarantee.
- All Retirees are included.
- Obesity coverage is excluded.

- Infertility coverage is included.
- Level 2 program members are excluded.
- A carveout solution is implemented, cancelled, or modified.
- If the number of covered medical Employees varies by 10% or more from the assumed enrollment of 5,766 Employees.
- An average contract size of 1.97. If the average contract size, defined as the total number of enrolled Plan Participants divided by the total number of enrolled Employees, varies by 10% or more from the assumed average contract size of 1.97.
- A geographic factor will be used to adjust for changes in the distribution of Employees from the base period and the claims guarantee period.
- Plan Manager and NHP reserve the right to restate the trend guarantee using actual 2027 enrollment in each product. Current assumed enrollment is:

Product	Plan Participants
UHC Choice Plus	90%
NHP	10%

- The benefits or service requirements requested and/or quoted change prior to or after January 1, 2027.
- Minimum in-network utilization of 92%.
- Plan Manager and NHP's trend guarantee takes into account gross savings expected from Plan Manager and NHP's value based contracting programs and/or initiatives. As such, any fees and/or bonus payment to providers associated with these programs and/or initiatives are excluded from the reconciliation of this guarantee.
- Plan Manager and NHP reserves the right to revise the guarantee if bulk recovery is suppressed.
- The trend guarantee assumes that there are no unique or special discount arrangements between Plan Manager and County such as higher negotiated facility or physician discount that is exclusive to County and not available to other customers using the same incumbent carriers.
- Due to the fact that a trend guarantee measurement inherently captures the overall effect of discounts, Employee behavior changes, and care/clinical management effectiveness, any fees that may be paid out on each of the individual guarantees for Network Discounts and Optum Health will be deducted from any potential fees owed as part of this trend guarantee reconciliation.
- Total penalty payout, across all performance guarantees that may be offered by Plan Manager and NHP, is capped at 50.0%.
- Plan Manager and NHP reserve the right to limit prior carrier baseline claims to those Plan Participants who were enrolled with the prior carrier during the baseline period and who elected medical coverage with Plan Manager or NHP during the guarantee period.
- Plan Manager and NHP reserve the right to adjust the trend guarantee based on unexpected or unforeseen runaway trend numbers that would be beyond the scope and intent of this guarantee. Plan Manager and NHP will identify 3 different mutually agreed upon consultant surveys to determine and measure a composite trend calculation (i.e. the sum of the trends

from the three survey sources divided by three). Runaway trend will be defined as a +1.0% change year over year from the trend numbers calculated from the consultant surveys. Any increase or decrease beyond this 1.0% will be used to adjust the trend guarantee target.

In addition, Plan Manager reserves the right to revise (or revoke) this guarantee if there are circumstances that affect the trend environment that fall outside of Plan Manager's reasonable control and the intended scope of this guarantee, including but not limited to:

- Change(s) to the current contribution strategy.
- A pandemic, as declared by the World Health Organization.
- County's actions or inactions (examples: failure to provide Plan Participant contact info for outreach programs, failure to communicate new Plan offerings/programs as agreed to).
- Fire, embargo, strike, war, accident, act of God, and/or acts of terrorism.
- Changes in (a) federal, state or other applicable law or regulation, (b) governmental guidance, or (c) executive order.
- Labor strife within a market, to the extent that the event affected the utilization of benefits or other demographic shifts.
- Other unforeseen macroeconomic events, disaster events, government/regulatory events, or County situational changes (e.g., mergers/acquisitions, layoffs, location closures) that cause material changes in unit cost trend, utilization trend, severity of claims, or claims mix.

(Remainder of page intentionally left blank.)

