Joe Lauro, CPPO/CPPB
Director

April 14, 2015

TO: ALL INTERESTED BIDDERS

INVITATION TO BID: PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS

BID NUMBER: 156-0174-P(JA)

PHASE II BID SUMITTAL DATE: ~~April 19, 2016 @ 3:00 p.m. EST~~

NEW PROPOSAL DUE DATE: April 26, 2016 @ 3:00 p.m. EST

ADDENDUM NO. 4

Following is additional information, clarifications, questions or responses relative to referenced Request for Proposal (RFP). No further questions will be entertained.

Please notice the new proposal due date noted above.

Questions/Answers:

1. **Question: The Q&A addendum that was sent to the vendors yesterday was very critical. We are unable to offer a Medicare Advantage product at that time. This means we cannot match what the County currently has for that part of the population. Based on the responses in the addendum it appears that the expectation is to quote both for the active and Med Advantage populations. We can offer alternative plans to replace the Medicare Advantage products or we can quote and allow a carve-out of this plan to another vendor. Would the County accept a quote that does not include a Medicare Advantage product?**

   Answer: Proposers may propose a Medicare Advantage product as an option, The Medicare Advantage portion is not a requirement for submittal.

Phase II Bid submittals are due no later than 3:00 p.m. on April 26, 2016 at 3:00 p.m. EST.

Sincerely,

Joe Lauro
Director of Purchasing

PLEASE ADDRESS REPLY TO:
400 South Ft. Harrison, Sixth Floor
Clearwater, Florida 33756
Phone: (727) 464-3311
FAX: (727) 464-3925
Website: www.pinellascounty.org/purchase

Joe Lauro, CPPO/CPPB
Director

April 12, 2015

TO: ALL INTERESTED BIDDERS

INVITATION TO BID: PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS

BID NUMBER: 156-0174-P(JA)

PHASE II BID SUMITTAL DATE: ~~April 19, 2016 @ 3:00 p.m. EST~~

NEW PROPOSAL DUE DATE: April 26, 2016 @ 3:00 p.m. EST

ADDENDUM NO. 3

Following is additional information, clarifications, questions or responses relative to referenced Request for Proposal (RFP). **No further questions will be entertained.**

Please notice the new proposal due date noted above.

Questions/Answers:

1. **Question: As we go through the proposal process we are worried a little about timing. There are over 450 questions or items we are looking to respond to plus any items that may come out of the questions that are due Apr 7th. If it takes a routine amount of time for purchasing to respond to the vendor questions we could be backing up right to the due date. Has here been any thought to delaying the due date given the volume?**

   Answer: The Phase II Submittal Date has been extended to April 26, 2016 at 3:00 p.m. EST.

2. **Question: Does the county currently have a wellness fund in place? If yes are those funds currently provided by the current carrier or budgeted by the county?**

   Answer: Pinellas has a wellness fund in place. They have a fund provided by the carrier and incentives are funded by the county.

3. **Question: Is HSA Banking account with current carrier or through separate banking arrangement?**

   Answer: HSA banking is provided by the current carrier.

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4. **Question: What is the current medical management model for inpatient and outpatient for prior authorization?**

   Answer: Pinellas County's prior authorization process are consistent with the current carrier's standard model.

5. **Question: Please provide additional information current incentives program? How are they funded?**

   Answer: Pinellas County funds the incentives. Additional information can be found at: http://www.pinellascounty.org/hr/health_wellness/healthincentives.htm

6. **Question: Please provide a copy of the current plan design or SPDs for the Medicare Advantage plan offered to the Medicare eligible retiree population.**

   Answer: See Attachment 3

7. **Question: Is the County seeking to replace the current Medicare Advantage plan matching current plan designs or would it consider alternative Medicare products?**

   Answer: Please match the current design.

8. **Question: Please provide 2015 rates and employer contribution for the Medicare eligible Retiree population. Are the rates for Medicare subsidized? If so please confirm subsidy amounts.**

   Answer: The Medicare rates are subsidized. The 2016 rate for the Medicare Advantage plan is $445.19. Retirees contribute $138.01 for retiree only coverage and $278.02 for retiree and spouse coverage.

9. **Question: In question 2.23.1.2.3.3 it asks, "Describe what resources support communication customization needs, as applicable." Please explain what is meant by "communication customization needs", and give examples.**

   Answer: Member communications that are customized for Pinellas County specifically, as opposed to your standard communication offering. For example, customized with Pinellas County's name and logo, as well as consistent with the plans offered.

10. **Question: In Question 2.23.1.3.6.1 it states, "Outline your efforts to date, future plans, strategy, timelines and any innovations in the following areas:" Please explain what is meant by "game mechanics" and "community based programs" in the chart and give examples.**

    Answer: Game mechanics such as digital gamification capabilities. Community based programs are any local programs you may be affiliated with such as weight loss, activity based or group support.

11. **Question: Questions 2.27.1 through 2.28.3 list performance guarantees that are being requested as part of this RFP. Can you please confirm if these PGs are in place with your current carrier? If so are they being met?**

    Answer: The performance guarantees requested are not in place with the current carrier.

12. **Question: Please provide a list of claimants with paid claims in excess of $250,000 with diagnosis during 2015.**

    Answer: This information has been securely uploaded through ProposalTech, address as shown in Addendum No. 2 at: http://www.proposaltech.com

13. **Question: Please provide a list of claimants with paid claims in excess of $250,000 with diagnosis during 2016.**

    Answer: Through February 2016, no claimants have exceed $250,000 in 2016.

14. **Question: There is a considerable discrepancy between the counts in the experience exhibits and the census. Can you please provide clarification as to why the numbers are different and what numbers are a more accurate representation?**

    Answer: The experience exhibits only include SI plans. The enrollment included in section 5 is vendor enrollment. The difference between the section 5 enrollment and the census enrollment is driven by split coverage families – Retirees enrolled in the Medicare Advantage plan who may have dependents that pay an ASO fee for a pre-65 plan.

15. **Question: The census provided doesn't include an indicator of Medicare eligibility aside from the Medicare Advantage Plan indicator. Please provide this if there are Medicare eligible participants in the POS plan.**

    Answer: Medicare eligible participants are in the "Traditional" plan.

16. **Question: Is the closed Traditional Plan part of this RFP? If so, is it administered under the ASO contract, is it covered under the ISL contract and can you please provide monthly claims, enrollment and large claim detail as requested for other plans under the ASO contract?**

    Answer: The Traditional plan is part of the RFP and is administered under the ASO contract. This plan is only available to Medicare eligible participants. It is covered under the ISL contract and included in the claims and enrollment information provided.

17. **Question: Please provide a copy of the current Administrative Services Agreement**

    Answer: See Attachment 1.

18. **Question: Please provide a copy of the current Stop Loss Contract.**

    Answer: See Attachment 2.

19. **Question: Please provide the current ASO fees**

    Answer: The current ASO fee is $33.71 PEPM. The HSA Fee is $1.34.

20. Question: Please provide the current stop loss premium rate

Answer: The current stop loss premium rate is $27.22.

21. Question: Please provide a description of medical plan design changes since 1/1/14 including before and after the change.

Answer:
PPO:
1/1/2015 – Include medical and Rx copays in OOP maximum
1/1/2015 – Rx preferred brand (retail) changed from $30 copay to 20% coinsurance with a $30 min and a $60 max
1/12015 – Rx non-preferred brand (retail) changed from a $45 copay to 40% coinsurance with a $45 min and a $90 max
1/1/2016 – No changes
HSA:
1/1/2015 – Increase deductible from $1,250 individual/$2,500 family to $1,300 individual/$2,600 family

22. Question: We offer the option to bill the HSA plan participant a monthly bank account maintenance fee or include this charge in the fee paid by PBOCC. Will PBOCC like to cover this expense or have us charge the participant?

Answer: Pinellas County will cover the expense.

23. Question: The table listed in question 2.27.2 includes several PGs around satisfaction for claimants/key customers, employer healthcare decision makers, and members. Can you please review the following metrics and provide additional clarification as to who the categories are referring to as well as what the differences are between the 3 metrics requested.

a. Claimant & Key customer overall satisfaction: 80% - 80% satisfaction score based on % responding: Completely satisfied, Very satisfied and Somewhat satisfied - Fees at risk 2%

Answer: These are covered members who have filed claims. Assuming you do provide them with surveys where they rate their satisfaction, the definitions of the three levels listed (completely satisfied, very satisfied and somewhat satisfied) are based on your standard surveys. The expectation is that 80% of those who respond will be 'somewhat satisfied' or better.

b. Employer healthcare decision makers: 0-5 - Based on the response to the question, "Overall, how satisfied are you with Pinellas County?" If the response is a score of 5-10 on a 0-10 scale where 0 means very dissatisfied and 10 means very satisfied, the guarantee has been met. - Fees at risk 2%

Answer: The employer healthcare decision maker is your primary contact at Pinellas County.

c. **Member satisfaction rate: 90% - Satisfaction survey results on a scale of 1-6, 90% of members who complete the satisfaction survey will respond favorably by indicating they "agree" or "agree strongly" - Fees at risk 1%**

Answer: Members are those covered by the health plan. Assuming you do provide them with surveys where they rate their satisfaction on a point scale, the expectation is that 90% will respond with 'agree' or better, regardless of how the points are correlated.

24. Question: Please provide additional information regarding tasks for onsite representative.

Answer:
The current registered nurse (RN) assists employees with the following:

- Navigate wellness tools and resources
- Find a doctor or specialist
- Identify and recommend medical condition-specific programs
- Manage chronic illnesses
- Select appropriate medical care and understand available treatment options
- Provide referrals to clinical and community programs
- Make better health care decisions

The current nurse also provides blood pressure screenings and provides group health presentations.

Additional information can be found at http://www.pinellascounty.org/hr/nurse/default.htm

25. Question: Is a Stop Loss Quote being requested? If so please provide the following information:

a. **What level of ISL is requested -** Answer: $500,000
b. **What level of ASL is requested –** Answer: Not requested
c. **Large Claims file which includes diagnosis information for the same time period as the medical claims –** Answer: Large claim information was added to ProposalTech.

Question: Is the request for Stop loss to cover both Medical and Pharmacy? If yes please provide the pharmacy claims data

Answer: Pharmacy is covered under stop loss. This information has been securely uploaded through ProposalTech.

26. Question: There is a Traditional Plan referenced on the census, is this plan out to bid? If so is it self-funded or fully insured? If so please provide this plan design. In addition, if this plan is to be included as part of the Stop Loss quote please provide claims data for at least the most recent 15 months.

Answer: The Traditional Plan is included in the bid. It is a self-funded plan provided to Medicare eligible employees.

27. **Question: Is a Medicare Advantage Quote being requested? If so please provide the current plan design**.

Answer: Yes. See Attachment 3.

28. Question: Please provide the current medical fees. Please include note any elements paid through the claim wire vs. included in the base PEPM fees.

Answer: Fee information provided in the contract. See Attachment 3.

29. **Question: What Medical Management, Disease Management and/or Wellness Programs are included today? Are they provided through the medical carrier or through a third party and if so who? Are these programs included in the base PEPM fees or billed separate and if so please provide those fees.**

    Answer:
    The current base ASO fee includes the following:
    - COPD disease management
    - Online self-support programs including diabetes, CAD and CHF
    - Bariatric Resources/Surgery COE steerage
    - Healthy back program
    - Telephonic Coaching
    - Rewards/incentive Tracking
    - Onsite Nurse Liaison

30. **Question: Please confirm whether or not the Medicare Advantage members are included in the pharmacy claim file.**

    Answer: Medicare Advantage members are not included in the pharmacy claim file.

31. **Question: Please confirm what type of Medicare Advantage plan you currently have in place today? MA? MAPD?**

    Answer: The current Medicare Advantage plan is a MAPD.

32. **Question: Please provide plan design summaries and claim files for any and all Medicare Advantage plans you have in place today.**

    Answer: Medicare Advantage is a fully insured plan and claim files are not available. See Attachment 3.

33. **Question: They appear to only have an MA PPO plan w/ a $1,500 OOP max with Vision, MH, and Prescription coverage through Express Scripts. Are you requesting a quote for MA only or MAPD?**

    Answer: The MAPD plan is provided by UHC.

34. **Question: Is Vision or EAP requested in this RFP? Is it a requirement to include quotes for?**

    Answer: Vision and EAP are not requested in this RFP.

35. **Question: For Medicare, are there any additional riders that need to be added (e.g., Silver Sneakers, etc.)?**

    Answer: See Attachment 3.

36. **Question: Are the Medicare lives included in commercial Rx or do they have a separate Part D plan?**

    Answer: The SI Medicare plan (“Traditional Plan”) is covered by ESI. The fully-insured MAPD plan includes pharmacy.

37. Question: For Rx and Medicare, please provide the Generic Dispensing Rate (GDR) utilization (normalized scripts) per month.

Answer: The FY2015 unadjusted GDR are as follows:
Overall GDR 84.7%

d. Mail only GDR 79.9%
e. Retail GDR 85.3%
    i. R30 GDR 85.3%
    ii. R90 GDR 85.4%

Please note that the above % reflect non-specialty utilization. This does not include Medicare Advantage.

38. Question: For all lines of coverage, please provide member level claim experience.

Answer: This level of claim experience is not available.

39. Question: For all lines of coverage, what is the Employer contribution %?

Answer:
Active - 88%
Pre-65 – 69%
Traditional Medicare– 59%
Medicare Advantage – 69%

40. Question: Please provide the 2016 retiree rate?

Answer: The 2016 Medicare Advantage plan rate is $445.19 PMPM.

41. Question: Are implementation budgets needed?

Answer: The RFP questions address implementation budgets.

42. Question: Below is a pivot of the 2016 file. It appears that there are 1,347 Medicare members. Can we assume that the remaining members under the "Retired – Pinellas" category are under 65? Can you confirm if any of those members are disabled and/or Medicare eligible?

Answer: Retired - Pinellas includes pre and post 65 retirees. "Med Plan" is the best way to distinguish pre and post 65 retires. The traditional plan and Medicare advantage plan are offered to post-65 retirees.

