ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") between United HealthCare Services, Inc. (“United” in this Agreement) and Pinellas County Board of County Commissioners (“Customer” in this Agreement) is effective January 1, 2017 (“Effective Date”). This Agreement covers the services United is providing to Customer, either directly or in conjunction with one of United’s affiliates, for use with Customer’s Self-Funded employee benefit plan and apply to claims for Plan benefits that are incurred on or after the Effective Date.

United HealthCare Services, Inc. identifies this arrangement as Contract No.: 214279

By signing below, each party agrees to the terms of this Agreement.

Pinellas County Board of County Commissioners
400 South Ft. Harrison Avenue
Clearwater, FL 33756

By: Mark S. Woodard

Authorized Signature

Print Name: Mark S. Woodard

Print Title: County Administrator

Date: 12/28/2016

United HealthCare Services, Inc.
185 Asylum Street
Hartford, CT 06103-3408

By: Tammy Johnson

Authorized Signature

Print Name: Tammy Johnson

Print Title: Regional Contract Manager

Date: 12/7/2016

ASA 2Q 2016

APPROVED AS TO FORM

By: _____

Office of the County Attorney

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Section 1 – Definitions

When these terms are capitalized in the Agreement they have the meanings set forth below. The words may be singular or plural.

Bank Account: Benefits Demand Deposit Bank Account maintained for the payment of Plan benefits, expenses and fees. Benefit Demand Deposit Bank Account maintained for the payment of plan benefits, expenses and fees.

Employee: A current or former employee of Customer or its affiliated employer.

HSA or Health Savings Account: A tax-advantaged account established by Customer's Employees principally to fund certain qualified medical expenses. This account is maintained in accordance with applicable provisions of the IRC and associated guidance issued by the IRS/Treasury Department, as well as under various agreements and documents maintained between an enrolling Employee and the HSA trustee or custodian.

IRC: The United States Internal Revenue Code of 1986, as amended from time to time.

IRS: The United States Internal Revenue Service.

Network: The group of Network Providers United makes available to the Plan who have entered into or are governed by contractual arrangements under which they agree to provide health care services to Participants and accept negotiated fees for these services.

Network Provider: The physician, or medical professional or facility which participates in a Network. A provider is only a Network Provider if they are participating in a Network at the time services are rendered to the Plan Participant.

Overpayments: Payments that exceed the amount payable under the Plan. This term does not include overpayments caused by untimely or inaccurate eligibility information.

Participant: Employee or dependent who is covered by the Plan.

PHI: Any information United receives or provides on behalf of the Plan which is considered Protected Health Information as the term is defined in the privacy regulations of the Health Insurance Portability and Accountability Act of 1996.

Plan: The plan to which this Agreement applies, but only with respect to those provisions of the plan relating to the Self-Funded health benefits United is administering, as described in the Summary Plan Description.

Plan Administrator: The current or succeeding person, committee, partnership, or other entity designated the Plan Administrator who is generally responsible for the Plan's operation.

Proprietary Business Information: Nonpublic information, trade secrets, and other data including, but not limited to, sales and marketing information, management systems, strategic plans and other information about the disclosing party's business, industry, products and services, plans, specifications, operation methods, pricing, costs, techniques, manuals, know-how and other intellectual property, in written, oral, electronic or other tangible form, provided by one party to another or its representative; and all information, documents, technology, products, and services containing or derived from Proprietary Business Information which was or may have been transmitted, given or made available to or viewed by one party or another in the course of the receiving party's relationship that meets the definition set forth in Fla. Stat. §288.9627. United's Proprietary Business Information shall include, but not be limited to, discounts and other financial provisions related to United's contracted healthcare providers and claims data from which those financial provisions can be derived and financial provisions related to prescription drug products covered under the medical benefit. This information is collectively known as "United's Financial PBI".

Rebate: Any discount, rebate administration fees, price concession or other direct or indirect remuneration United receives from a drug manufacturer under a rebate agreement that is contingent upon and related directly to Participant use of a prescription drug under the Plan's pharmacy benefit or the medical benefit during the Term. Rebate does not include any discount, price concession or other direct or indirect remuneration United receives from a drug manufacturer for direct purchase of a prescription drug.

Self-Fund or **Self-Funded:** Means that Customer, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. United has no liability or responsibility to provide these funds. This is true even if United or its affiliates provides stop loss insurance to Customer.

Summary Plan Description or SPD: The document(s) Customer provides to Plan Participants describing the terms and conditions of coverage offered under the Plan.

Systems: Means the systems United owns or makes available to Customer to facilitate the transfer of information in connection with this Agreement.

Tax or **Taxes:** A charge imposed, assessed or levied by any federal, state, local or other governmental entity.

Term or Term of the Agreement: The period of sixty (60) months commencing on the Effective Date and any renewals thereof.

Treasury Department: The United States Department of the Treasury.

Urgent Care Claims: A claim for medical services and supplies which meets ERISA's definition of Urgent Care Claim.

Section 2 – Customer Responsibilities

Section 2.1 Responsibility for the Plan. United is not the Plan Administrator of the Plan. Any references in this Agreement to United "administering the Plan" are descriptive only and do not confer upon United anything beyond certain agreed upon claim administration duties. Except to the extent this Agreement specifically requires United to have the fiduciary responsibility for a Plan administrative function, Customer accepts total responsibility for the Plan for purposes of this Agreement including its benefit design, the legal sufficiency and distribution of SPDs, and compliance with any laws that apply to Customer or the Plan, whether or not Customer or someone Customer designates is the Plan Administrator. The Customer represents and warrants that the Plan has the authority to pay fees due under this Agreement.

Section 2.2 Plan Consistent with the Agreement. Customer represents that Plan documents, including the Summary Plan Description as described in Exhibit A – Statement of Work, are consistent with this Agreement. Nevertheless, before distributing any communications describing Plan benefits or provisions to Participants or third parties, Customer will provide United with such communications which refer to United or United's services prior to distributing these materials to Employees or third parties. Customer will amend them if United reasonably determines that references to United are not accurate, or any Plan provision is not consistent with this Agreement or the services that United is providing.

Section 2.3 Plan Changes. Customer must provide United with notice of any changes to the Plan and/or Summary Plan Description within a reasonable period of time prior to the effective date of the change to allow United to determine if such change will alter the services United provides under this Agreement. Any change in the services to be provided by United under this Agreement which would be caused by any aforementioned changes must be mutually agreed to in writing prior to implementation of such change. United will notify Customer if (i) the change increases United's cost of providing services under this Agreement or (ii) United is reasonably unable to implement or administer the change. If the parties cannot agree to a new fee within (30) thirty days of the notice of the new fee or if United notifies Customer that United is unable to reasonably implement or administer the change, United shall have no obligation to implement or administer the change, and Customer may terminate this Agreement upon (90) ninety days written notice.

Section 2.4 Affiliated Employers. Customer represents that together Customer and any of its affiliates covered under the Plan make up a single "controlled group" as defined by the IRC. Customer agrees to provide United with a list of Customer's affiliates covered under the Plan upon request.

Section 2.5 Information Customer Provides to United. Customer will tell United which of Customer's Employees, their dependents and/or other persons are Participants. This information must be accurate and provided to United in a timely manner. United will accept eligibility data from Customer in the format described in Exhibit A – Statement of Work. Customer will notify United of any change to this information as soon as reasonably possible.

United will be entitled to rely on the most current information in United's possession regarding eligibility of Participants in paying Plan benefits and providing other services under this Agreement. United will not be required to process or reprocess claims, but if United agrees to do so, additional fees may apply.

United shall be entitled to rely upon any written communication from Customer, its designated employees, agents or authorized representatives.

Section 2.6 Notices to Participants. Customer will give Participants the information and documents they need to obtain benefits under the Plan within a reasonable period of time before coverage begins. In the event this Agreement is discontinued, Customer will notify all Participants that the services United is providing under this Agreement are discontinued.

Section 2.7 Escheat. Customer is solely responsible for complying with all applicable abandoned property or escheat laws, making any required payments, and filing any required reports.

Section 3 – Fees

Section 3.1 Fees. Customer will pay fees to United as compensation for the services provided by United. In addition to the fees specified in Exhibit B, Customer must also pay United any additional fee that is authorized by a provision elsewhere in this Agreement or is otherwise agreed to in writing by the parties. However, in no event will the Customer be obligated to pay United an amount in fees pursuant to this Agreement in excess of the amount of $1,921,525, for any Customer fiscal period during which services are performed, unless the parties have mutually executed a written amendment agreeing to the additional amount of compensation. Customer shall notify United immediately upon becoming aware that its enrollment will increase or will likely increase at an amount which would cause their fees for the fiscal year to exceed the above amount. Failure to execute such an amendment provides grounds to terminate this Agreement. In such event, United will only provide run-out services by separate agreement of the parties.

Section 3.2 Changes in Fees. After the initial Agreement Period United can change the fees on each Term anniversary ("Renewal Term"). United will provide Customer with one hundred eighty (180) days prior written notice of the revised fees for subsequent Renewal Terms. Any such fee change will become effective on the later of the first day of the new Renewal Term or thirty (180) days after United provides Customer with written notice of the new fees, whichever is later. United will provide Customer with a new Exhibit B that will replace the existing Exhibit B for the new Renewal Term.

Provided UHC shall have first provided detailed documentation satisfactory to the Customer demonstrating the impact and the necessity and proportionality of the proposed revision, United also can change the fees (i) any time there are changes made to this Agreement or the Plan, which affect the fees including the termination of the Shared Savings and/or Facility R&C Charge Determination Program, (ii) when there are changes in laws or regulations which affect or are related to the services United is providing, or will be required to provide, under this Agreement. including the Taxes and fees noted in Section 5 Taxes and Assessments (iii) if the number of Employees covered by the Plan or any Plan option changes by ten percent (10%) or more or (iv) if the average contract size, defined as the total number of enrolled Participants divided by the total number of enrolled Employees, varies by 10% or more from the assumed average contract size set forth in Exhibit B. Any new fee required by such change will be effective as of the date the changes occur, even if that date is retroactive.

If Customer does not agree to any change in fees, Customer may terminate this Agreement upon thirty (30) days written notice after Customer receives written notice of the new fees. Customer must still pay any amounts due for the periods during which the Agreement is in effect.

Section 3.3 Due Dates, Payments, and Penalties. For the Standard Medical Service Fees described in Exhibit B, United will provide Customer with an on-line invoice in advance of the first of each month, typically no later than the 18th of each month. The Due Date for payment of the invoiced amounts is on the first day of the next full calendar month. The fees will be paid in accordance with F.S. Section 218.70 et.seq. United will invoice Customer for any interest due on these amounts.

Section 3.4 Reconciliation. For each Renewal Term, United will reconcile the total amounts Customer paid with the total amounts Customer owed. If the reconciliation indicates that United owes Customer money, Customer's next fee invoice will be credited. If the reconciliation indicates that Customer owes United money, United will invoice Customer for the amount due.

If the Agreement is terminated, United will pay Customer the amount owed within thirty (30) days after United performs a final reconciliation, but in no event later than ninety (90) days from termination Effective Date. If the final reconciliation indicates that Customer owes United money, Customer will pay United after receiving notice of the amount owed in accordance with Fla. Stat. 218.70 et. seq..