**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 Resolution Call	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 A – 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.	3 rd 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
		<p>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(s) specified, regardless of the results, if 25% or less of the surveys distributed to members are completed and returned.</p>		
17.	Annual Formulary Update Notification	<p>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 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</p>	County results	\$2,000 Annually

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
		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.		
18.	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
19.	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 Manager’s standard letter is utilized. Plan Manager will provide County with a list of members and negative formulary change.	County results	\$2,000 Annually

#	Category	Measurement Description	Measurement Criteria	Performance Deduction & Frequency
20.	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
21.	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
22.	Retail Pharmacies	Plan Manager shall solicit specific pharmacies at County's request.	County results	\$3,000 Quarterly
23.	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 that require physician intervention will be dispensed within an average of four (4) days.	Plan Manager's Book of Business results	\$3,000 Quarterly
24.	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 claims trend guarantee achieved as stated in Exhibit F, Carrier-Specific Medical Claims Trend Guarantee.	County results	Annual	Fees at Risk as stated in Exhibit F, Carrier-Specific Medical Claims Trend 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 A 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
 - Outstanding Checks

- 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, Digital Experience Portal Activity and Gift Card Incentive Activity, Pharmacy Trend, Generic Dispensing Rate, Member Paid Share, Specialty Medications, Plan Paid Per Participant Per Month historical trend, Top Disease Categories by Plan Paid, Top Traditional Drug Classes Plan PMPM 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(s), shall not disseminate data without prior consent and approval from County.

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. **24/7 Virtual Visits:** Plan Participants have access to doctors and nurse practitioners who can assess and prescribe medication as well as give guidance on the need to go to an Urgent Care Center or the Emergency Room.
 - 1.8.2. **Maternity Support Online:** educates and guides expectant mothers to make the best choices to achieve a healthy pregnancy and, ultimately, a healthy baby. Using the various member tools and resources, Plan Participants can find help to learn what they need to know, including: What to expect during pregnancy; how to stay healthy before, during and after pregnancy; and ways to manage health through pregnancy and postpartum. Maternity support is designed to work for all mothers, no matter what the pregnancy journey looks like.
 - 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 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. **WELLOS APP:** Wellos is an engagement-driven health and wellness app designed to help Plan Participants begin, restart and continue their health journey. This dynamic program offers personalized guidance and support that empowers Plan Participants to set realistic health and wellness goals, address barriers to health and develop practical strategies for positive behavior change.
- 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 help 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, pharmacy 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. **LEVEL 2 Type 2 Diabetes Specific Health Plan:** Level 2 is a comprehensive, technology-driven program designed to help Plan Participants manage and potentially improve health outcomes of type 2 diabetes. Only adults and dependent Plan Participants diagnosed with type 2 diabetes are eligible for the program.

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.
- 3.4. Plan Manager will provide monthly wellness reporting and reviews to monitor wellness results and update on specified clinical programs.

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 Plans: Preventative or diagnostic mammogram and/or colonoscopy: Plan Manager agrees that a Plan Participant's first mammogram and first colonoscopy each calendar year will be at no cost to the Plan Participant when test is performed on an outpatient basis at an in-network hospital or alternate facility or in a physician's office.
- 5.2 HDHP Plans: First colonoscopy is covered in full if the visit is preventive and the test is performed on an out-patient basis at an in-network hospital or alternate facility or in a physician's office. 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 HDHP Plans: \$1,500 per ear benefit subject to meeting Annual Deductible first.
- 5.3.2 CDH Plans: 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 designated Plans. In addition, Plan Manager shall develop and maintain alternate/regional based Network options for County, taking into account market penetration, provider availability, and accessibility for Plan Participants.

County acknowledges that contracts with providers, facilities, and pharmacies are entered into solely by Plan Manager. Notwithstanding the foregoing, Plan Manager shall use commercially reasonable efforts to maximize provider participation and maintain a robust and accessible Network.