Row Labels	Count of Benefit Status
COBRA Benefit	5
Contingent Worker.Retired - Pinellas	2
Employee	2947
Employee.Ex-contingent Worker	24
Retired - Pinellas	1768
Retired - Pinellas.Ex-contingent Worker	2
Surviving Family Member	1
Surviving Spouse	167
Grand Total	**4916**

43. Question: Please confirm the number of onsite carrier representatives currently working at Pinellas County, their role, and their status as full time.

Answer: Currently there is a full-time onsite nurse (RN) provided by the carrier.

The current onsite nurse assist employees with the following:

- Navigate wellness tools and resources
- Find a doctor or specialist
- Identify and recommend medical condition-specific programs
- Manage chronic illnesses
- Select appropriate medical care and understand available treatment options
- Provide referrals to clinical and community programs
- Make better health care decisions

The current nurse also provides blood pressure screenings and provides group health presentations.

Additional information can be found at http://www.pinellascounty.org/hr/nurse/default.htm

44. Question: Is it the request that the selected carrier adopt Pinellas' eligibility file layout? If so please provide a sample of the requested layout.

Answer: This request has not been made.

45. Question: Does Pinellas County currently have an Onsite Nurse?

Answer: Yes.

46. Question: Is there an expectation that the selected carrier provides and/or funds an Onsite Nurse?

Answer: Yes.

47. Question: How many third party vendor logos and/or phone numbers are requested to be included on the Medical ID Cards?

Answer: Phone number for mental health is included on the medical ID card.

48. Question: Please provide details on the request for a custom website in terms of functionality, etc.

Answer: This bid is only seeking information on your capabilities and pricing beyond the standard customization.

49. Question: Please confirm that the expectation is that no customer facing services will be provided off shore for Pinellas County.

Answer: Confirmed.

50. Question: Is the expectation that the Year 1 through 3 fees will be Flat or are fee escalators in years 2 and 3 acceptable?

Answer: Years 1 through 3 fees should be flat. A fee escalator in years 2 and 3 is not acceptable.

51. **Question: Is the expectation that the Year 4 and 5 fees will be flat or is a fee escalator in year 5 acceptable?**

    Answer: A fee escalator in years 4 and 5 is acceptable.

52. **Question: Please confirm a COBRA quote is being requested?**

    Answer: A COBRA quote is not being requested.

53. **Question: What are your current ISL and ASL stop loss rates?**

    Answer: The current ISL stop loss premium rate is $27.22. A quote for ASL is not requested.

54. **Question: Are pre and post 65 retirees to be included in stop loss?**

    Answer: Yes.

55. **Question: What contract basis would you like us to quote (12/12, 24/12 etc.)**

    Answer: Paid.

56. **Question: Who is the current COBRA administrator?**

    Answer: We are not requesting a COBRA quote. The current vendor is WageWorks.

57. **Question: How many current and pending COBRA participants do they have?**

    Answer: There are currently 3 COBRA participants with medical coverage.

58. **Question: How many Qualifying Events do they average per year?**

    Answer: This information is not readily available and not necessary as we are not requesting a COBRA proposal.

59. **Question: How many Initial Rights Notices are sent on average per year?**

    Answer: This information is not readily available and not necessary as we are not requesting a COBRA proposal.

60. **Question: What is the average turnover rate per year?**

    Answer: This information is not readily available and not necessary as we are not requesting a COBRA proposal.

61. **Question: Please provide more details around your 3 tiered networks. How are they currently in place? Current plan designs that have been provided only show in and out of network options. If there are up to date or different plan designs reflect 3 tiers, please provide.**

    Answer: 3 tiered networks are not currently in place.

62. **Question: Is there a clinic in place currently today? If yes, please provide any information to help detail how it works.**

    Answer: Contracting is being finalized and implementation is expected to take place later this year.

63. Question: Please clarify what is needed from the project approach, the scope of work, and the statement of work. How do these three requirements differ? Are they in fact three separate documents?

Answer: Yes they are separate. The project approach requirements are outlined as noted. The scope of work is shown in Section E, Paragraph D and outlines what the County is requesting in coverage. A Statement of Work is to be provided by the vendor and details specific activities the vendor would provide to meet the County's requested scope of work.

64. What roles (nurse, liaison, wellness coach, etc.) are onsite today and which are funded through the County vs. the Carrier?

Answer: Currently there is an onsite nurse (RN) provided by the carrier.

The current onsite nurse assist employees with the following:

- Navigate wellness tools and resources
- Find a doctor or specialist
- Identify and recommend medical condition-specific programs
- Manage chronic illnesses
- Select appropriate medical care and understand available treatment options
- Provide referrals to clinical and community programs
- Make better health care decisions

The current nurse also provides blood pressure screenings and provides group health presentations.

Additional information can be found at http://www.pinellascounty.org/hr/nurse/default.htm

65. Given the scope of our questions and the level of detail in which we are requesting to accurately and best respond to this RFP, would you grant an extension on the due date of this response?

Answer: The proposal submittal date has been extended to April 26, 2016 at 3:00 p.m. EST.

66. Question: Can you please send us the Summary of Benefits and Coverage (SBCs) for the current plans?

Answer: SBCs can be found at http://www.pinellascounty.org/hr/benefits/health_plans.htm

67. Question: There was a date for a RFP Evaluation (June 2) listed in the Phase I RFP. We would like to know if this evaluation will be done in a public forum and if so, when will the additional details be posted regarding locations and times?

Answer: The RFP Evaluation date for Phase II is estimated at this time. The evaluation meeting is a public meeting; however, the public will not be able to contribute or interrupt the meeting in any way. The meeting, when set, will be posted on the County calendar available at: http://go.activecalendar.com/pinellascounty

68. Question: In order to complete a claims repricing, can the County provide a claims file?Humana prefers a file with ONE of the following field: Revenue Code, Bill Type Code, Place of Service/ Treatment Code

Answer: The RFP did not request claims repricing.

69. **Question: Can submit the hard copy binders on 4/19 on the same day we submit our online ProposalTech proposal with the hard copy binders arriving the following day on 4/20?**

    Answer: The hard copy documentation must be submitted at the same submittal date and time as was advertised, April 19, 2016 at 3:00 p.m. to the Pinellas County Purchasing Department.

70. **Question: Section 5.4 Medicare Advantage Retiree request a quote for the Medicare eligible retirees. Please explain the county contribution amount/percentage to the retiree coverage?**

    Answer: The county contributes $307.18 for retirees and their spouses (approximately 69%).

71. **Question: Please provide a copy of the current Medicare Advantage plan design(s)**

    Answer: See Attachment 3.

72. **Question: Can you provide Benefit Summary Plan Description for current plans? We will need further details for a sufficient benefit review.**

    Answer: SPDs can be found at http://www.pinellascounty.org/hr/benefits/health_plans.htm

73. **Question: Please provide current Medicare Advantage plan design (online questionnaire #2.29.2 asks proposer to match current MA plan design).**

    Answer: See Attachment 3.

74. **Question: Please provide description of current wellness program.**

    Answer: Information can be found at http://www.pinellascounty.org/hr/health_wellness/healthincentives.htm

75. **Question: Please provide an updated census as original census and enrollment numbers in online questionnaire (Section 5.1 – Medical ASO and 5.2 Stop Loss Pricing) do not match.**

    Answer: The census and section 5 enrollment are accurate. The enrollment included in section 5 is vendor enrollment. The difference is driven by split coverage families – Retirees enrolled in the Medicare Advantage plan who may have dependents that pay an ASO fee for a pre-65 plan.

76. **Question: Please provide current membership counts, if available.**

    Answer: Total self-insured enrolled employee count – 3275
    Total self-insured enrolled member count - 6103

77. **Question: Stop Loss – please provide aggregate corridor.**

    Answer: We are not requesting an aggregate stop loss quote.

78. **Question: Large claims – please provide 24 months of large claims.**

    Answer: This information has been securely uploaded through ProposalTech.

79. **Question: It appears that the claims experience provided doesn't include Medicare Advantage enrollment. Please confirm.**

    Answer: This is accurate. The Medicare Advantage plan is fully insured.

80. **Question: This RFP requests a provider disruption analysis. It is industry practice to include the provider's Tax ID number as one of the data elements used to match providers. It has been our experience that some providers do business under their SSN. This RFP requires that we respond in hard copy and/or electronically with multiple copies via [CD/Flash Drive]. It is a best practice to remove any Tax ID numbers from our response to the provider disruption analysis. Is this practice acceptable or will this create an issue of compliance when the RFP responses are being evaluated?**

Answer: The file we provided to respond to the disruption analysis should not be altered. Please upload this file through ProposalTech and do not provide a hard copy of the file. ProposalTech is available through address as shown in Addendum No. 2, at: http://www.proposaltech.com

81. **Question: Are any items from online questionnaire to be provided on hard copy/CD (i.e. 2.34 - Fee Requirements, 2.35 - Financial Assumptions, 5 - Pricing)?**

Answer: Items to be returned for Phase II to Pinellas County are outlined on page 21 of 52 of the Request for Proposal, as follows:

To be submitted to County as noted on Page 1 of the RFP:

Phase II		
i)	Page 1	Proposal Signature Page
j)	Section B	Item 2 Proposal Requirements
k)	Section G	Addendum Acknowledgement Form

To be submitted to County's health and welfare consultant per Section B:

- Phase II – online proposal submittal

82. **Question: Confirm items to be sent as hard copy and on CD:**
    a. **Signature Page**
    b. **Proposal Requirements**
        i. **Management Team Bios**
        ii. **Project Approach**
        iii. **Implementation Plan**
        iv. **Financial Information/Financial sections from Online Questionnaire?**
        v. **Deviations, Clarifications and Exceptions (Benefits, General Conditions, Insurance Requirements and Services Agreement)**
    c. **Addenda Acknowledgement Form**

Answer: Please see response to Question 81.

83. **Question: In regards to online question #2.25.1.7 "Please provide a copy of your most recent Standards for Attestation Engagements 16 (SSAE 16) report as an attachment." Does this relate to banking partner?**

Answer: If you use an external banking partner, you should provide a copy of their SSAE16.

84. **Question: In regards to online question # 2.25.2.32 "Mid-year new hires, reinstatements, and status changes can create complexities for the pro-ration of HSA and deductible balances. Briefly describe your approach and capabilities for this administration. (For example, can you calculate monthly pro-ration of HSA and deductible balances) Please be sure to indicate if you can administer monthly or quarterly pro-ration of HSA roll-over amounts for mid-year new hires." Does HSA roll-over amounts mean prorate Employer contribution to HSA?**

    Answer: Roll-over amounts mean prorate employer contribution to HSA.

Phase II Bid submittals are due no later than 3:00 p.m. on April 26, 2016 at 3:00 p.m. EST.

Sincerely,

Joe Lauro

Director of Purchasing

ATTACHMENT 1

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") between United HealthCare Services, Inc. ("Our," "Us," or "We" in this Agreement) and Pinellas County Board of County Commissioners ("You" or "Your" in this Agreement) is effective January 1, 2012 ("Effective Date"). This Agreement covers the services We are providing to You, either directly or in conjunction with one of Our affiliates, for use with Your self-funded employee benefit plan.

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

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

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

By _____
Authorized Signature

Print Name T. DAVID LEWIS

Print Title CEO-FL

Date 8/3/2011

ATTEST:

By _____
Attesting Witness (Name/Title)

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

By _____
Authorized Signature

Print Name SUSAN LATVALA

Print Title Chairman

Date 8-9-11

ATTEST:
KEN BURKE

By _____
Deputy Clerk

APPROVED AS TO FORM:

_____
Office of the County Attorney

UHCASA05 (2/05)

Table of Contents

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.

Agreement Period: The initial period of thirty-six months (36) months commencing on the effective date and any renewals thereof. This agreement may be renewed for up to two (2) additional twelve month periods if mutually agreed.

Bank: Bank of America, Hartford, Connecticut.

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

Employee: A current or former employee of You or an Affiliated Employer or an individual otherwise eligible under the Plan.

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

Managed Care Network: The group of Network Providers We make 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.

Medical Benefit Rebates: All rebates, discounts or other financial incentives (whether access, base, incentive, market share, volume, or other), administrative fees, and any interest thereon which We receive directly or through an intermediary and are obtained in connection with prescription drug products dispensed to Participants under the Plan's medical benefit. Medical Benefit Rebates do not include any amounts retained by an intermediary as compensation for its services under this Agreement, or any purchasing discounts or payment discounts obtained by an intermediary when purchasing drugs for distribution.

Network Provider: The physician, or medical professional or facility which participates in a Managed Care Network. A provider is only a Network Provider if they are participating in a Managed Care 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: Individuals who are enrolled in and covered by the Plan.

PHI: Any information We receive or provide 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 We are 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: Information about Your business or Our business that is confidential, proprietary, trade secret or is not readily available to the general public; or, information that has been designated by You or Us as confidential or proprietary. Proprietary Business Information may be referred to as "Your Proprietary Business Information" or "Our Proprietary Business Information", as applicable, throughout this Agreement.

Rebates: All rebates, discounts or other financial incentives (whether access, base, Prescription Drug List, incentive, market share, volume, or other), administrative fees, and any interest thereon which We receive from the PBS subcontractor and are obtained in connection with prescription drug products dispensed to

Participants under the Plan's prescription drug benefit. Rebates do not include any amounts retained by the PBS subcontractor as compensation for its services under this Agreement.

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

Summary Plan Description: The document(s) You provide to Plan Participants describing the terms and conditions of coverage offered under the Plan.

Systems: Means the systems We own or make available to You 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.

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

Section 2 - Employee Benefit Plan: Your Responsibilities

Section 2.1 Responsibility for the Plan. We are not the Plan Administrator of the Plan. Any references in this Agreement to Us "administering the plan" are descriptive only and do not confer upon us anything beyond certain agreed upon claim administration duties. Except to the extent this Agreement specifically requires Us to have the fiduciary responsibility for a Plan administrative function, You accept total responsibility for the Plan for purposes of this Agreement including its benefit design and compliance with any laws that apply to You or the Plan, whether or not You or someone You designate is the Plan Administrator.