Section 4 – Records, Information, Audits

Section 4.1 Records. United will keep records relating to the services it provides under this Agreement for as long as United is required to do so by law. United acknowledges that information and data it manages as part of the services may be public records in accordance with Chapter 119, Florida Statutes and Pinellas County public records policies. United agrees that prior to providing services it will implement policies and procedures to maintain, produce, secure, and retain public records in accordance with applicable laws, regulations, and County policies, including but not limited to the Section 119.0701, Florida Statutes. Notwithstanding any other provision of this Agreement relating to compensation, the United agrees to charge the Customer, and/or any third parties requesting public records only such fees allowed by Section 119.07, Florida Statutes, and County policy for locating and producing public records during the term of this Agreement.

If United has questions regarding the application of Chapter 119, Florida Statues, to United's duty to provide public records relating to this contract, contact the Pinellas County Board of County Commissioners, Purchasing Department, Operations Manager custodian of public records at 727-464-3311, purchase@pinellascounty.org, Pinellas County Government, Purchasing Department, Operations Manager, 400 S. Ft. Harrison Ave, 6th Floor, Clearwater, FL 33756.

Section 4.2 Proprietary Business Information. Each party will limit the use of the other's Proprietary Business Information to only the information required to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement. Neither party will disclose the other's Proprietary Business Information to any person or entity other than to the disclosing party's employees, subcontractors, or authorized agents needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement, or required by law. In the event a request is made under state law seeking disclosure by the County of information UHC has identified as Proprietary Business Information, the County will advise UHC of the request prior to disclosure so that UHC may take the steps, if necessary, to protect its Proprietary Business Information. To the extent permissible by law, neither party will disclose the other's Proprietary Business Information to any person or entity other than to the disclosing party's employees, subcontractors, or representatives needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement. This provision shall survive termination of the Agreement..

Section 4.3 Access to Information. Other than as provided for in Section 4.4, if Customer needs United's Proprietary Business Information in order to administer the Plan, United will allow Customer to use United's Proprietary Business Information, if it is legally permissible, the information relates to United's services under this Agreement, and Customer gives United reasonable advance notice and an explanation of the need for such information. Such use is subject to the terms of this Agreement.

If Customer is subject to a Freedom of Information Act (FOIA) request and the request includes United's Proprietary Business Information, Customer will contact United prior to releasing any information and give United the opportunity to review, respond and/or object to the FOIA request.

United will provide information only while this Agreement is in effect and for a period of six (6) months after the Agreement terminates, unless Customer demonstrates that the information is required by law or for Plan administration purposes.

United also will provide reasonable access to information to an entity providing Plan administrative services to Customer, such as a consultant or vendor, if Customer requests it. Before United provides PHI to that entity, the parties must sign a mutually agreed-upon confidentiality agreement, and the parties must agree as to what information is minimally necessary to accomplish the Plan administrative service.

Section 4.4 Audits. United shall retain all records relating to this Agreement for a period of at least three (3) years after final payment is made. All records shall be kept in such a way as will permit their inspection pursuant to Chapter 110, Florida Statutes. In addition, Customer reserves the right to audit such records pursuant to Pinellas County Code, Chapter 2.

During the term of the Agreement, and at any time within six (6) months following its termination, a mutually agreeable entity may audit United once each calendar year to determine whether United is fulfilling the terms of this Agreement. Prior to the commencement of this audit, United must receive a signed, mutually agreeable confidentiality agreement.

Customer must advise United in writing of its intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by United. All audits will be limited to information relating to the calendar year in which the audit is conducted, and/or the immediately preceding calendar year. With respect to United's transaction processing services, the audit scope and methodology will be consistent with generally acceptable auditing standards, including a statistically valid random sample or other acceptable audit technique as approved by United ("Scope").

Customer will pay any expenses that it incurs in connection with the audit. In addition, Customer will be charged a reasonable per claim charge for audits outside of the following parameters: (1) more than one audit per calendar year; (2) any on-site audit visit that is not completed within five (5) business days; (3) sample sizes exceeding the Scope specified above; or (4) any audit initiated after this Agreement has terminated. The additional fees cover the additional resources, facility fees, and other incremental costs associated with an audit that exceeds the Scope, but shall not exceed $5000, combined.

Section 4.5 Service Auditor Reports. United may make its Type II service auditor report ("Report") available to United's self-funded customers each year for Customer's review in connection with Plan administrative purposes only. The Report will be issued under the guidance of Statement on Standards for Attestation Engagements #16 (SSAE16). Should new guidelines covering service auditor reports be issued, United may make the equivalent of, or any successor to, the SSAE16 Type II Report available to United's self-funded customers. The Report is United's Proprietary Business Information and shall not be shared with any third parties without United's prior written approval, unless required by law; provided, however, that Customer can share the Report with: (i) Customer's independent public accounting firm; and/or (ii) Customer's consultants, provided that such consultants are not in any way a competitor of United's and that Customer informs its consultants that the report was not prepared for their use. To the extent that Customer does provide the Report to its independent public accounting firm or a consultant as permitted herein, Customer shall require that they retain the Report as confidential and that they not disclose such Report to any other persons or entities.

Section 4.6 PHI. The parties' obligations with respect to the use and disclosure of PHI are outlined in the Business Associate Agreement.

Section 5 – Taxes And Assessments

Section 5.1 Payment of Taxes and Expenses. The following provisions and obligations apply only to the extent that the County is legally subject to a Tax, and only to the extent permitted by applicable laws, including but not limited to Fla. Stat. 129.06-07. In the event that any Taxes are assessed against United as a claim administrator in connection with United's services under this Agreement, including all topics identified in Section 5.3 Customer will reimburse United through the Bank Account for Customer's proportionate share of such Taxes (but not Taxes on United's net income). United has the authority and discretion to reasonably determine whether any such Tax should be paid or disputed. Subject to the annual not-to-exceed figure in section 3.1, Customer will also reimburse United for a proportionate share of any cost or expense reasonably incurred by United in disputing such Tax, including costs and reasonable attorneys' fees and any interest, fines, or penalties relating to such Tax, unless caused by United's unreasonable delay or unreasonable determination to dispute such Tax.

Section 5.2 Tax Reporting. In the event that the reimbursement of any benefits to Participants in connection with this Agreement is subject to Plan or employer based tax reporting requirements, Customer agrees to comply with these requirements.

Section 5.3 State and Federal Surcharges, Fees and Assessments. The Plan is responsible for state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan or United, including, but not limited to, those imposed pursuant to The Patient Protection and Affordable Care Act of 2010 ("PPACA"), as amended from time to time. This includes the funding, remittance and determination of the amount due for PPACA required taxes and fees.

Section 6 – Indemnification

Section 6.1 Customer Indemnifies United. Customer, as a state agency or subdivision of the State of Florida, as defined in Fla. Stat. Section 768.28, agrees to be fully responsible to the limits set forth in Fla Stat. Section 768.28 for Customer's negligence or omissions covered under Fla. Stat. Section 768.28 for any damages proximately caused by said negligence or omissions. Nothing herein shall be construed to be a waiver of sovereign immunity by Customer if sovereign immunity applies.

Section 6.2 United Indemnifies Customer. United will indemnify Customer and hold Customer harmless and defend Customer against any and all losses, liabilities, penalties, fines, costs, damages, and expenses, including court costs and attorneys' fees, which arise out of United's negligence, willful misconduct, or omissions, or those of our employees and agents which in no event shall be deemed to include health care providers in the performance of Our obligations under this Agreement or Our material breach of this Agreement, as determined by a court or other tribunal having jurisdiction of the matter, has caused such damages.

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Section 7 – Plan Benefits Litigation

Section 7.1 Litigation Against Us. In performing our obligations under this Agreement, we neither insure nor underwrite any liability of you or the Plan, and with respect to you as employer or Plan Administrator, we act only as the provider of the administrative services described in this Agreement. We will have no duty or obligation to defend you or the Plan against any legal action or proceeding brought to recover Plan benefits ("Plan Benefits Litigation"). In the event that a Plan participant or health care provider seeks to recover Plan benefits through Plan Benefits Litigation, you agree to substitute yourself for us as the party in interest to the extent permitted by Florida law. We will make available to you and your counsel such evidence relevant to such action or proceeding as we may have as a result of our administration of the contested benefit determination. In the event Plan Benefits Litigation is instituted by a third party against both you and us, and you are unable to substitute yourself as the sole party in interest, then each of us shall have the sole authority to select legal counsel of our choice. In all events, you are responsible for the full amount of any Plan benefits paid as a result of such Plan Benefits Litigation.

Section 7.2 Litigation Against You. If litigation or administrative proceedings are begun against You and/or the Plan, You will select and retain counsel, and You will be responsible for all legal fees and costs in connection with such litigation. We will cooperate fully in the defense of litigation arising out of matters relating to this Agreement. This provision shall survive the termination of this Agreement.

Section 7.3 Survival. This provision shall survive the termination of this Agreement.

Section 8 – Mediation

Except in the case of United's termination due to Customer's failure to provide funds for benefits or fees, in the event that any dispute, claim, or controversy of any kind or nature relating to this Agreement arises between the parties, the parties agree to meet and make a good faith effort to resolve the dispute. If the dispute is not resolved within thirty (30) days after the parties first met to discuss it, the parties may, by mutual agreement, consent to mediate the dispute. Neither party will unreasonably withhold consent. If mediation is elected, it will be entered into by the parties with a single mediator agreed to by the parties. The mediation will be held in Pinellas County, Florida or at another mutually agreeable location. Nothing herein is intended to prevent either party from seeking any other remedy available in a court of competent jurisdiction.. This provision shall survive the termination of this Agreement.

Section 9 – Termination

Section 9.1 Services End. United's services under this Agreement stop on the date this Agreement terminates, regardless of the date that claims are incurred. However, United may agree to continue providing certain services beyond the termination date, as provided in Exhibit A – Statement of Work.

Section 9.2 Termination Events. This Agreement will terminate under the following circumstances: (i) The Plan terminates, (ii) Both parties agree in writing to terminate the Agreement, (iii) After the initial Term, either party gives the other party at least ninety (90) days prior written notice, (iv) United gives Customer notice of termination because Customer did not pay the fees or other amounts Customer owed United when due under the terms of this Agreement, (v) United gives Customer notice of termination if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement, (vi) Either party is in material breach of this Agreement, other than by non-payment or late payment of fees owed by Customer or the funding of Plan benefits, and does not correct the breach within sixty (60) days after being notified in writing by the other party, (vii) United may terminate this Agreement in the event of a filing by or against the Customer of a petition for relief under the Federal Bankruptcy Code, (viii) Any state or other jurisdiction prohibits a party from administering the Plan under the terms of this Agreement, or imposes a penalty on the Plan or United and such penalty is based on the administrative services specified in this Agreement. In this situation, the party may immediately discontinue the Agreement's application in such state or jurisdiction. Notice must be given to the other party when reasonably practical. The Agreement will continue to apply in all other states or jurisdictions, or (ix) As otherwise specified in this Agreement.

Section 9.3 Non-appropriation. It is understood that neither this Agreement nor any representation by any County employee or officer creates any obligation to appropriate or make monies available for the purpose of the Agreement beyond the calendar year 2017 year in which this Agreement is executed. If funds are not appropriated by the County for any or all of this Agreement, the County agrees to notify Contractor in writing within thirty (30) days of becoming aware of the likelihood, or as soon as reasonably possible if unforeseen, of such failure of appropriation, and upon receipt of such notice, this Agreement, and all rights and obligations contained herein, shall terminate on the last day funds are available.