1. Plan Manager shall provide access to Networks and Network providers, as well as related services including physician (and other health care professional) relations, clinical profiling, contracting, credentialing, network analysis, and system development. The make-up of the Network can change at any time. Plan Manager shall provide advance notice of changes to County, or as soon as reasonably possible if advance notice is not feasible.
2. 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.
3. 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.
4. 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.
5. 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.
6. Plan Manager acknowledges that providers of professional health care services under contract with a Network maintained by Plan Manager or by companies under common control with it comply with credentialing standards no less stringent than those prevailing in the industry.
7. 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. Plan Manager shall provide Plan Participant impact reporting and alternate locations for care for pending contract expiration of facilities and highly utilized provider groups.

8. Plan Manager shall report annually the aggregate number of new and terminated Network providers.
9. Plan Manager shall ensure Network providers are practicing generally accepted medical standards and practices to guarantee adherence.
10. Plan Manager contracts with some Network providers may include Capitation arrangements. County will fund these Capitation payments as soon as Plan Manager makes the determination that the capitated Preferred Provider is entitled to receive the payment. These payments are Plan benefits under the mutual agreed upon contract. County remains responsible for any claims costs that are not satisfied through a capitated Network provider arrangement.
11. Plan Manager shall provide the following national and/or regional/alternate networks for County that can be accessible to County for any and all medical and pharmacy benefit plan design(s): Choice Plus and NHP (Neighborhood Health Plan).
12. Plan Manager will ensure and provide Network adequacy (geographically convenient, sufficiency in number and variety) to preferred contracted laboratory network centers, locations, and facilities.
13. Plan Manager, if also the pharmacy benefit manager for the County, will provide Network adequacy (e.g., geographically convenient, sufficiency in number and variety, etc.) to: 1) major national network contracted pharmacy retail chains; 2) local and regional independent pharmacy chains; 3) mail order/home delivery options; and 4) specialty pharmacy network(s).
14. Plan Manager shall allow County to select at its discretion other network programs, and network access management and administration options such as:
 - 14.1. **Value Based Contracting Program.** Plan Manager's contracts with some Participating Providers may include withholds, incentives, and/or additional payments that may be earned by meeting standards relating to utilization, quality of care, efficiency measures (including better contract rates), compliance with Plan Manager's other policies or initiatives, or other clinical integration or practice transformation standards. County may fund these payments due to the Participating Providers as soon as the Plan Manager makes the determination the Participating Provider is entitled to receive the payment under the Participating Provider's contract, either upfront or after the standard has been met.
 - 14.2. **County Specific Provider(s).** In the event of the need to obtain specific case agreements with specified provider(s), Plan benefits for health care services rendered by a County Specific Provider will be equal to the amounts the County Specific Provider agreed to accept in the contractual arrangements governing their participation as a County Specific Provider. County and Plan Manager will

mutually decide and implement a County Specific Provider rate schedule, and County will notify Plan Manager ninety (90) days in advance of any requested rate change to County's contractual arrangements. Plan Manager will apply County's contracted rates until Plan Manager receives written instructions from County to cease applying the case specific rates for the County Specific Provider. Plan Manager does not make any performance guarantees for processing claims submitted by County Specific Providers.

15. Plan Manager will administer Network services in accordance with the No Surprises Act related to medical billing protections.

(Remainder of page intentionally left blank.)

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
Email: lmorrison@broward.org

Name: Esther Mitchell
Title: Assistant Benefits Manager
Company: Broward County
Address: 115 South Andrews Avenue, Room 514
Ft. Lauderdale, FL 33301
Telephone: 954-357-6740
Email: emitchell@broward.org

Name: Allen Wilson
Title: Human Resources Director
Company: Broward County
Address: 115 South Andrews Avenue, Room 508
Ft. Lauderdale, FL 33301
Telephone: 954-357-6090
Email: awilson@broward.org

Name: Bernardette Atesnak
Title: Administrative Officer
Company: Broward County
Address: 115 South Andrews Avenue, Room 514
Ft. Lauderdale, FL 33301
Telephone: 954-357-6739
Email: batesnak@broward.org