Section 2.2 Description of the Plan. To allow Us to begin administering the Plan on the Effective Date as provided under this Agreement, You must furnish Us with the Summary Plan Description described in Section 5.13 in a timely manner. If You are unable to provide Us with a Summary Plan Description sufficiently in advance of the Effective Date of Our services, We will create a summary of Plan benefits and exclusions based on Our understanding of Your plan design. We will administer claims processing and Our other services in accordance with this benefit summary document. This benefit summary document will govern and remain in full force and effect until a Summary Plan Description is provided to Us.

Section 2.3 Plan Consistent with the Agreement. You represent that Plan documents, including the Summary Plan Description or the benefit summary document We provide as described in Section 2.2, are consistent with this Agreement. Nevertheless, before distributing any communications describing Plan benefits or provisions to Participants or third parties, You will provide Us with copies of the Summary Plan Description and Employee communications which refer to Us or Our services prior to distributing these materials to Employees or third parties. You will amend them if We reasonably determine that references to Us are not accurate, or any Plan provision is not consistent with this Agreement or the services that We are providing.

Section 2.4 Plan Changes. You must provide Us with notice of any changes to the Plan or Summary Plan Description within a reasonable period of time prior to the effective date of the change to allow Us to determine if such change will alter the services We provide under this Agreement. Any change in the services to be provided by Us under this Agreement which would be caused by any such Plan changes must be mutually agreed to in writing prior to implementation of such change. We will notify You if (i) the change increases Our cost of providing services under this Agreement or (ii) We are 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 We notify You that We are unable to reasonably implement or administer the change, We shall have no obligation to implement or administer the change, and You may terminate this Agreement upon (90) ninety days written notice.

Section 3 - Your Other Responsibilities

Section 3.1 Eligibility Information. You will tell Us which of Your employees, their dependents and/or other persons are Participants. This information must be accurate and provided to Us in a timely manner and in an agreed upon format. You will notify Us of any change to this information as soon as reasonably possible.

We will be entitled to rely on the most current information in Our possession regarding eligibility of Participants in paying Plan benefits and providing other services under this Agreement. We will not be required to make retroactive eligibility changes, process or reprocess claims, but if We agree to do so, additional fees may apply as mutually agreed upon by the parties in writing upon such request for additional services.

Section 3.2 Notices to Participants. You 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, You will notify all Participants that the services We are providing under this Agreement are discontinued.

Section 3.3 Escheat. You are solely responsible for complying with all applicable abandoned property or escheat laws, making any required payments, and filing any required reports.

Section 4 - Responsibilities of the Parties

Responsibilites of the Parties. You, 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 Your negligence or omissions covered under Fla. Stat. Section 768.28 to the limits set forth in 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 You if soveriegn immunity applies.

We will indemnify You and hold You harmless and defend You against any and all losses, liabilities, penalties, fines, costs, damages, and expenses, including court costs and attorneys' fees, which arise out of Our 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.

Section 5 - Services Provisions

Section 5.1 Claims Processing. Claims for Plan benefits must be submitted in a form that is satisfactory to Us in order for Us to determine whether a benefit is payable under the Plan's provisions.

In applying the Plan's provisions, We will use claim procedures and standards that We develop for benefit claim determination. You delegate to Us the discretion and authority to use such procedures and standards.

The rate of accuracy of benefit payments shall be consistent with the accuracy rate that a reasonably prudent claims administrator would be expected to achieve under similar circumstances.

Section 5.2 Benefit Determination and Appeals.

Appeals of Non-Urgent Care Claims. This will apply to claims other than Urgent Care Claims. You appoint Us a named, fiduciary with respect to (i) performing initial internal benefit determinations and payment and (ii) performing the fair and impartial review of first level internal appeals. With respect to these functions, You delegate to Us the discretionary authority to (i) construe and interpret the terms of the Plan and (ii) determine the validity of charges submitted to Us under the Plan. This delegation is subject to Your retention of full responsibility as Plan Administrator for the final review of adverse benefit determinations, and You have the discretionary authority to construe and interpret the terms of the Plan and to make final, binding determinations concerning the availability of Plan benefits under the Plan's internal appeal process.

If it is determined that a benefit is payable, We will issue a check for, or otherwise credit, the benefit payment to the appropriate payee.

If We deny a Plan benefit claim, the claimant shall have the appeal rights set forth in the Summary Plan Description, and/or which are required under applicable laws. If We determine that all or a part of the benefit is not payable under the Plan, We will notify the claimant of the adverse benefit determination and of the claimant's right to further appeal the adverse benefit determination to You. This notification will be designed to comply with applicable requirements for adverse benefit determination notices.

If a second appeal is requested, We will forward to You or Your designee documentation regarding the adverse benefit determination necessary for You or Your designee to conduct the final internal appeal. You will review the appeal and determine whether the Plan benefit is payable. If, after the review, You determine that the Plan benefit is payable, You will notify Us and the claimant. If, after the review, You determine that the Plan benefit is still not payable, You will notify Us and the claimant of the adverse benefit determination. This notice will be designed to comply with applicable requirements for final appeal determination notices. Your 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 Section 5.3.

Appeals of Urgent Care Claims

Except as otherwise provided in this Agreement, You appoint Us a named fiduciary under the Plan with respect to appeals of Urgent Care Claims. We will conduct one review of a denied Urgent Care Claim and issue a final determination as soon as possible but not later than 72 hours from receipt of the request to appeal. You delegate to Us the discretionary authority to construe and interpret the terms of the Plan and to make final binding determinations concerning the availability of Plan benefits regarding these claims.

Section 5.3 Your Voluntary Review Program. You may provide voluntary additional appeal rights in the Summary Plan Description, which will be shared with Us prior to implementation in accordance with Section 2.2. You will notify claimants of the option to request a voluntary review of final appeals, following the required appeal process, through You or Your designee. If, after the voluntary review, You or Your designee determine that the Plan benefit is payable, You will notify Us.

Section 5.4 Managed Care Network Services. We will make a Managed Care Network available to Participants. The network will be located in mutually agreeable geographical sites with Network Providers who render health care. We will maintain directories of Network Providers, and will periodically update such directories on Our telephonic and online systems.

The make-up of the Managed Care Network can change at any time. Notice will be given in advance or as soon as reasonably possible.

We will maintain a grievance process so that Participants may obtain assistance with, and express their opinions about, their use of the Managed Care Network.

We do not employ Network Providers and they are not Our agents or partners. Network Providers participate in Managed Care Networks only as independent contractors. Network Providers and the Participants are solely responsible for any health care services rendered to Participants. We are not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, including Network Pharmacies, or the payment for services rendered by the provider or facility.

Section 5.5 Health Care Medical Management Services. We will provide Our care coordination services in accordance with the provisions contained in this section. The care coordination program focuses on offering education, accelerating access to care and providing surveillance and monitoring of chronic conditions.

Our care coordination services include the review of Participants' diagnosis and proposed health care treatments with respect to whether or not the service is appropriate to treat the condition. The services are designed to facilitate Participant education, identify and prevent delays in treatments, and provide intervention with respect to Participants' health care needs that are highly likely to drive utilization and medical expenses of the Plan.

We will review health care services and supplies to determine whether they are covered services under the Plan. If We determine that services or supplies are not covered under the Plan, then We will provide the appeal services outlined in Section 5.2 of the Agreement.

Section 5.6 Health Care Case Management Services. We may provide, when appropriate for the individual Participant, certain case management services. These services are designed to provide a proactive, systematic process of health care coordination, including the evaluation of inpatient, outpatient and ancillary services, Participant education, the review of the short term outpatient care needs and where appropriate, coordination and facilitation of discharge planning needs. The above services address the unmet health care needs of Participants who are not eligible for a disease management program under the Plan but are at significant risk for declining health status and high medical expenses.

We also provide an Alternative Care Proposal program (ACP) which offers benefit coverage for certain health care services. We have designed this program for the diagnosis and/or treatment of a particular Participant's illness or injury. It provides appropriate and cost effective health care services and supplies alternatives that would otherwise not be covered by the Plan. The Plan will pay for and cover as Plan benefits the health care services and supplies contained in the ACP program. You consent to Our use and administration of the ACP program and delegate to Us the discretion and authority to develop and revise ACPs.

We will work with Participants who satisfy the criteria for participation in case management services to develop a program of benefit coverage with appropriate and cost-effective health care services and supplies for the diagnosis and/or treatment of the Participant's condition. If the Participant and health care provider are not willing to participate in the process, We will not provide these services.

Section 5.7 Transplant Benefit Management Services.

Your Plan has agreed to adopt Transplant Benefit Management Services, as described below.

a. **U.R.N. Transplant Network Access.** We agree to provide You access to a network of credentialed transplant programs. Transplant services rendered by those facilities, and the discounted rates for those services, are available to You based upon the contractual relationship between Our affiliate, United Resource Networks (U.R.N.) and the facilities contained within the U.R.N. Transplant Network. Access to these relationships is made available to all Participants who need transplant-related services.

   U.R.N. determines what transplant programs are qualified for participation in the U.R.N. Transplant Network and will provide You with a list of those programs. The list of participating programs changes from time to time and You will be provided written notice of changes. You agree to amend the Plan consistent with the changes made to the list of participating programs within a reasonable period of time after notice is given.

   The following services and supplies offered by a participating transplant program are typically included in the U.R.N. Transplant Network contractual relationship: evaluation of the Participant for transplant; donor searches; organ acquisition and procurement; hospital and physician fees; transplant procedures; and follow-up care for a period up to one year after the transplant.

   You agree that the Plan will pay for and cover as Plan benefits the services and supplies rendered to Participants in a participating program in accordance with this section. You delegate to Us the discretion and authority to approve for payment under the Plan those services and supplies rendered to Participants for transplant services rendered at participating programs.

   Transplant services rendered at programs that do not participate in the U.R.N. Transplant Network or the Transplant Access Program as outlined in subsection b. below are not eligible for coverage under the Plan.

   U.R.N. is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, or the payment for services rendered by the provider or facility.

b. **Transplant Access Program.** We will also provide You with access to a group of transplant programs that, while not credentialed as part of the U.R.N. Transplant Network, have agreed to provide transplant services at discounted rates. U.R.N. coordinates the contractual arrangement with programs participating in the Transplant Access Program. All Participants who need transplant-related services may access these programs.

You will receive a list of facilities participating in the Transplant Access Program. You will also receive written notice of any changes or modifications to this list. The following services and supplies offered by a participating transplant program are typically included in the Transplant Access Program contractual relationship: evaluation of the Participant for transplant; donor searches; organ acquisition and procurement; hospital and physician fees; and transplant procedures. These programs do not typically include a discount for follow-up care.

You agree that the Plan will pay for and cover as Plan benefits the services and supplies rendered by the transplant programs participating in the Transplant Access Program. You delegate to Us the discretion and authority to approve for payment under the Plan those services and supplies rendered to Participants when these services cannot be provided through use of the U.R.N. Transplant Network as described in subsection a. above.

Section 5.8 Claim Recovery Services. We will provide recovery services for Overpayments, but We will not be responsible for recovery costs except as otherwise stated in this section. We will be responsible for recovery costs and reimbursement of any unrecovered Overpayment only to the extent the Overpayment was due to Our gross negligence.

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.

Section 5.9 Third Party Liability Recovery. We will 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"). You will not engage any entity except Us to provide the services described herein without Our prior approval.

Section 5.10 General Provisions Applicable to Sections 5.8 and 5.9. You will be charged fees when any of the services described in Sections 5.8 and 5.9 are provided by Us through a subcontractor or affiliate. The fees are deducted from the actual recoveries. You will be credited with the net amount of the recovery. We will provide You with a written notice of the basis of the fees for which You are charged and, advance notice of any material changes in such fees or Our recovery services.

You delegate to Us the discretion and authority to develop and use standards and procedures for any recovery under Sections 5.8 and 5.9, including but not limited to, whether or not to seek recovery, what steps to take if We decide to seek recovery, and, to the extent authorized by the Board of County Commissioners, the circumstances under which a claim may be compromised or settled for less than the full amount of the claim. Within the authority granted to Us, You acknowledge that use of Our standards and procedures may not result in full or partial recovery for any particular case.

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

Section 5.11 Abuse and Fraud Management. We or Our affiliate will provide services related to the detection, prevention, and recovery of abusive and fraudulent claims.

Our Abuse and Fraud Management processes will be based upon Our proprietary and confidential procedures, modes of analysis and investigations.

We will use these procedures and standards in delivering Abuse and Fraud Management services to You and Our other customers. These procedures and standards include, but are not limited to: whether or not to seek recovery, what steps to take if We decide to seek recovery, and under what circumstances to compromise a claim or settle for less than the full amount.

You delegate to Us 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.

You acknowledge that the use of these procedures and standards may not result in full or partial recovery or in full recovery for any particular case. We do not guarantee or warranty any particular level of prevention, detection, or recovery. We agree to perform Abuse and Fraud Management services pursuant to the industry standards for such services.

For each fraud and abuse recovery, a fee will apply as set forth in Exhibit A. This fee includes all work to identify recovery opportunities, research, conduct data analysis, investigate, negotiate settlements without the use of outside counsel, draft legal documents, and We will credit the recovery amount to You. 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. You will be given the option to participate or decline participation in the settlement. If this Agreement terminates, or if Our claim recovery services terminate, We can elect to continue fraud and abuse recoveries that are in progress, and the fees will continue to apply as mutually agreed upon by the parties in writing upon suhc request for additional services.

Section 5.12 Assistance with General Plan Administration. We will provide administrative services including (i) administration forms and service orientation, (ii) a toll-free customer service telephone line for Participants, (iii) enrollment support, and (iv) identification cards for Participants. Custom services, such as special forms or administrative support that exceeds the level standardly offered to Our self-funded customers will be subject to an additional fee determined by Us.