Section 10 – Miscellaneous

Section 10.1 Subcontractors. United can use its affiliates or subcontractors to perform United's services under this Agreement. United will be responsible for those services to the same extent that United would have been had it performed those services without the use of an affiliate or subcontractor.

Section 10.2 Assignment. Except as provided in this paragraph, neither party can assign this Agreement or any rights or obligations under this Agreement to anyone without the other party's written consent. That consent will not be unreasonably withheld. Nevertheless, United can assign this Agreement, including all of its rights and obligations to United's affiliates, to an entity controlling, controlled by, or under common control with United, or a purchaser of all or substantially all of United's assets, subject to notice to Customer of the assignment.

Section 10.3 Governing Law. This Agreement is governed by the applicable laws of the State of Florida. This provision shall survive the termination of this Agreement.

Section 10.4 Entire Agreement. This Agreement, with its exhibits, constitutes the entire agreement between the parties governing the subject matter of this Agreement. This Agreement replaces any prior written or oral communications or agreements between the parties relating to the subject matter of this Agreement. The headings and titles within this Agreement are for convenience only and are not part of the Agreement.

Section 10.5 Amendment. Except as may otherwise be specified in this Agreement, the Agreement may be amended only by both parties agreeing to the amendment in writing, executed by a duly authorized person of each party.

Section 10.6 Waiver/Estoppel. Nothing in this Agreement is considered to be waived by any party, unless the party claiming the waiver receives the waiver in writing. No breach of the Agreement is considered to be waived unless the non-breaching party waives it in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of this Agreement, or to exercise any option which is herein provided in this Agreement, will in no way be construed to be a waiver of such provision of this Agreement.

Section 10.7 Notices. Any notices, demands, or other communications required under this Agreement will be in writing and may be provided via electronic means or by United States Postal Service by certified or registered mail, return receipt requested, postage prepaid, or delivered by a service that provides written receipt of delivery.

Section 10.8 Use of Name. The parties agree not to use each other's name, logo, service marks, trademarks or other identifying information without the written permission of the other; provided, however, Customer grants United permission to use Customer's name, logo, service marks, trademarks or other identifying information to the extent necessary for United to carry out its obligations under this Agreement (e.g. on SPDs and ID cards).

Section 10.9 Compliance with Laws and Regulations. The parties agree to comply with all applicable federal, state and other laws and regulations with respect to this Agreement. Nothing stated in the documents comprising this Agreement shall limit the parties' obligations to comply with Florida's laws governing public records.

Section 10.10 No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

Section 10.11 Severability. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision. However, it is intended that a court of competent jurisdiction construe any invalid or unenforceable provision of this Agreement by limiting or reducing it so as to be valid or enforceable to the extent compatible with applicable law.

EXHIBIT A – STATEMENT OF WORK

The following are the administrative services United has agreed to provide to Customer. Customer may request that United provide services in addition to those set forth in this Agreement. If United agrees to provide them, those services will be governed by the terms of this Agreement and any amendments to this Agreement. Customer will pay an additional fee, determined by United and agreed to in writing by Customer, for these additional services. The Services described in this Exhibit will be made available to Customer's eligible Participants consistent with the Summary Plan Description under which the Participant is covered.

Section A1 Network

Network Access, Management and Administration. United will provide access to Networks and Network Providers, as well as related administrative services including physician (and other health care professional) relations, clinical profiling, contracting and credentialing, and network analysis and system development. The make-up of the Network can change at any time. Notice will be given in advance or as soon as reasonably possible.

United generally does not employ Network Providers and they are not United's agents or partners, although certain Network Providers are affiliated with United. Otherwise, Network Providers participate in Networks only as independent contractors. Network Providers and the Participants are solely responsible for any health care services rendered to Participants. United is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, including Network Pharmacies and services provided through United's affiliates' networks, or the payment for services rendered by the provider or facility.

Value Based Contracting Program. United's contracts with some Network Providers may include withholds, incentives, and/or additional payments that may be earned, conditioned on meeting standards relating to utilization, quality of care, efficiency measures, compliance with United's other policies or initiatives, or other clinical integration or practice transformation standards. Customer shall fund these payments due the Network Providers as soon as United makes the determination the Network Provider is entitled to receive the payment under the Network Provider's contract, either upfront or after the standard has been met. For upfront funding, if United makes the determination that the Network Provider failed to meet a standard, United will return to Customer the applicable amount. United shall provide Customer reports describing the amount of payments made on behalf of Customer's Plan.

Only the initial claims based reimbursement to Network Providers will be subject to the Participant's copayment, coinsurance or deductible requirements. Customer will pay the Network Provider the full amount earned or attributable to its Participants, without a reduction for copayments or deductibles and agree that there will be no impact from these payments on the calculation of the Participant's satisfaction of their annual deductible amount.

Section A2 Recovery Services

Claim Recoveries. United will provide recovery services for Overpayments, but United will not be responsible for recovery costs except as otherwise stated in this section. United will be responsible for recovery costs and reimbursement of any unrecovered Overpayment only to the extent the Overpayment was due to United's gross negligence.

In some instances, United may be able to obtain Overpayment recoveries by applying (or offsetting) the Overpayment against future payments to the provider made by United. In effectuating Overpayment recoveries through offset, United will follow its established Overpayment recovery rules which include, among other things, the prioritization of Overpayment credits based on the age of the Overpayment in United's system and funding type. In United's application of Overpayment recovery through offset, timing differences may arise in the processing of claims payments, disbursement of provider checks, and the recovery of Overpayments. As a result, the Plan may in some instances receive the benefit of an Overpayment recovery before United actually receives the funds from the provider. Conversely, United may receive the funds before the Plan receives the credit for the Overpayment. It is hereby understood that the parties may retain any interest that accrues as a result of these timing differences. Details associated with Overpayment recoveries made through offset will be identified in the monthly reconciliation report provided to the designated representative for Customer's Plan.

Procedures will be agreed upon in writing (and if any, associated costs) related to Claim Recovery Services will be agreed upon by both parties prior to implementation.

Subrogation. United will also provide services to recover Plan benefits that were paid and are recoverable by the Plan because payment was or should have been made by a third party for the same medical expense (other than in connection with coordination of benefits, Medicare, or other Overpayments). This is referred to as "Third Party Liability Recovery" (or "subrogation").Customer will not engage any entity except United to provide the services described herein without United's prior approval.

Recovery Fees. Customer will be charged fees when any of the services described herein are provided by United through a subcontractor or affiliate. The fees are deducted from the actual recoveries. Customer will be credited with the net amount of the recovery.

Recovery Process. Customer delegates to United the discretion and authority to develop and use standards and procedures for any recovery, including but not limited to, whether or not to seek recovery, what steps to take if United decides to seek recovery, and the circumstances under which a claim may be compromised or settled for less than the full amount of the claim. Customer acknowledges that use of United's standards and procedures may not result in full or partial recovery for any particular case. United will not pursue any recovery if it is not permitted by any applicable law, or if recovery would be impractical. United may initiate litigation to recover payments, but United has no obligation to do so. If United initiates litigation, Customer will cooperate with United in the litigation.

If this Agreement terminates, or, if United's recovery services terminate, United can continue to recover any payments United is in the process of recovering. The appropriate fees will continue to be deducted from the actual recovery, when and if a recovery is obtained.

Fraud and Abuse Management. United or its affiliate will provide services related to the detection, prevention, and recovery of abusive and fraudulent claims. United's Fraud and Abuse Management processes will be based upon United's proprietary and confidential procedures, modes of analysis and investigations.

United will use these procedures and standards in delivering Fraud and Abuse Management services to Customer and United's other customers. These procedures and standards include, but are not limited to: whether or not to seek recovery, what steps to take if United decides to seek recovery. United and Customer shall agree concerning under what circumstances to compromise a claim or settle for less than the full amount.

Customer delegates to United the discretion and authority to use such procedures and standards, including the authority to undertake actions, including legal actions, which have the largest impact for the largest number of customers. Customer acknowledges that the use of these procedures and standards may not result in full or partial recovery or in full recovery for any particular case. United does not guarantee or warranty any particular level of prevention, detection, or recovery. United agrees to perform Fraud and Abuse Management services pursuant to the industry standards for such services. If this Agreement terminates, or if United's claim recovery services terminate, United can elect to continue fraud and abuse recoveries that are in progress, and the fees will continue to apply.

Services include all work to identify recovery opportunities, research, conduct data analysis, investigate, negotiate settlements without the use of outside counsel, and draft legal documents. If outside counsel is retained for a group of payers seeking the recovery, a proportionate amount of the outside legal fees, equal to the payer's exposure in the case to the total exposure in the case, will be deducted from the gross recovery amount, after the fee has been deducted. Customer will be given the option to participate or decline participation in the settlement.

Section A3 Providing Funds

Responsibility for Payment of Plan Benefits. The Plan is Self-Funded. Customer is solely responsible for providing funds for payment for all Plan benefits payable to Participants, Network Providers and Non-Network Providers.

Bank Account. Customer will open and maintain a Bank Account to provide United the means to access Customer's funds for the purpose of payment of Plan benefits, Plan expenses (such as state surcharges or assessments), or, if authorized by Customer other Customer financial obligations and, when authorized by Customer, fees. The Bank Account will be a part of the network of accounts that have been established at the Bank for United's self-funded customers. The Bank Account and funds in the Bank Account are the Customer's and will not be comingled with any other customer funds.

Balance In Account. Customer will maintain a minimum balance in the Bank Account in an amount equal to not less than 5 days of expected Bank Account activity. United will establish this amount based on expected Plan payment obligations, with appropriate adjustments for anticipated non-daily activity (e.g., prescription drug benefits and fee payments) as determined by United. United will determine if circumstances warrant increasing this minimum balance, and will notify Customer if and when the required minimum balance or the amount changes.

The required minimum balance is based on Customer's financial condition as assessed by United. In the event United determines, based on reasonable information and belief, that Customer's financial condition has deteriorated or Customer continues to fail to comply with the material financial obligations specified in this Agreement, United may revise the required balance effective five (5) days from the date of notice to Customer.

Issuing and Providing Funds for Checks and Non-Draft Payments. Checks and/or non-draft payments will be written on and/or issued from one or more common accounts that are a part of the network of accounts maintained at the Bank for United's self-funded customers. When the checks for Plan benefits are presented to the Bank, the Bank will notify United and United will direct the Bank to either reject the checks or to withdraw funds from the Bank Account to fund the checks that are cashed.

Transfers of Funds. Funds will also be withdrawn from the Bank Account when a transfer of funds has been made electronically. United will direct the Bank to withdraw funds from the Bank Account to fund the non-draft payments or expenses as they are issued.

Calls for Funds. The withdrawals from the Bank Account for Plan benefits and service fees are paid for by the balance Customer maintains in the Bank Account.

Every five (5) business day(s), Customer will transfer to the Bank Account the amount of funds which have been withdrawn from Customer's Bank Account over the past five (5) business day(s). Customer will transfer that amount using a method agreed upon by Customer, United and the Bank. This transfer will replenish Customer's balance in the Bank Account.