Name: Georgena Riviere
Title: Accountant
Company: Broward County
Address: 115 South Andrews Avenue, Room 514
Ft. Lauderdale, FL 33301
Telephone: 954-357-8140
Email: griviere@broward.org

Name: Averill Dorsett
Title: ADA Administrator/HIPAA Privacy Officer
Company: Broward County
Address: 115 South Andrews Avenue, Room 427
Ft. Lauderdale, FL 33301
Telephone: 954-357-6503
Email: adorsett@broward.org

Name: Carlton Williams
Company: USI Insurance Services, LLC
Address: 2400 E. Commercial Blvd., Suite 600
Ft. Lauderdale, FL 33308
Telephone: 954-607-5272
Email: carlton.williams@usi.com

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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 with the exception of reward dollars for Employees and their spouses/domestic partners, which are invoiced to County on a monthly basis based on dollar amount(s) of redeemed gift cards. Rewards earned must be converted to and redeemed into gift cards by Enrollees no later than the specific date, as identified by County, of the following Plan Year or rewards earned will be forfeited.
- 1.2. Plan Manager will provide an annual credit to County in the amount of \$350,000 to support wellness-related activities and events including but not limited to health fairs, select preventive services (i.e., on-site flu shots), incentives, marketing promotion materials, printing expenses, and other direct costs associated with all wellness activities for this purpose. Any unused portion of the annual credit remaining at the end of a Plan Year shall be paid to County no later than March 31 of the following Plan Year.
- 1.3. The wellness account will be reconciled each month by Plan Manager with reporting to the County. County will also participate in the spending and approval discussion/process of this expense account.
- 1.4. Plan Manager agrees to provide a one (1) on-site Wellness Coordinator, one (1) on-site Wellness Nutritionist, and two (2) on-site representatives during weekday County business hours 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 monthly to review wellness activities. The meetings will include, but are not limited to, the Account Manager, Wellness Coordinator, Wellness Nutritionist, and representatives from the 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 agrees to provide eleven (11) HIGI Health Stations to County.

2. Digital Health Experience

- 2.1. Plan Manager will provide a digital health experience that will employ industry leading technologies.

- 2.2. **The Health Survey:** Easy-to-use across multiple devices, including smartphones, tablets and computers, the survey goes beyond physical health risks to ask Enrollees about emotional and financial well-being, and social and community connections. Based on the responses, together with claims and biometric data (when available), personalized recommendations are generated for Enrollees.
- 2.3. **Challenges:** Challenges are another integral part of the digital experience, designed to engage through friendly competition.
- 2.4. **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.
- 2.5. **Rewards:** Enrollees can earn rewards dollars for completing activities (e.g., completing the survey, checking in to a challenge and/or other activities in the digital experience).
- 2.6. **Device Integration:** Integration 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 account, making it a one-stop solution for data and progress tracking.
- 2.7. **Evidence-based Health Content:** Online content (RSS, blogs) and on-site licensed content are available. In addition, there is a growing library of custom original content, including exclusive infographics.

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 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 serve 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, virtual meeting 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 are 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

(Remainder of page intentionally left blank.)

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 between the cost threshold and cost limit. The cost threshold (minimum) and cost limit (maximum) are federally defined annual amounts of gross covered retiree plan-related prescription drug costs paid by a qualified retiree prescription drug plan and/or by qualifying covered retirees.

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 OptumRx, 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 work with County to draft, finalize, and mail an annual Creditable Coverage Disclosure Notice to all Plan Participants who will be age 65 in the following calendar year, on or before the deadline of October 15 of each year.

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 to be annually determined based on projected claims volume(s). 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 EFTs 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. Reconciliation will include a breakdown of medical and pharmacy expenses.

County will reimburse Plan Manager for any bank fees related to overdrafts caused by County 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:

Bernardette Atesnak batesnak@broward.org and Georgena Riviere, grieviere@broward.org
This Banking Arrangement is effective on January 1, 2027.