We will provide You with Our standard reports for self-funded customers. You may request that We provide additional reports. If We agree to provide them, an additional cost may apply. If reports are provided through Our Systems, We further reserve the right, from time to time, to change the content, format and/or type of Our standard reports.

You may request that We provide services in addition to those set forth in this Agreement. If We agree to provide them, those services will be governed by the terms of this Agreement, unless otherwise specified in an amendment to this Agreement. Additional fees may apply as mutually agreed upon by the parties in writing upon such request for additional services.

Section 5.13 Summary Plan Description. We will prepare a customized draft of a Summary Plan Description necessary for each plan ("SPD"). For purposes of this provision, plan means each individual plan design administered by Us. We will provide one additional draft, in response to Your comments, and a final draft SPD. The SPD will be in English. We will print each SPD in Our standard size and with Our standard cover in a quantity equal to 110% of the number of Employees participating in the plan, and ship to a single location. You agree to distribute these SPDs in accordance with applicable laws.

You will also furnish additional SPD information as may be required under applicable laws. You will be responsible for the legal sufficiency of the SPD, including any legally required information.

Section 5.14 Electronic Standard Transactions. We will comply with all applicable provisions of the Standards for Electronic Transactions Regulation (the "Standards"). We will also require any of Our contractors, subcontractors, or other agents that assist Us in conducting standard transactions to comply with the Standards in writing. We will not (i) change the definition, data condition, or use of a data element or segment as prohibited in the Standards, (ii) add any data elements or segments to the maximum defined data set as prohibited in the Standards, (iii) use any code or data elements that are either marked "not used" in the Standards' implementation specification or are not in the Standards' implementation specification(s), or (iv) change the meaning or intent of the Standards' implementation specifications(s).

Section 5.15 Health Insurance Portability and Accountability Act of 1996. We will produce Certification of Coverage forms for Participants who have lost or lose coverage under the Plan on or after the Effective Date of this Agreement, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This certification will be based on eligibility and termination data that You will

provide Us in accordance with Our data specifications. The Certification of Coverage forms will only include periods of coverage for which We have administered the Plan.

The Certification of Coverage forms will be based only on data that is currently indicated and available to Us in Our eligibility systems as of the date that the form is generated. We will give You reasonable advance notice of all additional data requirements for form completion and You agree to provide that information on a timely basis.

We reserve the right to discontinue providing this service if You do not provide the data We request in a timely manner.

Section 5.16 Medical Benefits Drug Rebates. From time to time, We or an intermediary 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. You will receive 80% of the Medical Benefit Rebates We receive in connection with prescription drug products dispensed to Participants under the Plan's medical benefit. We will retain the balance of such Medical Benefit Rebates as part of Our compensation under this Agreement. If an intermediary is involved, it may retain a portion of the gross amounts received from drug manufacturers in connection with the relevant prescription drug products dispensed to Participants under the Plan's medical benefit. We will provide information on the amount retained by the intermediary as compensation for its services, in advance of Your execution of this Agreement, which information is Proprietary Business Information under the terms of this Agreement. In addition, We will provide You with thirty (30) days advance notice of any material increase in intermediary compensation or material changes in the method for intermediary compensation. If at any time You do not find the intermediary compensation acceptable, You may terminate the Medical Benefits Rebates services under this Agreement after thirty (30) days advance notice to Us.

If We are not able to make payment to You within 30 calendar days of Our receipt of Medical Benefit Rebates, We will pay interest on Medical Benefit Rebates We receive from the 31st calendar day forward after Our receipt of the Medical Benefit Rebates, until We pay You Your Medical Benefit Rebates. We will pay Medical Benefit Rebates to You no less than annually. Interest will be paid at the one month London Interbank Offered Rate (LIBOR) in effect as of the date We pay You. We will retain any interest earned up to the 30 calendar day point, and upon Your request, We will provide information on the amount of such interest.

You will only receive Your Medical Benefit Rebates to the extent that Medical Benefit Rebates are actually received by Us. Thus, for example, if a government action or a major change in pharmaceutical industry practices prevents Us from receiving Medical Benefit Rebates, the amount You receive may be reduced or eliminated.

You agree that during the term of this Agreement, neither You 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 under this Agreement. In the event You or the Plan negotiates or arranges with a drug manufacturer for Medical Benefit Rebates on or the purchase of prescription drug products or services under the Plan's medical benefit, We may, without limiting Our right to other remedies, immediately terminate Your and Plan's entitlement to Medical Benefit Rebates (including forfeiture of any Rebates earned but not paid) or terminate Your Medical Benefit Rebate services under this Agreement.

In addition, You agree to other reasonable requests related to obtaining Medical Benefit Rebates that We may communicate to You from time to time.

Section 5.17 Facility Reasonable Charge Determination and Negotiation Reductions. We will evaluate certain facility-billed charges which may exceed reasonable charges under the terms of the Plan We will, negotiate with the facility as needed for reduction of billed charges in accordance with appropriate guidelines. The additional charge for this service is described in Exhibit A.

We can terminate the Facility Reasonable Charge program in whole or in part at any time for any reason.

In the event of termination, We can elect to continue any reviews and negotiations that are in progress at the time of termination. The additional service charge described in Exhibit A will continue to apply.

Section 5.18 Shared Savings Program. For the service fee specified in Exhibit A, We may make Our Shared Savings Program available to some or all of Your Plan Participants. This program provides access to discounted charges made available to Us from health care providers who contract with a third party to provide such discounted charges.

The amount payable under discounted portions of the Plan will be based on the Shared Savings Plan's discounted charges. If a Participant is enrolled in a network plan and receives services from a Network Provider benefits payable for that provider's services will be based on the applicable rates for fees included in Our agreement with that provider. These benefits will not be included in the calculation of the "Savings Obtained" under the Shared Savings Programs, and the service fee for the Shared Savings Program will not apply to these benefits.

You understand that the services under this program provide access to provider discounts only. These providers are not part of Our Managed Care Network. Therefore, Our services under this program do not include credentialing of providers or other Managed Care Network services. We are not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services under the Shared Savings Program.

We can terminate all or part of the Shared Savings Program at any time for any reason. You can terminate the program at any time for any reason by giving Us written notice. We will implement the termination within a reasonable period of time after receiving the notice.

Section 5.19.1 Personal Health Support. We will provide Your Participants with Personal Health Support services that offer education, accelerate access to care, provide support around specific treatment decisions, if applicable, and provide surveillance and monitoring of chronic conditions. We will review Participants' diagnosis and proposed health care treatments with respect to whether or not the service is appropriate to treat the condition. The services are designed to facilitate Participant education, identify and prevent delays in treatments, and provide intervention with respect to Participants' health care needs that are highly likely to drive utilization and medical expenses of the Plan.

We will also provide (i) a primary contact, who is a Registered Nurse ("primary contact"), and who is assigned to each identified high-risk Participant (as identified through Our predictive modeling tool described herein) and maintains an ongoing relationship with such Participant. The primary contact is part of a designated team with clinical knowledge, which team may serve additional customers and will have knowledge of Your culture, philosophy, population demographics, industry, benefit plan design and additional programs offered by You to Your Participants, as such information is provided to Us by You, (ii) a client services lead, who is a Registered Nurse or Licensed Practical Nurse, is part of the clinical team and is a liaison to each customer serviced by the team, (iii) a predictive model tool refreshed every thirty days, which is used to identify and risk score Participants who have the greatest risk for future disease, and which risk score is used to prioritize, at the customer and clinical team level, assignment of Participants to the primary contact for outreach by disease type, and (iv) coordination with up to two of Your external vendors that provide disease management and/or care management services to Your Participants.

We will review health care services and supplies to determine whether they are covered services under the Plan. If We determine that services or supplies are not covered under the Plan, then We will provide the appeal services outlined in Section 5.2 of the Agreement.

Section 5.19.2 Disease Management Services We will provide disease management services independently or through a third party contracted entity or affiliate. These services are designed to proactively (i) identify and stratify Participants diagnosed with specific chronic medical conditions and who may be at risk for developing chronic medical conditions, (ii) provide assessment and intervention to support such Participants, as well as the Participants' physicians, and (iii) help such Participants comply with a physician's established plan of care as well as monitoring and educating Participants regarding the medical condition. The services are designed to provide intervention with respect to Participants' specific chronic medical conditions that are highly likely to drive medical expenses of the Plan. Participant and

physician participation will be voluntary. These services include the congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, asthma programs.

We can terminate the disease management services in whole or in part at any time for any reason if such termination applies to all of Our similarly situated self-funded customers. After the initial twelve (12) months of disease management services under this Agreement, You may terminate the disease management services upon thirty (30) days prior written notice to Us.

We will provide reasonable transition services to Participants enrolled in a disease management program at the time of termination for a period not to exceed one hundred twenty (120) days following either party's notice of termination to the other, unless otherwise agreed to by the parties; provided however, We shall have no obligation to provide such transition services if termination is a result of Your material breach, Your failure to pay Us fees due, or Your failure to provide the funding required under Section 7.3 and services shall only be provided to those Participants currently enrolled in a disease management program prior to the termination date of the Agreement. All of the other terms of this Agreement will apply to these post-termination services.

Section 5.20 Cancer Resource Services. We agree to provide eligible Plan Participants access to a network of providers for Oncology Services. The term "Oncology Services" as used in this section includes health care services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to oncology. Oncology Services rendered by these providers, and the discounted rates for these services, are available to You based on the contractual relationship between Our affiliate, United Resource Networks (U.R.N.), and these providers.

You agree that the Plan will pay for and cover as Plan benefits Oncology Services, which includes supplies, rendered to Participants in accordance with this section. You delegate to Us the discretion and authority to reprice claims for Oncology Services and approve for Plan payment services and supplies rendered to Plan Participants under this Section.

Section 5.21 Bariatric Resource Services. We, through Our affiliate, United Resource Networks (U.R.N.) will provide Bariatric Resource Services ("BRS") to eligible Participants. BRS may include pre-surgical patient consultation and behavioral health evaluation, coordinated post-surgery follow-up and behavioral health support, long-term patient telephonic monitoring for behavioral health issues, as well as access to a network of providers for the provision of bariatric services. U.R.N. will use outreach strategies designed to maximize eligible Participants' program utilization. Outreach strategies that U.R.N. may employ currently include, but are not limited to, communications to all eligible Participants regarding availability of Bariatric Resource Service facilities, instructions for requesting educational materials, and/or direct mail to Participants diagnosed with bariatric conditions.

U.R.N. is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, or the payment for services rendered by the provider or facility.

Section 5.22 Healthy Back Services. We will provide Healthy Back Services for your eligible Participants. These services are designed to: (i) target high-risk individuals requiring support through predictive modeling, (ii) educate Participants through access to online or telephonic back resources, (iii) promote routine low back care, (iv) provide Participants with access to providers with the training and experience in lower back care, and (v) integrate with Your existing wellness and disease management programs. The services are designed to provide intervention services with respect to Participants' lower back conditions that are highly likely to drive medical expenses of the Plan. Participation in the program will be voluntary.

Section 6 - Service Fees

Section 6.1 Service Fees. You will pay Us fees for Our services. The service fees listed in Exhibit A of this Agreement are effective for the Agreement Period shown in the Exhibit. In addition to the service fees specified in Exhibit A, You must also pay Us any additional fee that is authorized by a provision elsewhere in this Agreement or is otherwise agreed to by the parties.

Section 6.2 Changes in Service Fees.

We can change the service fees after the initial Agreement Period: (1) on each Agreement Period anniversary; (2) any time there are changes made to this Agreement or the Plan which affect the fees; (3) when there are changes in laws or regulations which affect the services we are providing, or will be required to provide, under this Agreement; or (4) if the number of employees covered by the Plan or any option of the Plan changes by ten percent (10%) or more (e.g., when Participants change from an indemnity plan to a plan with a network differential). Any new service fee which arises out of such change will be effective on the date those changes occur, even if that date is retroactive.

We shall, however, provide you with one-hundred eighty (180) days prior written notice of the revised service fees for subsequent Agreement Periods, item (1) above and give you the opportunity to negotiate. Service fee adjustments relating to an Agreement Period anniversary shall become effective on the later of the first day of the new Agreement Period or thirty (30) days after we provide you with written notice of the new fees.

If you do not agree to the new service fees, you may terminate this Agreement upon thirty (30) days written notice after you receive written notice of the new fees. You must still pay any amounts due for the periods during which the Agreement is not terminated.

Section 6.3 Due Dates, Payments, and Penalties. In some cases, We will bill You for the amounts that You owe or We estimate You owe Us. In other cases, We will provide You with advance statements in advance that you complete and either send to Us or verify through electronic acknowledgement. In those cases, the Due Date for these amounts is on the first day of each calendar month. These fees will be paid in accordance with f.s.s. 218.70 et. seq. Interest may be charged in accordance with F.S. Section 218.70 et. seq. We will invoice you for any interst due on these amounts.

Section 6.4 Reconciliation. For each Agreement Period, We will reconcile the total amounts You paid with the total amounts You owed. If the reconciliation indicates that We owe You money, Your next payment will be credited. If the reconciliation indicates that You owe Us money, We will invoice You for the amount due. The Due Date for these amounts will be governed by F.S. 218.70, et. seq.

If the Agreement is terminated, We will pay You the amount owed within thirty (30) days after We perform a final reconciliation, but in no event later than 90 days from termination effective date. If the final reconciliation indicates that You owe Us money, You will pay Us after receiving notice of the amount owed in accordance with. F. S. 218.70, et. seq.

Section 7 - Providing Funds for Benefits

Section 7.1 Providing Funds for Benefits. The Plan is Self-Funded. You are solely responsible for providing funds for payment for all Plan benefits payable to Participants, Network Providers, or non-Network Providers.

Section 7.2 Bank Account. You will open and maintain a Bank Account at the Bank to provide Us the means to access Your funds for the sole purpose of payment of Plan benefits, expenses and fees. The Bank Account will be a part of the network of accounts that have been established at the Bank for Our self-funded customers. The Bank Account will belong to You and the funds in it are yours.