Underfunding. If Customer does not provide the amounts sufficient to maintain the required minimum balance in the Bank Account, or to cover Bank Account withdrawals: (1) Customer must immediately correct the deficiency and provide prompt notice to United. (2) If United learns of the funding deficiency, United will notify Customer within one business day so Customer can correct the deficiency. (3) United may stop issuing checks and non-draft payments and suspend any of its other services under this Agreement for the period of time Customer does not provide the required funding. (4) If Customer does not correct the funding deficiency within three banking days of United's notice to Customer, United may terminate this Agreement as otherwise set forth in this Agreement, such termination to be prospectively from the date of notice of termination which shall not be before the 3rd banking day of Uniteds notice to Customer to correct the deficiency.

At the end of each claims processing time period, United will notify Customer of the amount needed to pay claims processed and fees that are due. Upon notice to Customer of the amount due for claims processed and fees that are due, Customer will fund the designated amount(s) immediately via wire transfer to the designated Bank Account for payment of the Plan benefits. Customer will initiate the fund transfers unless United determines that Customer's financial condition as of the Effective Date, as assessed by United, has deteriorated or Customer fails to comply with the material funding and financial obligations specified in this Agreement. If this condition occurs, Customer agrees to authorize United to initiate the transfers.

Stop Payments on Outstanding Checks. At Customer's expense, United may place stop payments on checks if United determines that Customer has insufficient funds in its own designated funding bank account to honor such checks. United will send a search letter to the payee on all checks that have not been cashed within six (6) months. United will automatically stop payment on all checks that have not been cashed within twelve (12) months. Customer is solely responsible for determining to file and/or filing unclaimed property once notified, or for making unclaimed payee payments directly.

Funding After Termination. When this Agreement terminates, the funding method will remain in place for the length of the run-out period. After the run-out period has ended, that funding method will cease and Customer will deposit and maintain in the Bank Account sufficient funds to cover all checks for Plan benefits that have been issued but not cashed. This balance will remain in the Bank Account for a limited period of time to fund the outstanding checks and other funding obligations. This period will be reasonable, as determined by United. United will stop payment on all checks that remain uncashed at the end of this period and Customer will request in writing to close the Bank Account and recover any funds remaining in it. United will provide bank statements and Bank Account reconciliation reports, including reports Customer needs for the purposes of escheatment.

Section A4 Medical Benefit Drug Rebate Payments

Allocation and Payment of Rebates. From time to time, United or a subcontractor may negotiate with drug manufacturers regarding the payment of medical benefit Rebates on applicable prescription drug products dispensed to Participants under the Plan's medical benefit. Customer will receive 80% of the medical benefit Rebates United receives. United will retain the balance of such medical benefit Rebates as part of United's compensation. When United negotiates directly with drug manufacturers for the payment of medical benefit Rebates to United, United will pay Customer the agreed upon Rebates within thirty (30) calendar days of United's receipt of such Rebates from the drug manufacturer. If United is not able to make payment to Customer within thirty (30) calendar days, United will pay interest on such Rebates from the date of receipt until United makes payment to Customer, less approximately thirty (30) days for processing. United will retain interest earned during this processing timeframe. United will pay medical benefit Rebates to Customer in the agreed upon amount no less than annually. Interest will be paid at the one month London Interbank Offered Rate (LIBOR) in effect on the first business day of each applicable month.

Customer will only receive Customer's medical benefit Rebates to the extent that medical benefit Rebates are actually received by United. Thus, for example, if a government action or a major change in pharmaceutical industry practices prevents United from receiving medical benefit Rebates, the amount Customer receives may be reduced or eliminated.

Customer agrees that during the term of this Agreement, neither Customer nor the Plan will negotiate or arrange or contract in any way for medical benefit Rebates on or the purchase of prescription drug products from any manufacturer under the Plan's medical benefit. If Customer or the Plan does, United may, without limiting United's right to other remedies, immediately terminate Customer's and Plan's entitlement to medical benefit Rebates (including forfeiture of any medical benefit Rebates earned but not paid). In addition, Customer agrees to reasonably cooperate with United in order to obtain medical benefit Rebates.

Subcontractor Compensation. If a subcontractor is involved in negotiating with drug manufacturers regarding the payment of medical benefit Rebates, it may retain a portion of the gross amounts received from drug manufacturers in connection with such products. United will provide information on the amount, if any, retained by the subcontractor as compensation for its services, in advance of Customer's execution of this Agreement. In addition, United will provide Customer with thirty (30) days advance notice of any material increase in or method for subcontractor compensation. If at any time Customer does not find the subcontractor compensation acceptable, Customer may terminate the medical benefit Rebates services after thirty (30) days advance written notice to United.

Section A5 Claims Determinations and Appeals

Claim Procedures. Customer appoints United a named fiduciary under the Plan with respect to (i) performing initial benefit determinations and payment, and (ii) performing the fair and impartial review of first level internal appeals and (iii) performing the fair and impartial review of second level internal appeals. As such, Customer delegates to United the discretionary authority to (i) construe and interpret the terms of the Plan, (ii) to determine the validity of charges submitted to United under the Plan, and (iii) make final, binding determinations concerning the availability of Plan benefits under the Plan's internal appeal process, all in compliance with applicable law and regulation. If United denies a Plan benefit claim, in whole or in part, United will notify the claimant of the adverse benefit determination and the claimant shall have the appeal rights set forth in the Summary Plan Description, and/or those which are required under applicable law. If after the exhaustion of the two levels of internal appeal, United determines that the Plan benefit is still not payable, United will notify the claimant that the adverse benefit

determination has been upheld. This determination will be final and binding on the claimant, and all other interested parties, except as otherwise provided under the external review program described in this Section.

Appeals of Urgent Care Claims. Notwithstanding the foregoing, with respect to Urgent Care Claims, United will conduct one review of a denied Urgent Care Claim and issue a final determination as soon as possible, in accordance with applicable law.

External Review Program. United will notify claimants of the option to request an external review of adverse benefit determinations following the required internal appeal process. United will, in accordance with applicable law: (i) provide claimant with the necessary procedures to obtain the review (ii) coordinate submission of the claimant's case to an independent review organization, and (iii) direct the independent review organization to notify the claimant of the final external review decision. A fee will apply beyond the maximum number of free reviews, as listed in Exhibit B, Fees.

Section A6 Systems Access

Access. United grants Customer the nonexclusive, nontransferable right to access and use the functionalities contained within the Systems, under the terms specified in this Agreement. Customer agrees that all rights, title, and interest in the Systems and all rights in patents, copyrights, trademarks, and trade secrets encompassed in the Systems will remain United's. To obtain access to the Systems, Customer will obtain, and be responsible for maintaining, at no expense to United, the hardware, software, and Internet browser requirements United provides to Customer, including any amendments thereto. Customer will be responsible for obtaining an Internet Service Provider or other access to the Internet. Customer will not (i) access Systems or use, copy, reproduce, modify, or excerpt any Systems documentation provided by United in order to access or utilize Systems, for purposes other than as expressly permitted under this Agreement or (ii) share, transfer or lease Customer's right to access and use Systems, to any other person or entity which is not a party to this Agreement. Customer may designate any third party, with prior approval from United, to access Systems on Customer's behalf, provided the third party agrees to these terms and conditions of Systems access and Customer assumes joint responsibility for such access.

Security Procedures. Customer will use commercially reasonable physical and software-based measures to protect the passwords and user IDs provided by United for access to and use of any web site provided in connection with the services. Customer shall use commercially reasonable anti-virus software, intrusion detection and prevention system, secure file transfer and connectivity protocols to protect any email and confidential communications provided to United, and maintain appropriate logs and monitoring of system activity, Customer shall notify United within a reasonable timeframe of any (a) unauthorized access or damage, including damage caused by computer viruses resulting from direct access connection, and (b) misuse and/or unauthorized disclosure of passwords and user IDs provided by United which impact the System.

Termination. United reserves the right to terminate Customer's System access (i) on the date Customer fails to accept the hardware, software and browser requirements provided by United, including any amendments thereto or (ii) immediately on the date United reasonably determines that Customer has (i) breached, or allowed a breach of, any applicable provision of this Section or (ii) materially breached or allowed a material breach of, any other applicable provision of this Agreement. Customer's System Access will also terminate upon termination of this Agreement, provided however that if run-out is provided in accordance with Exhibit A - Services, Customer may continue to access applicable functionalities within the Systems during the run-out period. Upon any of the termination events described in this Agreement, Customer agrees to cease all use of Systems, and United will deactivate Customer's identification numbers, passwords, and access to the System.

Section A9 Health Savings Account (HSA)

Health Savings Account (HSA). United will provide Customer with an HSA in accordance with Exhibit A - Statement of Work. The HSA is not subject to ERISA, and accordingly, any provisions of this Agreement which reference ERISA or which establish upon United an obligation to provide reporting or other services standardly associated with an ERISA plan shall not apply to the HSA and any services relating thereto.

Customer acknowledges that HSAs are subject to contribution limits and other requirements imposed by the IRC and associated guidance issued by the IRS/Treasury Department. Customer acknowledges and agrees that United shall have no obligation to ensure compliance with any requirements or limitations pertaining to HSAs, their

establishment and/or use. To the extent that Customer has established contribution amounts and other HSA program requirements applicable to Customer Enrolling Employees, Customer will advise United of such requirements. United will not verify that distributions from Customer's Enrolling Employees' HSAs are for qualified medical expenses.

United's affiliate, Optum Bank, Inc., will accept HSA eligibility and account setup information from Customer directly for Customer's Participants as stated in Exhibit E.

Schedule of Services

A. ACCOUNT MANAGEMENT SERVICES

Service	Comments
Implementation and maintenance of account.	
Enrollment meetings and support for locations that meet United's criteria.	Minimum six weeks notice of meeting.
Standard initial enrollment kit.	
Bulk mailing of initial enrollment kits to Customer based on United's criteria.	
Ongoing account management including: • Designated account resources. • Ongoing management and review of benefits and data. • Plan review meetings with the Customer	Four (4) meetings per year, minimum. No fewer than two (2) on-site of customer
Standard accounting structure based on United's criteria: • Suffixes to accommodate separate claims reporting for different benefit plans. • Claim accounts to accommodate separate claims data for different locations and groups.	
Maintenance of benefit plans.	
Electronic Bill Presentment and Payment (EBPP), which provides capabilities to: • View invoices online. • Sort and search enrollee information. • Download billing information. • Remit payment online.	
Online administration services accessed through United's Employer eServices Web site including online eligibility maintenance and claim status inquiry.	Customer reporting is included to the extent indicated in Section D. eServices Customer Reporting Services.
Summary Plan Description (SPD) Assistance. United will prepare a customized draft of an SPD, either for each plan or multiple plans, as mutually agreed upon with one additional draft, in response to Customer's comments, and a final draft SPD. "Plan", for purposes of this paragraph, means each individual plan design administered by United. The SPD will be in English.	If the SPD is not finalized sufficiently in advance of the Effective Date of United's services, United will either (i) utilize the summary of Plan benefits and exclusions that United has created based on its understanding of Customer's Plan design and which Customer has reviewed and approved or (ii) create, at United's discretion, an operational SPD which will be based upon the summary of Plan benefits that Customer has reviewed and approved. United will administer claims and otherwise provide its services in accordance with this summary of Plan benefits and exclusions or operational SPD, as the case may be, and it will govern and remain in full force and effect until a final SPD is provided to United. Printing of SPDs is available at an additional cost.
Summary of Benefits and Coverage: • Electronic version in United's standard format. • For medical Plans administered by United. • Initial request and up to 1 amendment per year.	