Section 7.3 Balance In Account. You will maintain a minimum balance in the Bank Account in an amount equal to not less than five (5) days of expected Bank Account activity. We will establish this amount based on expected Plan benefit payments, with appropriate adjustments for anticipated non-daily activity (e.g., prescription drug benefits and administrative fee payments) as determined by Us. We will

determine if circumstances warrant increasing this minimum balance, and will notify You if and when the required balance or the amount identified above changes.

The required minimum balance is based on Your financial condition as assessed by Us. In the event We determine, based on reasonable information and belief, that Your financial condition has deteriorated or You continue to fail to comply with the material financial obligations specified in this Agreement, We may revise the required balance effective five (5) days from the date of notice.

Section 7.4 Issuing and Providing Funds for Checks. The checks We write and issue to pay Plan benefits under this Agreement will be written on one or more common accounts that are a part of the network of accounts maintained at the Bank for Our self-funded customers. When the checks for Plan benefits are presented to the Bank, the Bank will notify Us and We will direct the Bank to accept or reject the checks. The Bank will then withdraw funds from Your Bank Account to fund the checks that are cashed.

Section 7.5 Transfers of Funds. Funds will also be withdrawn from Your Bank Account when a transfer of funds We made to pay Plan benefits is made by the Bank. For example, when a wire transfer has been made to a health care provider to pay benefits under the Plan.

Section 7.6 Service Fees and Other Expenses. Funds will also be withdrawn from Your Bank Account on the due date of any service fees which You have authorized to be paid to Us and for the payment of other Plan expenses from Your Bank Account.

Section 7.7 Calls for Funds. The withdrawals for Plan benefits and service fees are paid for by the balance You maintain in the Bank Account.

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

Section 7.8 Underfunding. If You do not provide the amounts sufficient to maintain the required minimum balance in Your Bank Account, or to cover Bank Account withdrawals: (1) You must immediately correct the deficiency and provide prompt notice to Us in either event. (2) If We learn of the funding deficiency, We will notify You so You can correct the deficiency. (3) You agree that We may stop issuing checks and suspend any of Our other services under this Agreement for the period of time You do not provide the required funding. (4) If You do not make the required payment(s) to correct the funding deficiency, We may terminate this Agreement effective as of any date following three business days after We provide notice of the funding deficiency. At Your expense, We may also place stop payments on checks if We determine that You have insufficient funds in Your corporate funding bank account to honor such checks. You will pay interest on the amount of underfunding at the standard rate that We charge to Our self-funded customers for underfunding of bank accounts. The notice provisions contained in Termination Events, Section 9.1, do not apply to this breach. So long as both parties are working together in good faith to resolve any disputes, We will not terminate this Agreement.

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

Section 7.9 Outstanding Checks. At Your expense, We will stop payment on all checks We have issued under this Agreement that have not been cashed within a reasonable period determined by Us. This period will be applied on a consistent basis to Our self-funded customers.

Section 7.10 Termination of Agreement. When this Agreement terminates, the funding method for Plan benefits will remain in place for a limited period of time. After this period, that funding method will cease.

You will then deposit and maintain in the Bank Account enough 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. This period will be reasonable, as determined by the parties, and applied on a consistent basis to Our self-funded customers. At Your expense, We will stop payment, , on all checks that remain uncashed at the end of this period You will close Your Bank Account and recover any funds remaining in it. We will provide bank account statements and bank reconciliation reports, including reports You need for the purposes of escheatment.

Section 8 - Term Of The Agreement

Section 8.1 Services Begin. We will begin providing You claim processing services under this Agreement on the Effective Date. These services apply only to claims for Plan benefits that are incurred on or after the Effective Date.

This Agreement will apply for an initial Agreement Period commencing on the Effective Date and will continue for additional Agreement Periods if renewed by the parties, unless and until this Agreement is terminated.

Section 8.2 Services End. Our services under this Agreement stop on the date this Agreement terminates, regardless of the date that claims are incurred. However, We may agree to continue providing certain services beyond the termination date, as provided in Section 9.2.

Section 9 - Termination Of The Agreement

Section 9.1 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 Agreement Period, either party gives the other party at least ninety (90) days prior written notice, (iv) We give You notice of termination because You did not pay the fees or other amounts You owed Us when due under the terms of this Agreement, (v) You fail 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 You 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) 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 Us 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 (viii) As otherwise specified in this Agreement.

Section 9.2 Run-Out Administration. We will provide run-out claim processing services for a period of six (6) months following the Agreement's termination. This provision applies only to claims for health services incurred prior to the termination date. All other terms of this Agreement will apply to these post-termination services. However, We will not provide these services after the Agreement's termination, if the Agreement was terminated because You failed to pay Us fees due, You did not provide the funding required under Section 7.3, or when We terminate for any other material breach. The fee for run-out services, if applicable, will be determined by written agreement, as mutually agreed upon by the parties, in writing, upon such request for those services.

Section 9.3 Funding After Termination. When this Agreement terminates, the funding method for Plan benefits will remain in place for a limited period as determined by the parties. At the end of this period, We will place stop payments, at Your expense, on all checks that remain uncashed.

Section 10 - Records, Information, Audits

Section 10.1 Records. We will keep records relating to the services We provide under this Agreement for as long as We are required to do so by law.

Section 10.2 Access to Information. If You need information in Our possession for purposes other than an audit, but in order to administer the Plan, We will provide You access to that information, if it is legally permissible, the information relates to Our services under this Agreement, and You give Us reasonable advance notice and an explanation of the need for such information.

You represent that You have reasonable procedures in place for handling PHI, as required by law. You will only use or disclose PHI to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement.

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

We also will provide reasonable access to information to an entity providing Plan administrative services to You, such as a consultant or vendor, if You request it. Before We provide 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 10.3 Audits. The Contractor shall retain all records relating to this contract 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 119, Florida Statutes. In addition, Pinellas County 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, You or a mutually agreeable entity may audit Us once each calendar year to determine whether We are fulfilling the terms of this Agreement. Prior to the commencement of this audit, We must receive a signed, mutually agreeable confidentiality agreement.

You must advise Us in writing of Your intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by Us. 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 Our 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 Us ("Scope").

You will pay any expenses that you incur, and will be charged an additional fee, determined by us, for more than one audit every twelve (12) months or for any on-site audit visit that is not completed within five (5) business days. You will also pay any unanticipated expenses we incur and all expenses incurred by us on any audit initiated after this Agreement is discontinued. The additional fee as described in this paragraph for unanticipated expenses and expenses for an audit initiated after Agreement discontinuance, together will not exceed $5,000.

You will provide Us with a copy of any audit reports within 30 days after You receive the audit report(s) from the auditor.

Section 10.4 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 unless otherwise required by law. In the event that a request is made under state law that seeks disclosure by the County of information United HealthCare has identified to the County as Proprietary Business Information, the County will, prior to disclosure advise United HealthCare of the request so that United HealthCare may take steps, if necessary, to protect its Proprietary Business Information. To the extent permissable 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 the termination of this Agreement.

Section 10.5 SAS 70 Reports. We may periodically provide You with Our SAS 70 report ("Report") for Your review in connection with Plan administrative purposes only. The Report is Our Proprietary Business Information and shall not be shared with any third parties without Our prior written approval; provided, however, that You can share the Report with: (i) Your independent public accounting firm; and / or (ii) Your consultants, provided that such consultants are not in any way a competitor of ours (iii) or as otherwise may be rquired by law. To the extent that You do provide the Report to Your independent public accounting firm or a consultant as permitted herein, You shall require that they retain the Report as confidential and that they not disclose such Report to any other persons or entities, unless required by law.

Section 10.6 PHI. The parties' obligations with respect to the use and disclosure of PHI are outlined in the Business Associate Agreement shown separately.

Section 11 - System Access

Section 11.1 System Access. We grant You the nonexclusive, nontransferable right to access and use the functionalities contained within the Systems, under the terms specified in this Agreement. You agree 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 ours. To obtain access to the Systems, You will obtain, and be responsible for maintaining, at no expense to Us, the hardware, software and Internet browser requirements We provide to You, including any amendments thereto. You will responsible for obtaining an Internet Service Provider or other access to the Internet. You will not (i) access Systems or use, copy, reproduce, modify, or excerpt any Systems documentation provided by Us in order to access or utilize Systems, for purposes other than as expressly permitted under this Agreement or (ii) share, transfer or lease Your right to access and use Systems, to any other person or entity which is not a party to this Agreement. You may designate any third party to access Systems on Your behalf, provided the third party agrees to these terms and conditions of Systems access and You assume joint responsibility for such access.

Section 11.2 Security Procedures. You will use commercially reasonable physical and software-based measures, and comply with Our security procedures, as may be amended from time to time, to protect the System, its functionalities, and data accessed through Systems from any unauthorized access or damage (including damage caused by computer viruses). You will notify Us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

Section 11.3 System Access Termination. We reserve the right to terminate Your System access (i) on the date You fail to accept the hardware, software and browser requirements provided by Us, including any amendments thereto or (ii) immediately on the date We reasonably determine that You have (i) breached, or allowed a breach of, any applicable provision of this Section 11 or (ii) materially breached or allowed a material breach of, any other applicable provision of this Agreement. Your System Access will also terminate upon termination of this Agreement, provided however that if run-out is provided in accordance with Section 9.2, You may continue to access applicable functionalities within the Systems during the run-out period. Upon any of the termination events described in this Agreement, You agree to cease all use of Systems, and We will deactivate Your identification numbers, passwords, and access to the System.

Section 12 - Taxes And Assessments

Section 12.1 Payment of Taxes and Expenses. In the event that any Taxes are assessed against Us as a claim administrator in connection with Our services under this Agreement, You will reimburse Us through the Bank Account for Your proportionate share of such Taxes (but not Taxes on Our net income). We have the authority and discretion to reasonably determine whether any such Tax should be paid or disputed. You will also reimburse Us for a proportionate share of any cost or expense reasonably incurred by Us in disputing such Tax, including costs and reasonable attorneys' fees and any interest, fines, or penalties relating to such Tax, unless caused by Our unreasonable delay or unreasonable determination to dispute such Tax.

Section 12.2 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, You agree to comply with these requirements.

Section 12.3 Surcharges. The Plan will remain responsible for state surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan.

Section 13 - Plan Benefits Litigation

Section 13.1 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 13.2 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 14 - Mediation

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 meet to discuss it, the parties may, by mutual agreement consent to mediate the dispute. Neither party will withhold consent unreasonably. 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 at law including seeking redress in a court of competent jurisdiction. This provision shall survive the termination of this Agreement.

Section 15 - Miscellaneous

Section 15.1 Subcontractors. We can use Our affiliates as subcontractors, or other subcontractors, to perform Our services under this Agreement. We will be responsible for those services to the same extent that We would have been had We performed those services without the use of an affiliate or subcontractor.

Section 15.2 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, We can assign this Agreement, including all of Our rights and obligations to Our affiliates, to an entity controlling, controlled by, or under common control with Us, or a purchaser of all or substantially all of Our assets, subject to notice to You of the assignment.

Section 15.3 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 15.4 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 15.5 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 15.6 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 15.7 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 15.8 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, You grant Us permission to use Your name, logo, service marks, trademarks or other identifying information to the extent necessary for Us to carry out Our obligations under this Agreement (e.g. on SPDs and ID cards).

EXHIBIT A - SERVICE FEES

This exhibit lists the service fees You must pay Us for Our services during the term of the Agreement. These fees apply for the period from January 1, 2012 through December 31, 2014. You acknowledge that the amounts paid for administrative services are reasonable.

Adjustments to Fees

The fees for standard medical service fees described below, excluding optional and non-standard fees, are adjusted as set forth in the applicable performance standards.

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

- $32.04 per Employee per month covered under the "UnitedHealthcare *Choice Plus*" portion of the Plan.
- $35.39 per Employee per month covered under the "UnitedHealthcare *Choice Plus Definity HRA*" portion of the Plan.
- $33.33 per Employee per month covered under the "UnitedHealthcare *Choice Plus Definity HSA*" portion of the Plan.
- $32.04 per Employee per month covered under the "UnitedHealthcare *Options PPO Non-Differential*" portion of the Plan.

Average Contract Size

Your Average Contract Size is 1.79.

The optional and non-standard fees are the sum of the following:

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.
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 Bill Management -- We will bill You for the amounts You owe Us. The bill will reflect reductions obtained during the preceding month and adjustments, if any, from previous months	Fee for Our services, equal to thirty percent (30%) of the amount of reductions obtained through Our efforts
Shared Savings Program	You will pay a fee equal to thirty-five percent (35%) of the "Savings Obtained" as a result of the Shared Savings Program. "Savings Obtained" means the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again, including amounts payable by both the Participant and the Plan, after the discount is taken.

EXHIBIT B - PERFORMANCE STANDARDS FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees), (hereinafter referred to as "Fees") payable by You under this Agreement will be adjusted through a credit to your Service 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 beginning January 1, 2012 and ending on December 31, 2012 ("Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are your exclusive financial remedies.

We reserve the right from time to time to replace any report or change the format of any report referenced in these guarantees. In such event, the guarantees will be modified to the degree necessary to carry out the intent of the parties. We shall not be required to meet any of the guarantees provided for in this Agreement or amendments thereto to the extent Our failure is due to Your actions or inactions or if We fail to meet these standards due to fire, embargo, strike, war, accident, act of God, acts of terrorism or 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.

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.

Ongoing ID Card 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 and passed a system load test.		
Measurement	Percentage of cards issued		98%
	Issuance time frame, in 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		5%
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		
Claim Operations			
Time to Process in 10 Days			
Definition	The percentage of all claims We receive in any 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	Site Level	
▪ Period	Annually	
Payment Period	Annually	
Fees at Risk	Percentage of Fees at Risk for this metric	2%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	11 business days 12 business days 13 business days 14 business days 15 business days or more	

Financial Accuracy (FAR)

Definition	Financial accuracy rate of not less than the designated percent.	
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%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	99.29% - 99.06% 99.05% - 98.81% 98.80% - 98.56% 98.55% - 98.30% Below 98.30	

Procedural Accuracy

Definition	Procedural accuracy rate of not less than the designated percent.	
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	Annually	
Payment Period	Annually	
Fees at Risk	Percentage of Fees at Risk for this metric	2%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	96.99% - 96.50% 96.49% - 96.00% 95.99% - 95.50% 95.49% - 95.00% Below 95.00%	

Member Phone Service

Phone service guarantees and standards apply to Participant calls made to the customer care center that primarily services Your Participants. 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, dental, vision, flexible spending accounts, Health Reimbursement Account, Health Savings Account, etc.

Average Speed of 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%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	32 seconds or less	
	34 seconds or less	
	36 seconds or less	
	38 seconds or less	
	Greater than 38 seconds	
	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	2%
▪ 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%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	2.01% - 2.50%	
	2.51% - 3.00%	
	3.01% - 3.50%	
	3.51% - 4.00%	
	Greater than 4.00%	
	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%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	20%
Gradients	92.99% - 91.00%	
	90.99% - 89.00%	
	88.99% - 87.00%	
	86.99% - 85.00%	
	Below 85.00%	
	Satisfaction	
	Employee (Member) Satisfaction	
Definition	The overall satisfaction will be determined by the question that reads *"Overall, how satisfied are you with the way we administer your 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%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient	N/A
Gradients	Not applicable	
	Customer Satisfaction	
Definition	The overall satisfaction will be determined by the question that reads *"How satisfied are you overall with UnitedHealthcare?"*	
Measurement	Minimum score on a 10 point scale	score 5
▪ Criteria	Standard Customer Scorecard Survey	
▪ Level	Customer specific	
▪ Period	Annually	

Payment Period	Annually		
Fees at Risk	Percentage of Fees at Risk for this metric		2%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Eligibility			
Eligibility - Annual Enrollment Period			
Definition	We will load your open enrollment electronic eligibility file received within the guaranteed number of business days of receipt.		
Measurement	Percentage of total files to be loaded		100%
	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	5
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%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		
Eligibility – Monthly Updates			
Definition	We will load the guaranteed percent of monthly electronic eligibility files received within the guaranteed number of business days of receipt.		
Measurement	Percentage of total files to be loaded		100%
	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	2
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%
Payment Amount	Of the Fees at Risk for this metric, percentage at risk for each gradient		N/A
Gradients	Not applicable		

OptumHealth Clinical Performance Guarantee Summary (Unless otherwise Specified, these guarantees are effective for the period from January 1, 2012 through December 31, 2014 (each year a "Guarantee Period"))						
Metric	Definition	Guaranteed Result	Result Timeframe	% Fee at Risk	Calculation	Terms and Conditions
Operations						
Case Management Enrollment	Percent of qualified members reached who enroll in an Optum PHS case management program.	60%	Annual	$3,334	**Denominator:** Total number of reached members **Numerator:** Total number of members that enroll	• This guarantee includes acute case management Post discharge readmission management program, predictive model outreach, and high risk case management. • 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. • Client must ensure receipt of prior 12 months of medical & Rx claims at least 90 days prior to program effective date in order for guarantee to be valid in first year of program.
Disease Management Program Enrollment	A minimum of eighty-five percent (85%) of qualified members will participate in the applicable program. Reported at the program level, guaranteed at the aggregate level (weighted average of all programs)	85%	Annual	$3,333	**Denominator:** Qualified members, as defined by each clinical program, and as validated with initial clinical screenings when appropriate. **Numerator:** Those individuals in the denominator who engage in the program in a clinically appropriate way as defined by the program and the ID/Stratification process.	• Included Program(s) – DM • Target measured against the higher of Client Specific or OptumHealth reported book of business.

Wellness Coaching Enrollment	The percentage of contacted members who enroll in a telephone, mail or online coaching program.	15%	Annual	$3,333	The percentage of contacted members who enroll in a telephone, mail or online coaching program.	**1.** Minimum group size: 5,000 members **2.** Inclusion of OptumHealth's standard health assessment and portal, consumer engagement and coaching processes apply. **3.** Inclusion of OptumHealth's wellness consulting services.
Outcomes: Savings and ROI						
PMPM Savings: Combined CM / DM	Meet or exceed the targeted savings for all CM and DM programs	**PMPM SAVINGS $3.00**	Annual	$10,000	**Case Management** The CM medical cost savings will be calculated by comparing the costs of members who participated in the CM programs with a matched group of members who did not participate during the 12 month intervention period (with 3 months of claims run out). Several methods will be used to maximize the comparability of the groups including: - participants and non-participants will be matched on characteristics including medical conditions (e.g. co morbidities), risk scores and presence of admissions in the past six months - cost outliers, including catastrophic claimants will be capped on a prorated basis at $100,000 in each applicable year. - savings will be calculated by	When appropriate, 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 Payout: 100% savings achieved - 0% 90 - 100% of savings - 25% of fees at risk 80 - 89% of savings - 50% of fees at risk 70 - 79% of savings - 75% of fees at risk 70% of savings - 100% of fees at risk The following requirements must be met to measure this guarantee in any given year: - Access to Medical and Pharmacy claims data during the measurement

					comparing the medical cost trends for the participant and non-participants groups, during the intervention year. **Disease Management** DM cost savings will be calculated by comparing medical costs across two time periods--prior to program implementation (baseline group) and after the program was initiated (intervention group). A "24-12" identification approach is used, whereby individuals are identified for the baseline and intervention periods using 24 months of data but claims costs for conditions are calculated using the most recent 12 months of experience (with 3 months of claims run out).	year - Access to 24 months of Medical and Rx claims history prior to program implementation - Maintain an 85% valid phone number rate for those members identified for telephonic outreach

Total Fees at Risk $20,000

EXHIBIT C - NETWORK PROVIDER DISCOUNTS

Adjustment to Standard Service Fees

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees), (hereinafter referred to as "Fees") for Employees covered under the UnitedHealthcare Choice Plus portion of the Plan, payable by You under this Agreement, will be adjusted through a credit to your Fees in accordance with the Network Provider Discount Guarantee set forth in this Exhibit. Unless otherwise specified, these provider discounts are effective for the period from January 1, 2012 through December 31, 2012. The settlement of provider discounts will be performed on an annual basis at the time of the year end reconciliation.

Choice Plus Network Discount Guarantee	
Actual Network Discounts	**Percentage of Fees At Risk**
Less than 57.2%	15.0%
57.2% to 58.2%	12.0%
58.2% to 59.2%	9.0%
59.2% to 60.2%	6.0%
60.2% to 61.2%	3.0%
Greater than 61.2%	0.0%

Assumptions

- Target in-Network Provider Choice Plus Discount Percentage 64.2%.
- The target discount percentage is based on the current distribution percentage of in-network employees by market. The current distribution for the larger markets is illustrated below. The distribution of smaller markets is combined into the All Other market.
- Savings are defined as the sum of 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.
- 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.
- Claims where We are the secondary payor are excluded from the Network Savings and Network Savings Factor determination.
- Mental Health/Substance Abuse claims are excluded.
- Medicare and Out of Area subscribers are excluded.
- We reserve the right to revise the target discount percentage should there be a significant change in this Employee distribution (+ or - 10% change in any of the markets identified below). The figures above are based upon the following markets and Employee counts:

Market	Employee Distribution
Tampa	3,123
Total	**3,123**

EXHIBIT D – INSURANCE REQUIREMENTS

Minimum Insurance Requirements For General Low Risk Contracts

A. Prior to the time Contractor is entitled to commence any part of the project, work or services under this Contract, Contractor shall procure, pay for and maintain at least the following insurance coverage's and limits. Said insurance shall be evidenced by delivery to the County of (1) certificates of insurance executed by the insurers listing coverage's and limits, expiration dates and terms of policies and all endorsements whether or. not required by the County, and listing all carriers issuing said policies; The insurance requirements shall remain in effect throughout the term of this Contract

1. Worker's Compensation in at least the limits as required by law; Employers' Liability Insurance of not less than $100,000 for each accident.

2. Comprehensive General Liability Insurance including, but not limited to, Independent Contractor, Contractual, Premises/Operations, Products/Completed Operation and Personal Injury covering the liability assumed under indemnification provisions of this Contract with limits of liability for personal injury and/or bodily injury, including death, of not less than $1,000,000 each occurrence; and property damage of not less than $100,000, each occurrence. Coverage shall be on an "occurrence" basis, and the policy shall include Broad Form Property Damage coverage, and Fire Legal Liability of not less than $50,000 per occurrence, unless otherwise stated by exception herein.

3. Comprehensive Automobile liability covering owned, hired and non-owned vehicles with minimum limits of $500,000 each occurrence, for bodily injury including death, and property damage of not less than $100,000, each occurrence. Coverage shall be on an "occurrence" basis, such insurance to include coverage for loading and inloading hazards.

4. Professional Liability Insurance (including Errors and Omissions with minimum limits of $5,000,000 per occurrence, if occurrence form is available; or claims made form with "tail coverage" extending three (3) years beyond completion and acceptance of the PROJECT with proof of "tail coverage" to be submitted with the invoice for final payment. In lieu of "tail coverage", CONSULTANT may submit annually to the COUNTY a current Certificate of Insurance proving claims:made insurance-remains force throughout the same.three (3) year period.

B. Each insurance policy shall include the following conditions by endorsement to the policy:

1. Each policy shall require that thirty (30) days prior to cancellation, non-renewal or any material change in coverage's or limits, a notice thereof shall be given to County by mail to: Pinellas County Purchasing Department, 400 S. Ft. Harrison Avenue, 6th Floor, Clearwater, Florida 33756. Contractor shall also notify County, in a like manner, within twenty-four (24) hours after receipt, of any notices of cancellation, non-renewal or material change in coverage received by said Contractor from its insurer; and nothing contained herein shall absolve Contractor of this requirement to provide notice.

2. Companies issuing the insurance policy, or policies, shall have no recourse against County for payment of premiums or assessments for any deductibles which all are at the sole responsibility and risk of Contractor.

3. The term "County" or "Pinellas County" shall include all Authorities, Boards, Bureaus, Commissions, Divisions, Departments and offices of County and individual members, employees -thereof in their. official capacities, and/or while acting on behalf of Pinellas County.

4. Pinellas County shall be endorsed to the General Liability and Automobile Liability policies as an additional insured. The policy clause "Other Insurance" shall not apply to any insurance coverage currently held by County to any such future coverage, or to County's Self-Insured Retention's of whatever nature.

C. Contractor hereby waives subrogation rights for loss or damage against the County.

Minimum Insurance Requirements For High Risk Contracts over $1,000,000

A. For selected high-risk contracts over $100,000.00 aggregate value, the County may require an insurance certificate and required endorsements. These required items shall be received by the County after formal Board of County Commissioners award and prior to execution of contract. Failure to provide required insurance documentation may cause your company to forfeit award.

B. There may be certain projects or services less than $100,000.00 in aggregate value that would be an exception and must be treated the same way as those services of $100,000.00 and greater i.e. services involving obvious potentially dangerous conditions. Examples of such services would be any contracts involving construction, alterations, renovations, painting, spraying, roofing, mowing, scaffolding, excavation, demolition, environmentally sensitive work and any other condition that appears to be dangerous in nature.

EXHIBIT E – HEALTH REIMBURSEMENT ACCOUNT AND HEALTH SAVINGS ACCOUNT ADMINISTRATIVE SERVICES

This Exhibit covers the administrative services We are providing to You, either directly or in conjunction with one of Our affiliates, for use with Your self-funded employee benefit plan.

We provide group health plan administration and related services through an Administrative Service Agreement ("Agreement") with You effective January 1, 2012. You desire to engage Us to provide the Definity[SM] Health Reimbursement Account product and Health Savings Account product described in this Exhibit, and We desire to provide those services.

Section 1 Definitions

The following definitions and sections are specific to administration of the Definity[SM] Health Reimbursement Account product and Health Savings Account product described in this Exhibit. Any other capitalized terms used in this Exhibit have the meanings set forth in the Agreement. These terms may or may not have been capitalized in prior contractual documents between the parties but will have the same meaning as if capitalized.

Definity [SM] Health Reimbursement Account: The Health Reimbursement Account and the associated medical Plan.

Definity [SM] Health Savings Account: The Health Savings Account and the associated high deductible medical Plan.

HRA or Health Reimbursement Account: An account established by You to fund certain eligible benefits described in the Summary Plan Description. This account is maintained in accordance with applicable provisions of the IRC and associated guidance issued by the IRS/Treasury Department.

HSA or Health Savings Account: A tax-advantaged account established by Your 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.

IRS: The United States Internal Revenue Service.

Treasury Department: The United States Department of the Treasury.

Section 2 Our Additional Duties

Section 2.1 Definity [SM] Health Reimbursement Account. We agree to provide You with Our standard administrative services in support of a Definity [SM] Health Reimbursement Account You offer to Participants.

You agree to provide all Participants enrolled in the Definity [SM] Health Reimbursement Account with a copy of the Summary Plan Description (SPD) in a timely manner, and in accordance with Section 5.13 of the Agreement. You will determine the annual amount to be placed in the Definity [SM] Health Reimbursement Account on an Employee plus one or family basis.

With Our review and approval, funding amounts and other HRA program requirements may be changed by You on a calendar year basis. You must provide Us one hundred and twenty (120) days written notice of such changes prior to the beginning of a new calendar year. Plan design changes may affect Our services and fees. Upon receipt and review of Your requested Plan changes, We will inform You if the changes can be implemented, and Our fees associated with incorporating such changes.

The HRA will be funded solely by You and not through Participant contributions. The administrative fees for these services are shown in Section 5.

Section 2.2 Definity [SM] Health Savings Account. We agree to provide You with Our standard administrative services in support of a Definity [SM] Health Savings Account offered to Participants, (hereinafter referred to in this Section as "Enrolling Employees"). The administrative fees for these services are shown in Section 6. The HSA itself is not subject to ERISA, and accordingly, any provisions of this Agreement which reference ERISA or which establish upon Us 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.