B. ELIGIBILITY MANAGEMENT SERVICES

Service	Comments
Standard ID Card production and issuance.	United has assumed the addition of Customer's logo in an acceptable format to the ID card.
Alternative member ID numbers generated by United (not based on SSN).	
Electronic Eligibility Processing	
Electronic Enrollment processing: • Each submission to be a single consolidated file. Separate eligibility submissions for COBRA. • Initial load of primary physician data (when applicable) to be supplied electronically.	
Submission format: • UnitedHealth Group® Standard 3005 Format; HIPAA 834 Compliant Format; or HR-XML format. • Single data source required. **Submission frequency:** • Changes file daily in combination with a full population file on a monthly schedule. **Or** • Changes file weekly or bi-weekly in combination with a full population file on a monthly or quarterly schedule. **Or** • Full file weekly or bi-weekly**.** **Transmission method:** • FTP with United's approved encryption or direct connect.	

C. UNDERWRITING AND FINANCIAL SERVICES

Service	Comments
Overall program accounting (year-end reconciliation).	
Claim projections.	
Annual Projection of cost impact for benefit design changes.	
Annual Projection of conventional premium equivalent rates.	
Annual Reserve estimates.	
Annual government filings of 1099 reports to the IRS regarding payments made to physicians and other health care professionals.	
Provide required data necessary to enable Customer to file Form 5500.	

D. eSERVICES® CUSTOMER REPORTING SERVICES

Service	Comments
An online customer reporting system including up to five customer IDs.	
Reporting Access Levels: • Standard – Basic report package of "subscription" financial and utilization information produced on a pre-scheduled basis. • Select – In addition to the Standard features, interactive access to eCR tools allowing the user to customize report parameters to facilitate detailed views of the data. Includes a broad array of membership and utilization reports. • Expanded – In addition to the Select features, allows the user greater ad-hoc and customizable capabilities to obtain detailed performance information.	Customer's access level is based upon its election. Expanded Level reports are available to customers with Select Level reporting on an ad hoc basis for an additional charge per report.
Non-standard or ad hoc reports	Fees are determined on a report-specific basis

Service	Comments
HCC Reporting	Monthly reporting provided no later than 45 days following the close of the month
United reserves the right, from time to time, to change the content, format and/or type of its reports.	

E. CLAIMS ADMINISTRATION SERVICES

Service	Comments
Claims for Plan benefits must be submitted in a form that is satisfactory to United in order for it to determine whether a benefit is payable under the Plan's provisions. Customer delegates to United the discretion and authority to use United's claim procedures and standards for Plan benefit claim determination.	
Implementation of Customer's benefit plans.	
Claim history load from one prior carrier using United's standard process.	
Standard claims processing including: • Re-pricing and payment of claims. • Auto and manual adjudication using proprietary software. • Claim edit/review and cost containment program • Pending and subsequent claim review.	
Standard claim forms (when applicable).	
Medical claim review of specific health care claims to promote coding accuracy, benefit interpretation, and apply reimbursement policy.	
Standard coordination of benefits for all claims with automated investigation once every 12 months.	
Production and distribution of monthly Health Statements.	
Processing of run-out claims (meaning claims incurred prior to the termination date) for six (6) months following termination.	If the Agreement terminates because Customer fails to pay United fees due, fails to provide the funding for the payment of benefits, or United terminates for any other material breach, run-out will not apply. Run-out fees may apply to partial terminations at United's discretion. The fees associated with providing run-out claims processing are included in United's monthly administrative fees as described in Exhibit A. No additional fee will apply to run-out claims processing, provided, however, if the Agreement is terminated prior to the end of the initial Term for any reason, there will be an additional fee, determined by United, for the remaining months of the run-out claims processing term. **Suspension of Run-out Processing** If Customer does not pay the run-out fees it owes United when due as set forth above, United will notify Customer. If Customer does not make the required payment within five (5) business days of United's notice to Customer, United may stop issuing checks and non-draft payments and suspend its run-out claims processing under this Agreement, such suspension to apply to all claims regardless of dates of service and shall remain in effect until such date when Customer makes the required payment. **Termination of Run-out Processing** Run-out claims processing will terminate if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement. Such termination shall apply to all claims regardless of dates of service.
Subrogation Services.	
Fraud and Abuse Management Recovery Program.	

Service	Comments
Hospital Bill Audit Program.	
Credit Balance Recovery Program.	

F. MEMBER SERVICES

Service	Comments
Toll-free access to a customer care unit using a dedicated number	
Employee access to a member website enabling Participants to: • Check claim status. • Check eligibility information. • Search for providers and online health information.	

G. MEDICARE SERVICES

Service	Comments
Medicare crossover	
Medicare crossover initial enrollment solicitation	
Medicare Secondary Payer Reporting. United shall provide to applicable parties the applicable reports in a time and manner as required according to the Medicare Secondary Payer Mandatory Reporting Provisions (the Reporting Requirements) in Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. United shall not be responsible for any noncompliance penalties in connection with the Reporting Requirements that are related to the Customer's failure to provide the required data.	Customer agrees to provide to United in a timely manner and in an agreed upon format any and all data that United requires to comply with the Reporting Requirements.

H. NETWORK SERVICES

Service	Comments
Network access, management and administrative activities	Standard on all network plans.
UnitedHealth Premium℠ Designation Program	Available in designated markets.
Network access to chiropractic and complementary alternative medicine providers	
Physical Health Clinical Support Program for Chiropractic and Complementary Alternative providers.	
Transplant Solutions (TS) Services • Transplant Network via Centers of Excellence (COE) • Transplant Access Program (TAP) Network • Extra-Contractual Services - contracting on a case-by case basis for transplant care outside of the COE or TAP Networks for a standard negotiating fee.	
Reasonable and customary charge guidelines for out of network surgical, medical, lab and x-ray claims.	
Shared Savings Program Standard Application of the Shared Savings Program provides additional savings on select 1) non-Network facility and 2) physician claims that are not eligible for standard network discounts. Program provides access to discounted charges made available to United from health care providers who contract or will negotiate with, a third party to provide such discounted charges.	The services under this program provide access to provider discounts only and do not include credentialing of providers or other Network services. United is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services under the Shared Savings Program. United can terminate the Shared Savings Program at any time for any reason.
Facility Reasonable & Customary Charge Determination Program. This program provides for reduction of facility billed charges in accordance with appropriate guidelines.	United can terminate the program in whole or in part at any time for any reason.

Service	Comments
Access to Extended Networks (leased networks)	Available at an additional charge.

I. CARE MANAGEMENT AND OUTREACH SERVICES

Service	Comments
Custom Care Management Unit (CCMU) providing a customized, integrated care management solution built on clinical services and network solutions	
Medical policy functions, as guided by a medical director.	Standard on all managed plans.
Complex Medical Conditions: • **Bariatric Resource Services** • **Cancer Resource Services** • **Cancer Support** • **Congenital Heart Disease Resource Services** • **Healthy Back** • **Healthy Pregnancy** • **Kidney Resource Services** • **Maternity Support Program** • **Neonatal Resource Services** • **Case Management (CM) and Disease Management (DM) (includes: asthma, CAD, Diabetes, Heart Failure)** • **Nurseline/Decision Support** • **Telephonic Wellness Coaching**	Included in Custom Care Management Unit (CCMU)
Wellness Coaching	
Alternate Care Proposals (ACP) which provide appropriate and cost effective health care services and supplies alternatives that would otherwise not be covered by the Plan.	Customer consents to United's use and administration of the ACP program and delegate to United the discretion and authority to develop and revise ACPs.
Activation programs to engage Participants including, monthly health statements member call services, and access to member portal with consumer messaging	
Predictive modeling, using data from a proprietary system, to identify individuals at risk and offer proactive programs to improve their health status.	Additional charges apply for integrating an outside vendor's pharmacy data.
Obesity and Diabetes Prevention Services, customizable program delivered to eligible Participants with a goal of preventing diabetes and other obesity related diseases. The program uses a 52-week approach with online technology and live audio/video capabilities.	Services are delivered by United Network Providers.
Spine and Joint Solution, includes access to specialized surgeons and care teams that guide treatment and recoveries to eligible Participants with spinal surgeries and knee and hip replacements.	
Rewards Program	Customer will be responsible for funding any applicable financial incentives.
Custom Plan Cost Estimator, comparative health care plan information through the myUHC.com portal to allow Participants to research the key benefit and financial differences of the various healthcare plans Customer offers Participants.	

Service	Comments
Nurse Liaison Program, provide eligible Participants with access to the Nurse Liaison Program. Manage assigned nurses who will be led by the Health Strategies Team and Nurse Liaison National Lead. Activities included in the program include but are not limited to: (i) one on one education with Participants; (ii) group presentations; (iii) myuhc.com education; (iv) health risk assessment education; (v) case management and disease management referrals (vi) NurseLine education; and (vii) wellness committee support.	

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K. EMPLOYEE HEALTH EDUCATION AND MEDICAL SELF-CARE PROGRAM SERVICES

Service	Comments
Health Content – providing members with access to online services which may include but are not limited to health and wellness content, health assessments, health coaching, personal health records and/or automated messaging, available through myuhc.com and other online resources.	

L. UNITEDHEALTH ALLIES® DISCOUNT PROGRAM

Service	Comments
UnitedHealth Allies® Discount Program enabling plan participants to access pre-negotiated savings on certain out-of-pocket health care purchases. The discount value program is not a health insurance plan.	UnitedHealth Allies® Discount Program can be made available to non-covered employees or employees participating in plans not administered by United for an additional fee.

M. MANAGED PHARMACY - CARVE OUT

Service	Comments
Integration of external pharmacy vendor data into predictive model with a pharmacy benefit manager (PBM) with which United has an existing data sharing agreement.	Additional fee applies for data integration with PBMs that United does not have an existing data sharing agreement with.

N. HEALTH SAVINGS ACCOUNT (HSA) SERVICES

Service	Comments
Standard HSA services. United's affiliate will be Customer's preferred HSA custodian for eligible employees' HSAs. United will provide the following services in relation to those HSA custodial services: • Pre-enrollment brochures – one per employee. • Human Resources Communication Toolkit. • Provide access to bank account information through a member website for account holders enrolled in health plans administered by United.	

EXHIBIT B –FEES

This exhibit lists the fees Customer must pay United for its services during the term of the Agreement. These fees apply for the period from January 1, 2017 through December 31, 2019. Customer acknowledges that the amounts paid for administrative services are reasonable. If authorized by Customer pursuant to this Agreement or by subsequent authorization, certain fees will be paid through a withdrawal from the Bank Account.

Standard Medical Service Fees

The Standard Medical Service Fees described below, excluding optional and non-standard fees, are adjusted as set forth in the applicable performance standard(s).