You will tell Us which of Your Employees are enrolling in the HSA. This information must be provided to Us in the specific format that We provide to You. You will notify Us of any change to this information as soon as reasonably possible. You authorize Us to provide this information to the HSA trustee or custodian for the purpose of establishing and maintaining the HSA.

You may elect, with Our consent, to allow Enrolling Employees to make contributions to HSAs maintained by Us or Our affiliate, by means of payroll deduction and transfer of such contributions to Our affiliate. Should the parties adopt such process, You agree to execute such documentation and take such further action as We or Our affiliate may reasonably request to effectuate such deduction and transfer. You authorize Us and Our affiliate to accept payroll contributions to HSAs pending application and approval of Employees for HSA accounts.

You agree to provide, in a timely manner and in accordance with Section 5.13 of the Agreement, all Enrolling Employees with a copy of the Summary Plan Description (SPD) for the high deductible health plan.

You acknowledge that HSAs are subject to contribution limits and other requirements imposed by the IRC and associated guidance issued by the IRS/Treasury Department. You acknowledge and agree that We shall have no obligation to ensure compliance with any requirements or limitations pertaining to HSAs, their establishment and/or use. To the extent that You have established contribution amounts and other HSA program requirements applicable to Your Enrolling Employees, You will advise Us of such requirements and will also provide Us one hundred and twenty (120) days written notice of such changes prior to implementation of such changes, as the changes may affect Our services and Fees. Upon receipt and review of such changes, We will inform You if the changes can be implemented, and Our fees associated with incorporating such changes.

We will not verify that distributions from Your Enrolling Employees' HSAs are for qualified medical expenses.

Section 2.3 Assistance with General Plan Administration. We will provide member outreach and communication materials including monthly member statements, and member activation campaigns.

Section 3 Miscellaneous

Section 3.1 Scope of Services. The services described in the Agreement and this Exhibit will be made available to Your Participants consistent with the Summary Plan Description under which the Participant is covered.

Section 3.2 This Exhibit will not affect any of the terms, provisions or conditions of the Agreement except as stated herein.

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Summary of Renewal Fees

This self-funded renewal is based on your current plan designs, contribution levels, size of the account (number of employees and dependents) and case complexity.

A comparison of the current and renewal fees is provided below.

	Choice Plus	Choice Plus (HSA)	ISL Fee
January 1, 2016	$33.71	$35.05	$27.22

The above ISL change for January 1, 2016 assumes a deductible of $500,000.

There are no commissions included in the fees.
The fees assume Pinellas County will be the claims fiduciary.

Shared Savings and Facility R&C are included in the plan. These services will be billed separately as a percentage of savings only when individuals access a non-UnitedHealthcare physician or health care professional and we are able to obtain a savings.

Shared Savings	35 percent of network savings
Facility R & C	35 percent of negotiated discounts

The fees include the following:

- Personal Health Support 2.0 with HealtheNotes, Disease Management, and Treatment Decision Support
- HIPAA Certificates of Coverage
- COPD Disease Management
- Data exchange with ESI (including RationalMed)
- Nurseline
- Dedicated Full Time Onsite Nurse Liaison
- Personal Rewards on Rally Engage
- Telephonic Coaching
- Designated Public Sector Customer Care Team
- Wellness Budget - $50,000
- United Resource Network programs
    - Kidney Resource Services
    - Cancer Resource Services
    - Healthy Pregnancy Program
    - Transplant Resource Services
    - Congenital Heart Disease Resource Services
    - Bariatric Resource Services

IMPREST Balance

Based on the claim projections, the required 6-day bank balance beginning January 1 will be set at $663,000. The bank balance will be reviewed periodically during the year and may be adjusted again based on claim fluctuation.

Stop Loss Renewal

Advantages of Stop Loss Coverage through UnitedHealthcare
UnitedHealthcare's Stop Loss Insurance helps you achieve two major objectives in managing the costs of employee benefit plans: cash flow management and risk management. There are several advantages to maintaining Stop Loss coverage through UnitedHealthcare.

- We **automatically** process large claim reimbursements for Individual and Aggregate Stop Loss.
- We **automatically** identify claims exceeding the stop loss limit so there's no risk of incurring penalties for late reporting.
- We provide you with **ONE consolidated reporting package** that includes Stop Loss and medical plan data.
- There is **no discrepancy in definition of cashed, paid or incurred dates** (such as date of admission or discharge), because the Stop Loss and underlying medical plan are BOTH with UnitedHealthcare.
- Stop Loss **premiums appear on the same bill** as other UnitedHealthcare services – providing easier administration and reconciliation for you.

Individual Stop Loss

The current Individual Stop Loss (ISL) limit is $500,000 and is based on a Paid/ 12 contract. The lifetime maximum for the ISL is Unlimited. The fee for ISL is $27.22 effective 1/1/16.

ATTACHMENT 3

2016 Plan Guide

What you need to know about your plan.

Pinellas County

UnitedHealthcare® Group Medicare Advantage (PPO)

Effective: January 1, 2016 through December 31, 2016

Group Number: 68124

UnitedHealthcare®

Table of Contents

Working with you to create a positive Medicare experience.

Dear Retiree,

We are pleased that your former employer or plan sponsor has selected UnitedHealthcare® to offer health care coverage for all eligible retirees. At UnitedHealthcare we believe you deserve more than just a good insurance plan to help maintain your health. We want to work with you to help you live a healthier life.

We want to:

- Help you get access to the care you may need when you need it
- Give you tools and resources to be in control
- Try to help you find ways to save money, so you can spend less on health care coverage and more on the things that matter most to you
- Be there for you when and where you need us

In this book you will find:

- A description of this plan and how it works
- Information on benefits, programs and services — and how much they cost
- What you can expect after you enroll

Your 2016 plan information is also available online. You will need your Group Number found on the front cover of your booklet to access the website.

How to enroll.

Your plan sponsor will provide additional information before you enroll in the plan.

We're with you every step of the way.

If you have any questions, please give us a call. Our Customer Service team has been specially trained on the details of your plan. They are happy to answer any questions you have.

Toll-Free **1-877-714-0178,** TTY **711** 8 a.m. to 8 p.m. local time, 7 days a week

Learn more online at **www.UHCRetiree.com**

[1]2014 UnitedHealth Group Annual Report

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NOTES

Plan INFORMATION

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Benefit highlights

Pinellas County 68124
Effective January 1, 2016 to December 31, 2016

This is a short description of plan benefits. For complete information, please refer to your Summary of Benefits or Evidence of Coverage. Limitations, exclusions, and restrictions may apply.

Plan Costs	In-Network	Out-of-Network
Annual out-of-pocket maximum	Your plan has an annual combined in-network and out-of-network out-of-pocket maximum of $1,500 each plan year	

Medical Benefits	In-Network	Out-of-Network
Benefits covered by Original Medicare and your plan		
Doctor's office visit	Primary Care Provider: $10 copay Specialist: $15 copay	Primary Care Provider: $10 copay Specialist: $15 copay
Preventive services	$0 copay for Medicare-covered preventive services. Refer to the Summary of Benefits or Evidence of Coverage for additional information.	
Inpatient hospital care	$50 copay per admission	$50 copay per admission
Skilled nursing facility (SNF)	$0 copay per day: days 1-20 $25 copay per additional day up to 100 days	$0 copay per day: days 1-20 $25 copay per additional day up to 100 days
Outpatient surgery	$25 copay	$25 copay
Outpatient rehabilitation (physical, occupational, or speech/ language therapy)	$0 copay	$0 copay
Diagnostic radiology services (such as MRIs, CT scans)	$0 copay	$0 copay
Lab services	$0 copay	$0 copay
Outpatient x-rays	$0 copay	$0 copay
Therapeutic radiology services (such as radiation treatment for cancer)	$0 copay	$0 copay
Ambulance	$50 copay	$50 copay
Emergency care	$50 copay (worldwide)	
Urgently needed services	$35 copay (worldwide)	$35 copay (worldwide)
Additional benefits and programs not covered by Original Medicare		
Routine physical	$0 copay; 1 per plan year*	$0 copay; 1 per plan year*
Foot care - routine	$15 copay (Up to 6 visits per plan year)*	$15 copay (Up to 6 visits per plan year)*
Hearing - routine exam	$0 copay (1 exam every 12 months)*	$0 copay (1 exam every 12 months)*
Hearing aids	Plan pays up to $500 (every 3 years)*	Plan pays up to $500 (every 3 years)*
Vision - routine eye exams	$15 copay (1 exam every 12 months)*	$15 copay (1 exam every 12 months)*

Medical Benefits	In-Network	Out-of-Network
Fitness program through SilverSneakers® Fitness program	Stay active with a basic membership at a participating location at no extra cost to you	
NurseLine℠	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	

*Benefits are combined in and out-of-network

Prescription Drugs	Your Cost	
Initial coverage stage	Network Pharmacy (30-day retail supply)	Mail Service Pharmacy (90-day supply)
Tier 1: Preferred generic	$6 copay	$12 copay
Tier 2: Preferred brand (includes some generic)	$15 copay	$30 copay
Tier 3: Non-preferred brand (includes some generic)	$30 copay	$60 copay
Tier 4: Specialty tier	$30 copay	$60 copay
Coverage gap stage	After your total drug costs reach $3,310, the plan continues to pay its share of the cost of your drugs and you pay your share of the cost	
Catastrophic coverage stage	After your total out-of-pocket costs reach $4,850, you will pay the greater of $2.95 copay for generic (including brand drugs treated as generic), $7.40 copay for all other drugs, or 5% of the cost	

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see your Additional Drug Coverage list for more information.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

Retiree plan prospects must meet the eligibility requirements to enroll for group coverage. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change each plan year.

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UnitedHealthcare® Group Medicare Advantage (PPO)

Let's start with a quick look at how your plan works. Your plan sponsor has chosen a UnitedHealthcare® Group Medicare Advantage plan. What is a Group Medicare Advantage plan? The word "Group" means that this is a plan designed just for a plan sponsor, like yours. Only eligible retirees of your plan sponsor can enroll in this plan. You can't get it anywhere else.

"Medicare Advantage" is also known as Medicare Part C. Medicare Advantage plans are a part of Medicare that combine all the benefits of Medicare Part A (hospital coverage) and Medicare Part B (doctor and outpatient care) into one convenient plan. Plus, your plan includes programs that go beyond Original Medicare Part A and Part B.

Medicare Part A
Hospital

Medicare Part B
Doctor and outpatient

Medicare Part D
Prescription drugs

Extra Programs
Beyond Original Medicare

Make sure you are signed up for Medicare.

You must be entitled to Medicare Part A and enrolled in Medicare Part B to enroll in this plan.

- If you're not sure if you are enrolled in Medicare Part B, check with your local Social Security office
- You must continue paying your Medicare Part B premium to keep your coverage under this group-sponsored plan
- If you stop your payments, you may be disenrolled from this plan

Remember: If you drop your group-sponsored retiree health coverage, you may not be able to re-enroll. Limitations and restrictions vary by plan sponsor.

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Plan basics

How your medical coverage works.

Your plan is a Preferred Provider Organization (PPO) plan. With this plan, you have access to our national network of health care providers. You can see providers out-of-network at the same co-pay or co-insurance as in-network providers, as long as they participate in Medicare and accept the plan.

	In-Network	Out-of-Network
Will the doctor or hospital accept my plan?	Yes	Has the choice to accept plan (except for emergencies).
What is my co-pay or co-insurance?	Co-pays and co-insurance vary by service.[1]	
Do I need to choose a primary care provider (PCP)?	No	No
Do I need a referral to see a specialist?	No	No
Are emergency and urgently needed services covered?	Yes	Yes
Do I have to pay the full cost for all doctor or hospital services?	You will pay your standard co-pay or co-insurance for the service you receive.[1]	
Is there a limit on my total out-of-pocket spending for the year?	Yes	Yes

[1]Refer to the Summary of Benefits or Benefit Highlights for more information.

Manage your account details online.

Keeping track of bills and payments can be overwhelming. Once your plan is effective, create your secure online account at **UHCRetiree.com**. After you've registered, you can track your bills and payments, view your account history and plan details and so much more in one easy location online.

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Plan basics

How your prescription drug coverage works.

Your Medicare Part D prescription drug coverage includes thousands of brand name and generic prescription drugs. To if your drugs are covered, please review your plan's drug list.

	How it works
What pharmacies can I use?	You can choose from over 65,000 pharmacies across the United States including national chain, regional and independent local retail pharmacies.
What will I pay for my prescription drugs?	What you pay will depend on the coverage your plan sponsor has arranged. Your exact cost may depend on what drug cost tier your prescription belongs to. Your cost may also change during the year based on the total cost of the drugs you have taken. To learn more about your coverage, please refer to your Benefit Highlights or your Summary of Benefits.
What is a tier?	Drugs are divided into different cost levels or tiers. In general, the higher the tier, the higher the cost of the drug.
Do I need to keep paying my Part B monthly premium?	Yes. Medicare requires that you continue to pay your Part B monthly premium (to Social Security). If you stop paying your monthly Part B premium, you may be disenrolled from your plan.
Can I have more than one prescription drug plan?	No. Medicare only allows you to have one Medicare prescription drug plan at a time. If you enroll in another Medicare prescription drug plan OR a Medicare Advantage plan that includes prescription drug coverage, you may be disenrolled from this plan.

Plan basics

	How it works
What is IRMAA?	IRMAA stands for the Income-Related Monthly Adjustment Amount. If your modified adjusted gross income as reported on your IRS tax return from two years ago (the most recent tax return information provided to Social Security by the IRS) is above a certain limit, you may pay a Part D income-related monthly adjustment amount (Part D-IRMAA) in addition to your monthly plan premium. This extra amount is paid directly to Social Security, not to your plan. Social Security will contact you if you have to pay Part D-IRMAA, based on your income.
What is a Medicare Part D Late Enrollment Penalty (LEP)?	You may pay a late enrollment penalty if, at any time after you first become eligible for Part D, there's a period of at least 63 days in a row when you didn't have Part D or other creditable prescription drug coverage. Creditable coverage means that the prescription drug coverage you have had is at least as good as or better than what Medicare provides. The late enrollment penalty is an amount added to your monthly Medicare premium which you may have to pay. When you become a member, your plan sponsor will be asked to attest or validate that you have had continuous Part D plan coverage. If your plan sponsor asks for information about your prescription drug coverage history, please respond as quickly as possible to avoid the risk of paying a penalty in error. Once you become a member, more information will be available in your Evidence of Coverage (EOC).