The Standard Medical Fees listed below are based upon an estimated minimum of 3,263 enrolled Employees

The Standard Medical Service Fees are the sum of the following:

Effective January 1, 2017 through December 31, 2019

- $45.28 per Employee per month covered under the *Unitedhealthcare Choice Plus HSA** portion of the Plan.
- $43.90 per Employee per month covered under the *Unitedhealthcare Choice Plus* portion of the Plan.
- $43.90 per Employee per month covered under the "*UnitedHealthcare Options PPO Non-Differential*" portion of the Plan.
-
- **Average Contract Size:** 1.86

Other Fees

Service Description	Fee
Fraud and Abuse Management	Fee equal to thirty-two and five-tenths percent (32.5%) of the gross recovery amount
Hospital Audit Program Services	Fee not to exceed thirty-one percent (31%) of the gross recovery amount
Credit Balance Recovery Services	Fee not to exceed ten percent (10%) of the gross recovery amount.
Standardized Summary of Benefits and Coverage (SBC) as established under The Patient Protection and Affordable Care Act of 2010	United will provide, at no additional charge, standard format, electronic copies of the SBC documents (twice per year) for medical benefit plans administered by United. Customer logos can be included on the SBC at no additional charge. Additional fees will apply for other services. United will not create SBCs for medical plans it does not administer.
Third Party Liability Recovery (Subrogation) Services	Fee equal to thirty-three and one-third percent (33.3%) of the gross recovery amount
Facility R&C Charge Determination Program -- United will bill Customer for the amounts Customer owes United. The bill will reflect reductions obtained during the preceding month and adjustments, if any, from previous months	Fee for United's services, equal to 35% of the amount of reductions obtained through United's efforts.
Shared Savings Program	Customer will pay a fee equal to 35% of the Savings Obtained as a result of the Shared Savings Program.
External Reviews	For each subsequent external review beyond 5 total reviews per year, a fee of $500 will apply per review.
*Health Savings Account - Monthly Maintenance Fee	$1.00 per Employee (account) per month

Custom Care Management Model (“CCMU”)	Included in the Standard Medical Service Fee)

EXHIBIT C – PERFORMANCE GUARANTEES FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees and that portion of the Standard Medical Service Fees attributable to Commission Funds, if applicable, as described in Exhibit B), (hereinafter referred to as "Fees" in this Exhibit) payable by Customer under this Agreement will be adjusted through a credit to its fees in accordance with the performance guarantees set forth below unless otherwise defined in the guarantee. Unless otherwise specified, these guarantees apply to medical benefits and are effective for the period January 1, 2017 through December 31, 2017 ("Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies.

These guarantees will become effective upon the later of (1) the effective date of the Guarantee Period; or (2) the date this Agreement is signed by both parties. In the event these guarantees become effective later than the effective date of the Guarantee Period: (1) quarterly guarantees will become effective beginning with the next calendar quarter following signature of this Agreement by both parties and (2) annual guarantees will become effective commencing with the Term of the Agreement during which this Agreement is signed by both parties.

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

Prior to the end of the Guarantee Period, and provided that this Agreement remains in force, United may specify to Customer in writing new performance guarantees for the subsequent Guarantee Period. If United specifies new performance guarantees, United will also provide you with a new Exhibit that will replace this Exhibit for that subsequent Guarantee Period.

Claim is defined as an initial and complete written request for payment of a Plan benefit made by an enrollee, physician, or other healthcare provider on an accepted format. Unless stated otherwise, the claims are limited to medical claims processed through the UNET claims systems. Claims processed and products administered through any other system, including claims for other products such as vision, dental, flexible spending accounts, health reimbursement accounts, health savings accounts, or pharmacy coverage, are not included in the calculation of the performance measurements. Also, services provided under capitated arrangements are not processed as a typical claim; therefore capitated payments are not included in the performance measurements.

Total Fees at Risk as a Percent of Medical ASO Fees			**26.0 %**
Member Phone Service			
Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Your Participants. If Customer elects a specialized phone service model the results may be blended with more than one call center and/or level. They do not include calls made to care management personnel and/or calls to the senior center for Medicare Participants, nor do they include calls for services/products other than medical, such as mental health/substance abuse, pharmacy (except where We are Your pharmacy benefit services administrator), dental, vision, Health Savings Account, etc.			
Average Speed To Answer			
Definition	Calls will sequence through our phone system and be answered by customer service within the parameters set forth.		
Measurement	Percentage of calls answered		100%
	Time answered in seconds, on average	seconds	30
• Criteria	Standard tracking reports produced by the phone system for all calls		
• Level	Team that services Your account		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	30.01 to 32.00 seconds		

	32.01 to 34.00 seconds 34.01 to 36.00 seconds 36.01 seconds or greater		
Abandonment Rate			
Definition	The average call abandonment rate will be no greater than the percentage set forth		
Measurement	Percentage of total incoming calls to customer service abandoned, on average		1%
• Criteria	Standard tracking reports produced by the phone system for all calls		
• Level	Team that services Your account		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	2.01% - 2.50% 2.51% - 3.00% 3.01% - 3.50% 3.51% or more		
Call Quality Score			
Definition	Maintain a call quality score of not less than the percent set forth		
Measurement	Call quality score to meet or exceed		93%
• Criteria	Random sampling of calls are each assigned a customer service quality score, using our standard internal call quality assurance program.		
• Level	Office that services Your account		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	92.99% - 91.00% 90.99% - 89.00% 88.99% - 87.00% 86.99% or less		
First Call Resolution			
Definition	Calls that are resolved during and/or after the call is received and do not result in a repeat or follow-up call from the Participant regarding the exact same claim issue within the designated number of calendar days of the first call.		
Measurement	Percentage of calls resolved		85%
	With no repeat, in calendar days	calendar days	60
• Criteria	Standard system tracking reports		
• Level	Customer specific		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	84.99% - 83.00% 82.99% - 81.00% 80.99% - 79.00% 78.99% or less		
Call Issue Resolution in 5 Days			
Definition	Time to resolve inquiries received from a Participant via a call to customer service.		
Measurement	Percentage of issues resolved		88%
	Time to resolve, in business days or less after the issue is reported	business days	5
• Criteria	Standard system tracking reports		
• Level	Customer specific		
• Period	Annually		
Payment Period	Annually		

Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	87.99% - 87.50% 87.49% - 87.00% 86.99% - 86.50% 86.49% - 86.00%		
Satisfaction			
Employee (Member) Satisfaction			
Definition	The overall satisfaction will be determined using the members' evaluation of United's ability to administer their medical health insurance plan.		
Measurement	Percentage of respondents, on average, indicating a grade of satisfied or higher		80%
• Criteria	Operations standard survey, conducted over the course of the year; may be customer specific for an additional charge.		
• Level	Office that services Your account		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Account Management Team Satisfaction			
Definition	Customer satisfaction survey. The question is part of our AMT Scorecard survey instrument and reads *"How satisfied are you overall with the AMT?"*		
Measurement	Minimum score on a 10 point scale	score	5
• Criteria	Standard Account Management Team Scorecard		
• Level	Customer specific		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Claim Operations - Medical			
Time to Process in 10 Days			
Definition	The percentage of all claims We receive in any quarter will be processed within the designated number of business days of receipt.		
Measurement	Percentage of claims processed		94%
	Time to process, in business days or less after receipt of claim	business days	10
• Criteria	Standard claim operations reports		
• Level	Office Level		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	11 business days 12 business days 13 business days 14 business days or more		
Financial Accuracy (FAR)			
Definition	Financial accuracy rate of not less than the designated percent in any quarter.		
Measurement	Percentage of claims dollars processed accurately		99.3 %

• Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed correctly out of the total claim dollars submitted for payment.		
• Level	Office Level		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	99.29% - 99.05% 99.04% - 98.80% 98.79% - 98.55% 98.54% or less		
Procedural Accuracy			
Definition	Procedural accuracy rate of not less than the designated percent in any quarter.		
Measurement	Percentage of claims processed without procedural (i.e. non-financial) errors		97%
• Criteria	Statistically significant random sample of claims processed is reviewed to determine the percentage of claim dollars processed without procedural (i.e. non-financial) errors.		
• Level	Office Level		
• Period	Quarterly		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% or less		
Claim Adjustment Time in 5 Days			
Definition	Claim adjustments completed within 5 business days of the member request not less than the designated percent		
Measurement	Percentage of claim adjustments to be processed within 5 business days of the member request.		85%
• Criteria	Business days from the date stamp of when the adjustment request was received		
• Level	Office Level		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	6 business days 7 business days 8 business days 9 business days or more		
Eligibility			
Eligibility Update Work Days/Eligibility Data Work Days			
Definition	We will load the guaranteed percent of the electronic eligibility files received within the guaranteed number of business days of receipt.		
Measurement	Percentage of total files to be loaded		94%
	Business days after file is received (must be received by 12:00 noon EST otherwise they are considered received on the following business day)	business days	3
• Criteria	An electronic load will be considered to have met the standard if the time between the date the file is received by Us and the date upon which the file is loaded to the eligibility system(s) is guaranteed number of business days or less. The guarantee is waived for electronic files that cannot be loaded due to file errors or for files that require reformatting of data; files must meet all standards defines in Our electronic eligibility handbook.		

• Level	Customer specific		
• Period	Annually		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	93.99% - 93.00% 92.99% - 92.00% 91.99% - 91.00% 90.99% or less		
Ongoing ID Cards Issuance			
Definition	ID cards will be postmarked within the parameters set forth after the final eligibility data has been system loaded, passed a quality assurance check, passed a system load test, and has been released to the I.D. card production area.		
Measurement	Percentage of cards issued		98%
	Issued time frame, business days or less	business days	10
• Criteria	Calculated on a pro-rated basis, based on the actual number of late cards as a percent of the total number of cards.		
• Level	Customer specific		
• Period	Ongoing		
Payment Period	Annually		
Fees at Risk	Percentage of **Fees at Risk** for this metric		2.0%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		25%
Gradients	11 business days 12 business days 13 business days 14 business days or more		
Reporting			
Claim Report (eCR)			
Definition	Data files via interactive reports including all paid claims, according to the parties agreed upon structure, will be available online within the designated number of days after the end of the month.		
Measurement	Number of business days after the end of the month	business days	10
• Criteria	Business day on which the agreed upon reports are delivered will be compared to the end of the month		
• Level	Customer Specific		
• Period	Monthly		
Claim Report (EPR)			
Definition	Executive Performance Report with at minimum one month of run-out each quarter		
Measurement	Number of business days after the end of the run-out month	calendar days	45
• Criteria	Business day on which the agreed upon reports are delivered will be compared to the end of the month		
• Level	Customer Specific		
• Period	Quarterly		
Consultative Analysis (HPR)			
Definition	Healthplan Performance Report with at minimum one month of run-out semi-annually		
Measurement	Number of business days after the end of the run-out month	calendar days	90
• Criteria	Business day on which the agreed upon reports are delivered will be compared to the end of the month		
• Level	Customer Specific		
• Period	Semi-Annually		
Fees at Risk	**Dollars at Risk** for this metric		$25,000
Payment Amount	Of the Dollars at Risk for this metric, percentage at risk for each gradient		25%
Payment Period	Annually		

Gradients	1 Overdue Report 2 Overdue Reports 3 Overdue Reports
	4 or more Overdue Reports

UnitedHealthcare Choice Network Savings Guarantee

The Network Savings Guarantee is effective during the incurred period 1/1/2017 through 12/31/2017 and applies only to in-network claims paid within 3 months following the end of the Network Savings Guarantee Period.

Commitment

Actual Discount Range				Fees At Risk			
Less Than 57.5%				20.0%			
57.5% - 58.5%				16.0%			
58.5% - 59.5%				12.0%			
59.5% - 60.5%				8.0%			
60.5% - 61.5%				4.0%			
Greater Than 61.5%				0.0%			

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

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

- ☐ Employees enrolled in a UnitedHealthcare Choice Network 3,182
- ☐ Target Network Savings Percentage (Illustrative) 63.5%
- ☐ Risk Free Corridor 2.0%

- ☐ For the UnitedHealthcare Choice network to be accessed, a sufficient benefit differential between in and out of network benefits must exist to promote in-network usage. Whether a sufficient benefit differential exists will be measured by UnitedHealthcare with the measurement based on coinsurance differentials, deductible differentials, out of pocket maximum differentials, and combinations of the former, among others.
- ☐ Savings are defined as the sum of: (1) the difference between the covered billed charges (excluding ineligible and not covered charges) submitted by the network provider and the amount based on the negotiated rate with that provider. This may also include specially negotiated discounts with network providers in outlier claim situations. No reasonable and customary (R&C) reductions are taken when a negotiated rate is in place with a network provider. The calculation is performed before the application of copayments, deductibles, or other coinsurance. (2) savings that result from the application of claims payment logic that bundles claims, consistent with provisions in our provider contracts.
- ☐ We reserve the right to exclude claims billed utilizing billing software, showing billed charges (excluding ineligible and not covered charges) equal to the negotiated rate from this guarantee.
- ☐ We reserve the right to exclude all claims for claimants with covered charges $75,000 or greater during the guarantee period.
- ☐ Claims where UnitedHealthcare is the secondary payor are excluded from the Network Savings and Network Savings Factor determination.

- Mental Health/Substance Abuse claims are excluded.

The table below provides the in-network savings for those markets with the largest number of employees based on the PINELLAS COUNTY GOVERNMENT network match. These savings will be utilized to determine PINELLAS COUNTY GOVERNMENT's final Target In-Network Savings Percentage based on actual enrollments by market.

Market Name	Employees	Employee %	In-network Savings
TAMPA	3,116	97.9%	63.7%
Other	66	2.1%	54.8%
Total/Average*	3,182	100.0%	63.5%

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

A minimum of 3,000 total employees enrolled in the UnitedHealthcare plan is required for the Network Savings Guarantee to remain in effect.

UnitedHealthcare reserves the right to revise this quotation under the following circumstances:

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

UHC reserves the right to adjust the discount guarantee should provider chargemaster increases (the rate by which provider charges increase) vary from assumed levels.

* These numbers are estimated only. Final numbers will depend on actual enrollment by network. At the time of reconciliation, discounts will be calculated per the language set forth in this guarantee and may not match figures shown in other client reports produced throughout the year.

CCMU Performance Guarantees

Client Name **Pinellas County Board of County Commissioners**
Contract Start Date **1/1/2017**
Contract End Date **12/31/2019**

Metric	Definition	Guaranteed Result	Methodology	Year 1 PMPM Fees at Risk	Year 2 + PMPM Fees at Risk	Basis for PG	Terms & Conditions	
Financial Performance								
Meet or Exceed Return on Investment	Represents gross savings in the clinical components of the CCMU program (excluding incremental vendor fees, Towers Watson fees and buy up fees)	$6.20 PMPM	A combined "best-in-class" measurement techniques for each condition/intervention type and then aggregate the results using a disease/condition hierarchy to prevent double-counting of savings for members who participate in multiple services. (excludes incremental vendor fees and Towers Watson fees) Actuarial techniques will be used to blend Book of Business results with Client specific results to mitigate the impact of random variation and small population volatility.	$ 0.51	$ 0.51	Client Specific	Payout Savings > $6.20 PMPM - 0% $5.20 to $6.19 PMPM - 75% of fees at risk < $5.20 PMPM - 100% of fees at risk	
Utilization								

Reduction in Hospital Admits Per 1,000 Members	Percent reduction in the number of acute hospital admissions / 1,000 members for consumers with CHF, COPD, CAD, Diabetes and Asthma adjusted for the trend of the population without CHF, COPD, CAD, Diabetes and Asthma. Will exclude trauma and maternity.	5% Y/Y reduction	Measured on the total CCMU and requires a minimum of 60,000 managed lives. Note that PG measurement requires 12 months of medical and pharmacy claims history with 3 months of runout for both baseline and each measurement period. Also requires 6 months of eligibility for outreach in each measurement year, i.e. 6 months (or more) of identification as a diabetic, etc.	$ 0.03	$ 0.03	CCMU		
Reduction in Emergency Room Visits Per 1,000 Members	Percent reduction in the number of ER admits / 1,000 members for consumers with CHF, COPD, CAD, Diabetes and Asthma adjusted for the trend of the population without CHF, COPD, CAD, Diabetes and Asthma. Will exclude trauma and maternity.	2% Y/Y reduction	Measured on the total CCMU and requires a minimum of 60,000 managed lives. Note that PG measurement requires 12 months of medical and pharmacy claims history with 3 months of runout for both baseline and each measurement period. Also requires 6 months of eligibility for outreach in each measurement year, i.e. 6 months (or more) of identification as a diabetic, etc.	$ 0.03	$ 0.03	CCMU		
Reductions in Readmissions Per 1,000 Members (within 30 days)	Percent reduction in the number of IP re-admissions within 30 days / 1,000 members for all readmissions excluding planned readmissions, trauma, maternity.	2% Y/Y reduction	Measured on the total CCMU and requires a minimum of 60,000 managed lives. Note that PG measurement requires 12 months of medical and pharmacy claims history with 3	$ 0.03	$ 0.03	CCMU		

			months of runout for both baseline and each measurement period. Also requires 6 months of eligibility for outreach in each measurement year, i.e. 6 months (or more) of identification as a diabetic, etc.					
Population Health								
Engagement of Large Cases in Case Management	Large claimants are defined as any member that has incurred $50,000 or more in claims during the previous 6 months. The operational report will be generated monthly but the PG will be assessed annually.	75%	OptumHealth will actively engage with 75% or better of all unique eligible members with medical claims>$50,000. Eligibility requirements include the following: Member is eligible for benefits / Member is eligible for program enrollment / Optum is able to obtain a valid phone number / Member is responsive to contact attempts.	$ 0.10	$ 0.10	Client-specific Requires minimum of 3,000 members for client-specific report		
Increased Annual LDL Test Rates	Improvement in the adherent rate for LDL Cholesterol Screening qualified members with Diabetes and CAD compared to the baseline period (or the prior measurement period).	5% improvement in the non-adherent population or achieve a target of 65%	**Denominator:** All consumers who meet the requirements for inclusion in the CAD and diabetes measures between ages 18 and 64 **Numerator:** Those in the denominator with a claim for LDL testing in the 12 month measurement period.	$ 0.03	$ 0.03	CCMU	Improvement in the non-adherent is the industry standard	

Improvement in LDL Levels	Improvement in the % of members with most recent LDL results < 100mg/dL		**Denominator:** All consumers who meet the requirements for inclusion in the CAD and diabetes measures between ages 18 and 64 who have LDL lab results reported **Numerator:** Those in the denominator with most recent LDL results < 100 mg/dL.	N/A	$ -	CCMU	• Optum will measure this in Year one and revisit the potential for fees at risk on it in year 2. • Requires lab results to be reported for 30% of diabetic and CAD population in both years of measurement, or % of fees at risk is defaulted to Increased Annual LDL Test Rates.
Increased Annual A1c Test Rates	Percentage of diabetes members receiving minimum of 2 A1c tests per year	5% improvement in the non-adherent population or achieve a target of 65%	**Denominator:** All identified members with diabetes between ages 18-64 **Numerator:** Those in the denominator with medical claims during the review period for lab tests, with CPT - 4 codes identified as A1c testing 2/year: count>=2 in 12 months	$ 0.03	$ 0.03	CCMU	The target for this PG will be reviewed on an annual basis and updated
Improvement in A1c Levels	Improvement in the % of members with most recent A1c levels < 7		**Denominator:** All identified members with diabetes between ages 18-64 who have A1c lab results reported **Numerator:** Those in the denominator with most recent A1c levels < 7.	N/A	$ -	CCMU	• Optum will measure this in Year one and revisit the potential for fees at risk on it in year 2. • Requires lab results to be reported for 30% of diabetic and CAD population in both years of measurement, or % of fees at risk is defaulted to Increased Annual A1c Test Rates
Improvement in Medication Compliance for Adult Asthmatics (Mid to Severe Persistence)	Percentage of managed Asthma members with persistent asthma (mild to severe persistent) who are adherent with taking their control medications. Measured through the use of pharmacy claims data.	5% improvement in the non-adherent population or achieve a target of 65%	**Denominator:** All identified asthmatics with mild, moderate or severe persistent asthma **Numerator :** Asthma Members with pharmacy claims during the review	$ 0.03	$ 0.03	CCMU	The target for this PG will be reviewed on an annual basis and updated

			period for drugs with class codes identified as long term-control medications				
Operational Performance							
Case Management Enrollment	Percent of qualified members reached who enrolled in a case management program. Qualified members are those members identified for: acute case management, pre-admission counseling, post-discharge counseling, readmission management program, predictive model outreach, and high risk case management. Members reached should only exclude: (1) those members with no or incorrect phone numbers, and (2) those members for whom 2 or more unsuccessful contact attempts were made specific to the triggering event	75% enrollment	**Denominator:** Total number of reached members **Numerator:** Total number of members that enroll	$ 0.13	$ 0.13	Client-specific Requires minimum of 3,000 members for client-specific report	
High Acuity Disease Management Program Enrollment	Qualified members reached for the outbound call program will enroll in the applicable program. Reported at the program level, guaranteed at the aggregate level (weighted average of all programs)	40%	**Denominator:** Qualified members, as defined by each clinical program, and as validated with initial clinical screenings when appropriate. Qualified members with invalid phone numbers will be excluded from the denominator. **Numerator:** Those individuals in the denominator who	$ 0.13	$ 0.13	Client-specific Requires minimum of 3,000 members for client-specific report	

			enroll in the telephonic coaching program.					
				$ 1.05	$ 1.05			

1. New companies into the BOB will be excluded from the PG's in their first year unless the company can provide credible historical medical and Rx claims data for the prior 24 month period. Must include the following fields on an individual member basis:
 * Insert list of fields required for historical data
loading

2. PG's are relevant for UHC-specific membership but will need to be reassessed for any cross-carrier companies

Optum Clinical Performance Guarantee Summary

Guarantee Terms & Conditions

Our guarantees become effective on the later of the service implementation date or execution of a services agreement; we shall not be required to meet any guarantees in the event of early termination of our services agreement; performance guarantees shall not apply to contract renewals or extensions of less than twelve months.

We shall not be required to meet any guarantee to the extent our failure is due to your actions or inactions, including failure to provide 85% valid contact information, including member email, cell, work and home phone on a timely basis; or failure to execute agreed-upon communications or incentive strategies.

Penalties are waived in all cases where our performance failure is caused in whole or part by fire, embargo, strike, war, accident, acts of God, acts of terrorism, or pandemic; our required compliance with any law, regulation, or governmental agency mandate; or anything beyond our reasonable control.

Prior to the end of the guarantee period, and provided that this agreement remains in force, we may specify to you in writing new performance guarantees for the subsequent guarantee period. If we specify new performance guarantees, we will also provide you with a new exhibit that will replace this exhibit for that subsequent guarantee period.

We reserve the right to revise these guarantees should the services implemented vary from those quoted here, an award is not made within 90 days of submission of these proposed guarantees, communications or incentive strategies change from the information and descriptions provided to us at the time of this quote, or where covered members or average contract size (ACS) varies by more than 10% from assumptions used here of 6,100 actives and pre-65 retiree members and ACS of 1.86 respectively.

We will measure and report results for each standard on a calendar year basis unless otherwise indicated; results will be rounded to the nearest whole number unless the target is specified with more precision. A minimum of 50 qualified members are required to provide measurement for any guarantee, although individual programs/guarantees may have additional higher thresholds. Performance guarantees that are not settled within 9 months of the completion of measurement are considered void.

Any penalties payable pursuant to this Exhibit shall be deducted from an upcoming monthly payment payable by Customer.
Optum may use a variety of interventions and reporting mechanisms to collect data and report against these PGs, including but not limited to IVR (interactive voice response), online survey tools and assessments, claims mining or other methodologies. Acceptance of these PGs includes client approval for Optum to utilize any or all of these methods without additional express or prior permission.

Customer agrees that the penalties payable under this Agreement are Customer's sole remedies for such Performance Standards hereunder, and that failure of Optum to meet a Performance Standard for which a penalty has been paid or is payable shall not, by itself, constitute a terminable breach under the Agreement.

Requires the purchase of Case Management PHS 2.0, Disease Management (all five conditions: CHF, COPD, CAD, Diabetes, Asthma), Wellness Coaching and Rally.

Client Name: Pinellas County Board of County Commissioners
Contract Start Date: 1/1/2017
Contract End Date: 12/31/2019

				Annual Wellness Fees at Risk				
Metric	**Definition**	**Guaranteed Result**	**Result Timeframe**	**Year 1**	**Year 2**	**Year 3**	**Calculation**	**Terms and Conditions**
Operations								
Wellness Coaching Enrollment	The percentage of reached members who enroll in a coaching program (excludes claims-based referrals)	20%	Annual	$3,333	$3,333	$3,333	Numerator: Number of telephonic, mail or online coaching enrollments. Denominator: Number of members reached (excluding claims-based referrals).	• Minimum wellness coaching client size of 5,000 members (eligible for client wellness program) • Requires the purchase of Optum's standard wellness coaching program, including health assessment, ID/stratification criteria, consumer engagement and coaching processes. • Mutually agreed upon incentive and communication strategy that includes a minimum $50 incentive for completing a coaching program. • Health assessment promotion period occurs within the first three months of the measurement year. • Payout: 100% target achieved - 0% 75 - 99% of target - 40% of fees at risk < 75% of target - 100% of fees at risk
			Total Fees at Risk	**$3,333**	**$3,333**	**$3,333**		

EXHIBIT E – HEALTH SAVINGS ACCOUNT ENROLLMENT AND CONTRIBUTION

Important Note About This Exhibit: Federal and state laws and regulations require United to have an executed document with Customer in advance of implementation of Customer's Participant HSAs, most notably prior to the receipt of HSA eligibility and account setup information from Customer. This only applies if Customer opts to send HSA information for Participants directly to United. If Customer choses this option, United needs to expedite signature of this Exhibit so as to not delay HSA implementation. This Exhibit is structured to be executed separately from the agreement if need be.

If Customer opts to have its Participants work directly with Optum Bank for the establishment of their individual HSAs, this Exhibit is not needed and will be removed. Thank you.

This Health Savings Account Enrollment and Contribution Exhibit (the "HSA Exhibit") is made to the Administrative Services Agreement ("Agreement") between United HealthCare Services, Inc. on behalf of itself and its Affiliates, including Optum Bank, Inc., a Utah chartered FDIC insured financial institution, (the "Bank"), and Pinellas County Board of County Commissioners ("Customer"), and is effective on January 1, 2017.

The Parties hereby agree as follows:

1. HSA Documentation. A deposit and custodial agreement (together with other HSA notices, disclosures or information as each may be amended from time to time, the "HSA Documentation") between eligible employees who are approved by the Bank to establish a HSA ("Account Holders") and the Bank governs the rights and obligations of the Account Holder and Bank with regard to the HSA custodial services and nothing in the Agreement or this HSA Exhibit modifies or amends the terms of any HSA Documentation.

2. Contributions. Customer may forward payroll deduction contributions and other contributions to Bank in a manner and form acceptable to Bank. Bank shall have no liability for any payroll deduction files or funds not received by Bank or for any error in crediting contributions to HSAs in reliance on data provided by Customer. Customer's HSA contributions are non-forfeitable and subject to the rules restricting recoupment by employers.

3. Account Holder Employment Termination. Customer shall notify Bank of an Account Holder's termination of employment as soon as administratively feasible and in a manner acceptable to Bank and shall provide Bank with any other information requested by Bank from time to time to comply with applicable law.

4. Representations, Warranties and Obligations. If Customer provides assistance in opening and administering HSAs, then Customer represents and warrants that Customer has been designated by each prospective Account Holder as their authorized agent and Customer: (i) have verified the identity and eligibility pursuant to Section 223 of the Code of each prospective Account Holder in accordance with applicable laws; (ii) have designed Customer benefits enrollment systems to prevent fraud in the enrollment process; (iii) will, for a period of seven (7) years, maintain records of (a) Customer's designation as authorized agent, (b) authorizations from each prospective Account Holder authorizing Customer to open and administer a HSA with Bank, (c) prospective Account Holder enrollments and debit card request, and (d) any other information and documents related to Customer opening and administering the HSA; and (iv) agree to take such actions or provide any information requested by the Bank in order to open and administer a HSA and comply with any statute, regulation or governmental mandate as deemed necessary and appropriate by Bank.

5. Patriot Act Notice. As authorized agent for each Account Holder, Customer hereby: (i) accept the following Patriot Act Notice: **"IMPORTANT INFORMATION ABOUT PROCEDURES FOR OPENING A NEW ACCOUNT — To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. United may also ask to**

see your driver's license or other identifying documents" and (ii) represent and warrant that Customer has provided each prospective Account Holder with the Patriot Act Notice during enrollment.

6. Request to Open Account. As an authorized agent with respect to each prospective Account Holder, Customer hereby requests that Bank open a HSA for and issue a debit card to each prospective Account Holder and Customer agrees that monthly account statements related to each HSA shall be provided to each Account Holder electronically.

7. Communications. Customer will provide the Bank a list of all personnel authorized by Customer to receive and furnish information under the Agreement and Customer hereby authorizes Bank to honor or act upon any facsimile, electronic direction/data transmission, mail and other order, instruction, action or transmission from Customer or Customer authorized personnel ("Employer Communication"). Customer is responsible for the accuracy and completeness of any Employer Communication and Customer is solely responsible for any adverse consequences that may result from errors or inaccuracies within any Employer Communication. Bank will act within a reasonable time after receipt of any communication Customer shall be responsible for all costs and expenses incurred by Bank for error correction undertaken by Bank as a result of an erroneous Employer Communication to Bank.

8. Limitation of Liability. Bank will not be responsible for claims, damages or liabilities resulting from: (i) acts or omissions based on instructions or directions received from Customer or Customer agents, representatives or employees; or (ii) errors caused by incomplete, inaccurate or untimely information provided by Customer or Customer agents, representatives or employees, or Customer's failure to perform its obligations as required by the Agreement and this HSA Exhibit. Section 7.2 of the Agreement shall not apply to the Bank or to services performed pursuant to this HSA Exhibit.

9. Mutual Fund Investments. In the event Customer elects to offer eligible Account Holders the ability to invest HSA funds, Customer acknowledges and agrees that: (a) the Bank is not a fiduciary in any capacity is not responsible for any mutual funds selected by its registered investment advisor or Customer; (b) the Bank will not provide any investment advice to any Account Holder; (c) the Bank has no duty to determine whether Account Holders are afforded a reasonable choice of investment options, monitor the mutual funds, or determine the suitability of such funds; (d) the Bank is under no obligation to substitute, replace and/or remove any mutual funds offered to Account Holders; (e) if the Bank has agreed in writing to allow Customer to select additional or alternative mutual funds, any such mutual funds consist of a subset of mutual fund investments offered under Customer's 401(k) plan. Customer will be liable to and will defend, indemnify and hold harmless the Bank, its Affiliates and their respective officers, directors, employees, successors and permitted assigns from and against any and all liability, damages, costs, losses and expenses, penalties or excise taxes, including attorneys' fees, disbursements and court costs, imposed upon or incurred by the Bank in connection with any threatened, pending, or adjudicated claim, demand, action, suit or proceeding arising in connection with any mutual fund added at Customer's request.

10. Election to Pay Fees. In the event Customer or Customer designee pays the monthly fee for an Account Holder, Customer shall continue to pay such fee on behalf of the Account Holder until the first of the month following thirty one (31) calendar days after the date the Bank receives written notice that Customer will no longer pay such fees on behalf of the Account Holder. Unpaid fees may be charged by the Bank to each Account Holder's HSA.

11. Confidentiality and Privacy. All of the Bank's confidentiality obligations to an Account Holder are contained in the HSA Documentation. Confidential Information about an Account Holder that is provided to the Bank, by either the Account Holder, or Customer as an authorized agent, is provided pursuant to the HSA Documentation between Account Holders and the Bank. The Bank is not receiving Customer's Confidential Information pursuant to the Agreement or this HSA Exhibit. To the extent Customer receives information about HSAs and Account Holders from the Bank, Customer shall employ measures designed to ensure the security and confidentiality of Account Holder information in connection with the HSAs and Account Holders, protect against reasonably foreseeable threats to the security or integrity of such information, protect against unauthorized access to or use of such information and ensure the proper disposal of Account Holder information. Customer understands that Bank is not a "covered entity", "business associate" or "plan sponsor" as those terms are defined by the Health Insurance Portability and Accountability Act of 1996, and the amendments and regulations related thereto.

12. Termination. Bank may terminate the services described in this HSA Exhibit immediately if at any time Customer fails to comply with any of its material obligations, Customer is appointed a receiver, a general

assignment is made for the benefit of its creditors, a bankruptcy proceeding has been commenced, or any representation made or information provided is false or misleading in any material respect when made or provided. Termination of this HSA Exhibit or the Agreement will not terminate Bank's provision of services to Account Holders.

13. Amendments. The Bank may unilaterally amend the Agreement as it may determine, in its reasonable discretion, if necessary for the HSA Exhibit to comply with applicable laws, rules and regulations (including without limitation, HIPAA) by providing written notice of such amendment to Customer (an "Amendment Notice"). Such amendment shall be effective upon receipt of the Amendment Notice or such other date specified in the Amendment Notice. All other amendments shall be by mutual written agreement by an authorized officer of each of the parties.

14. Regulatory Audits. Customer shall make its facilities, systems, personnel, and records, related to its performance under this Agreement available for audit when required by applicable law or by state or federal bank regulatory authorities with jurisdiction over Bank.

15. Survival. The provisions of this Agreement that by their operation or effect apply after the expiration or termination of this Agreement will apply after such expiration or termination, including but not limited to Sections 4, 7, 8, 11, 14, 15 and 16.

16. Governing Law. The Bank is chartered and located in the State of Utah and as such, the HSAs are governed by Utah laws and regulations. Accordingly, this HSA Exhibit shall be governed by laws of the state of Utah without giving effect to its conflicts of law provisions.

By signing below, each party agrees to the terms of this Exhibit.

United HealthCare Services, Inc. **185 Asylum Street** **Hartford, CT 06103-3408**	**Pinellas County Board of County Commissioners** **400 South Ft. Harrison Avenue** **Clearwater, FL 33756**
By: _____	**By: _____**
Authorized Signature	Authorized Signature
Print Name: _____	**Print Name: _____**
Print Title: _____	**Print Title: _____**
Date: _____	**Date: _____**