Getting the health care coverage you may need

Your care begins with your doctor.

With this plan, you have the flexibility to see doctors that are both inside and outside the UnitedHealthcare network. Unlike most PPO plans, with this plan, you pay the same share of cost in and out-of-network. With your UnitedHealthcare Group Medicare Advantage plan, you're connected to programs, resources, tools and people that can help you live a healthier life.

Finding a doctor is easy.

If you need help finding a doctor or a specialist, just give us a call. We can help you find a doctor or a specialist, and we can even help schedule that first appointment.

Why use a UnitedHealthcare network doctor?

If you need to find a new doctor or specialist, we hope you will consider a doctor in the plan's network. We work closely with our network of doctors to give them access to resources and tools that can help them.

Filling your prescriptions is convenient.

UnitedHealthcare has over 65,000 national, regional and local chains, as well as thousands of independent neighborhood pharmacies in its network. Using a UnitedHealthcare network pharmacy may help make sure you are getting the lowest cost available through your plan.

We can help you find doctors in your area.

Toll-Free **1-877-714-0178,** TTY **711** 8 a.m. to 8 p.m. local time, 7 days a week

Learn more online at **www.UHCRetiree.com**

[1]2015 Internal Report Data

Getting the health care coverage you may need

Additional support and programs.

At UnitedHealthcare, we want to make it easier for you and your doctor to take care of your health. Here are just a few of the ways we help.

Annual Wellness Visit and preventive services at $0 co-pay.

One of the best ways to stay on top of your health is with an Annual Wellness Visit with your doctor. Identify the preventive screenings you may need, review all your medications and talk to your doctor about any health concerns. You can even receive a reward just for completing your Annual Wellness Visit.

You are never alone with NurseLine℠

Doctor's office not open? Whether it's a question about a medication or a health concern in the middle of the night, with NurseLine,℠ registered nurses answer your call 24 hours a day.

Special programs for people with chronic or complex health needs.

UnitedHealthcare offers special programs to doctors to help their patients who are living with chronic disease, like diabetes or heart disease. These programs can be very helpful for both patients and doctors. The patients get personal attention and the doctor gets up-to-date information to help them make decisions.

Make caring for a loved one easier.

At no additional cost, Solutions for Caregivers supports you, your family and those you care for by providing information, education, resources and care planning. Also included is an on-site evaluation by a Registered Nurse and a personal plan of care developed by a Geriatric Case Manager. You will also have access to our Caregiver Partners website so you can explore our library of articles, buy caregiver related products and services and share information among family members to help improve communication and decision-making.

Tools and resources to put you in control

Good health care decisions can help you to live healthier and may help lower your health care costs. It's good to remember the old saying, "An ounce of prevention is worth a pound of cure," but knowing how to make those decisions may not be as easy as it used to be. It's no secret that health care has gotten more complicated. UnitedHealthcare strives to make it easier by giving you the tools and resources you may need to help make good health decisions for you.

Valuable information is just a few clicks away.

As a UnitedHealthcare member, you will have access to a safe, secure and personalized website that gives you access 24 hours a day to many valuable programs and information. Once you register, you can:

- Review your personal health record
- Look up your latest claim information
- Search for network doctors
- Search for drugs and how much they cost under your plan
- Learn more about wellness topics and sign up for healthy challenges that are based on your interests and goals

Take control of your fitness with SilverSneakers.®

Stay active with the SilverSneakers® Fitness Program. SilverSneakers members receive a basic fitness membership and access to more than 13,000 participating locations. Don't live near a fitness center? SilverSneakers Steps is a personalized fitness program for members who can't get to a SilverSneakers location. Once enrolled in Steps, you may select one of four programs that best fits your needs — general fitness, strength, walking or yoga. The Steps wellness tools can help you get fit at home or on the go.

The importance of a living will.

By completing a living will or advance directive, you control how you want to be cared for when you are not able to make decisions for yourself. If you want to learn more, give us a call. Another good resource is Aging With Dignity. They have created a very simple easy to use document called 5 Wishes. To learn more, go to **www.AgingWithDignity.org**.

We're with you every step of the way.

Toll-Free **1-877-714-0178,** TTY **711** 8 a.m. to 8 p.m. local time, 7 days a week

Learn more online at **www.UHCRetiree.com**

Ways to help you save

One of the advantages of having your health care coverage through UnitedHealthcare is our size and experience. As one of the largest and oldest Medicare Advantage and Medicare prescription drug plans in the country, we bring you savings that are exclusive to UnitedHealthcare.

Pharmacy Saver.™ Save on the cost of generic prescription drugs. Many, but not all, of the pharmacies in UnitedHealthcare's national pharmacy network participate in a special program that could help you save more on your prescriptions drugs. This program is called the Pharmacy Saver™ program.[1] With the Pharmacy Saver program, you can fill your prescriptions for as low as $1.50 at participating pharmacies located in grocery, discount and drug stores where you already shop.

Best of all, Pharmacy Saver is easy. No additional enrollment is necessary. Simply take your qualifying prescription to a participating pharmacy, show your UnitedHealthcare member ID card, and they can help you switch.

Here are just some of the national and local retailers with pharmacies that participate in the Pharmacy Saver program:

Note: Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

[1]Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, co-pay amounts may be higher.

To see a listing of drugs available through Pharmacy Saver or to find a participating pharmacy, visit **UnitedPharmacySaver.com**.

More ways you could save on your prescription drugs

You could save money on prescription drugs with exclusive member pricing at pharmacies in your local grocery, drug and discount stores.

Save on the medications you take regularly.

If you prefer the convenience of mail order, you could save time and money on your maintenance medications with our mail service pharmacy. You will have access to licensed pharmacists and, in addition, you can receive automatic refill reminders with OptumRx Mail Service Pharmacy.

Get a 90-day[1] supply at retail pharmacies.

In addition to your Mail Service Pharmacy, most retail pharmacies offer 90-day supplies for some prescription drugs.

To find out if a retail pharmacy offers 90-day supplies, you can check your UnitedHealthcare pharmacy directory and look for the symbol.

Ask your doctor about trial supplies.

Before you get a prescription for a one-month supply, ask your doctor about a trial supply. A trial supply allows you to fill a prescription for less than 30 days. This way you can pay a reduced co-pay or co-insurance and make sure the medication works for you before getting a full month supply.

The UnitedHealthcare Savings Promise

UnitedHealthcare is committed to keeping your costs down for prescription drugs. As a member of our Medicare Advantage Prescription Drug plans, you have our Savings Promise that you'll get the lowest price available. That low price may be your plan co-pay, the pharmacy's retail price or our contracted price with the pharmacy.

Explore lower cost options.

Each covered drug in your drug list is assigned to a tier. Generally, the lower the tier, the less you pay. If you're taking a higher-tier drug, you may want to talk to your doctor to see if there's a lower-tier drug you could take instead.

Have an annual medication review.

Take some time during your Annual Wellness Visit to make sure you are only taking the drugs you need.

[1]Your plan sponsor may provide coverage beyond 90 days. Please refer to the Benefit Highlights or Summary of Benefits for more information.

Call Medicare to see if you qualify for Extra Help.

If you have a limited income, you may be able to get Extra Help from Medicare. If you qualify, Medicare could pay up to 75% or more of your drug costs. Many people qualify and don't know it. There's no penalty for applying, and you can re-apply every year.

Toll-Free **1-800-633-4227**, TTY **1-877-486-2048**, 24 hours a day, 7 days a week

2016 Summary of BENEFITS

UnitedHealthcare® Group Medicare Advantage (PPO)

Group Name (plan sponsor): Pinellas County
Group Number: 68124
H2001-816

UnitedHealthcare®

Y0066_150629_152255

Summary of Benefits

January 1, 2016 - December 31, 2016
This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

Your Health Care Coverage

This plan is offered through your plan sponsor.

You may be able to join or leave a plan only at certain times designated by your plan sponsor. If you choose to enroll in a Medicare health plan or Medicare Prescription Drug plan that is not offered by your plan sponsor, you may lose the option to enroll in a plan offered by your plan sponsor in the future. You could also lose coverage for other plan sponsor retirement benefits you may currently have. Once enrolled in our plan, if you choose to end your membership outside of your plan sponsor's open enrollment period, re-enrollment in any plan your plan sponsor offers may not be permitted, or you may have to wait until their next open enrollment period.

It is important to understand your plan sponsor's eligibility policies, and the possible impact to your retiree health care coverage options and other benefits before submitting a request to enroll in a plan not offered by your plan sponsor, or a request to end your membership in our plan.

For more information please call UnitedHealthcare® Group Medicare Advantage (PPO) at the number listed below.

If you want information about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About UnitedHealthcare® Group Medicare Advantage (PPO)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at **1-877-714-0178**.

Things to Know About UnitedHealthcare® Group Medicare Advantage (PPO)

Hours of Operation

You can call us 8 a.m. to 8 p.m. local time, 7 days a week

UnitedHealthcare® Group Medicare Advantage (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free **1-800-457-8506**.

- If you are not a member of this plan, call toll-free **1-877-714-0178**.
- Our website: **www.UHCRetiree.com**

Who can join?

To join UnitedHealthcare® Group Medicare Advantage (PPO), you must be entitled to Medicare Part A, be enrolled in Medicare Part B, live in our service area, and meet the eligibility requirements of your former employer, union group or trust administrator (plan sponsor).

Our service area includes the 50 United States, the District of Columbia and all US territories.

Which doctors, hospitals, and pharmacies can I use?

UnitedHealthcare® Group Medicare Advantage (PPO) has a network of doctors, hospitals, pharmacies, and other providers. You can see any provider (in-network or out-of-network) that participates in Medicare at the same cost share. Your copays or coinsurance will be the same.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website www.UHCRetiree.com. Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and more.

- **Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get more than what is covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

- You can learn about the complete plan formulary (list of Part D prescription drugs) and any restrictions by calling us.

How will I determine my drug costs?

Our plan groups each medication into one of four "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If the actual cost for a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Your plan sponsor has chosen to make supplemental drug coverage available to you. This coverage is in addition to your Part D prescription drug benefit. The drug copays in this section are for drugs that are covered by both your Part D prescription drug benefit and your

supplemental drug coverage. Once you are enrolled in this plan, you will receive a separate document called the “Certificate of Coverage” with more information about this supplemental drug coverage.

Summary of Benefits

January 1, 2016 - December 31, 2016

Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services	
How much is the monthly premium?	Contact your group plan benefit administrator to determine your actual premium amount, if applicable.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $1,500 for services you receive from in-network providers. • $1,500 for services you receive from any provider. Your limit for services received from in-network and out-of-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.
Covered Medical and Hospital Benefits	
Outpatient Care and Services	
Ambulance	• In-network: $50 copay • Out-of-network: $50 copay
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: 50% of the cost • Out-of-network: 50% of the cost
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $15 copay • Out-of-network: $15 copay
Diabetes Supplies and	Diabetes monitoring supplies: • In-network: You pay nothing

Services	• Out-of-network: You pay nothing Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 20% of the cost For Diabetes monitoring supplies, we only cover blood glucose monitors and test strips from the following brands: OneTouch® Ultra® 2 System, OneTouch® UltraMini®, OneTouch® Verio® Sync, OneTouch® Verio® IQ, ACCU-CHEK® Nano SmartView, and ACCU-CHEK® Aviva Plus.
Diagnostic Tests, Lab and Radiology Services, and X-Rays (Costs for services may be different if received in an outpatient surgery setting)	Diagnostic radiology services (such as MRIs, CT scans): • In-network: You pay nothing • Out-of-network: You pay nothing Diagnostic tests and procedures: • In-network: $25 copay • Out-of-network: $25 copay Lab services: • In-network: You pay nothing • Out-of-network: You pay nothing Outpatient x-rays: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic radiology services (such as radiation treatment for cancer): • In-network: You pay nothing • Out-of-network: You pay nothing
Doctor's Office Visits	Primary care physician visit: • In-network: $10 copay • Out-of-network: $10 copay Specialist visit: • In-network: $15 copay • Out-of-network: $15 copay
Durable Medical Equipment (wheelchairs, oxygen, etc.)	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Emergency Care	• $50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.

Foot Care (podiatry services)	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: ● In-network: $15 copay ● Out-of-network: $15 copay **Additional benefit not covered by Original Medicare** Routine foot care (for up to 6 visits every year): ● In-network: $15 copay for each visit ● Out-of-network: $15 copay for each visit Benefit is combined in and out-of-network.
Hearing Services	Exam to diagnose and treat hearing and balance issues: ● In-network: $15 copay ● Out-of-network: $15 copay **Additional benefit not covered by Original Medicare** Routine hearing exam (for up to 1 every year): ● In-network: You pay nothing for each visit ● Out-of-network: You pay nothing for each visit Benefit is combined in and out-of-network Hearing aid: ● In-network: Our plan pays up to a $500 allowance for hearing aids every 3 years ● Out-of-network: Our plan pays up to a $500 allowance for hearing aids every 3 years Benefit is combined in and out-of-network
Home Health Care	● In-network: You pay nothing ● Out-of-network: You pay nothing
Mental Health Care	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. ● In-network: ○ $50 copay per stay, up to 190 days ● Out-of-network: ○ $50 copay per stay, up to 190 days Outpatient group therapy visit: ● In-network: $10 copay ● Out-of-network: $10 copay Outpatient individual therapy visit: ● In-network: $15 copay ● Out-of-network: $15 copay
Outpatient	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per

Rehabilitation	day for up to 36 sessions up to 36 weeks): • In-network: You pay nothing • Out-of-network: You pay nothing Occupational therapy visit: • In-network: You pay nothing • Out-of-network: You pay nothing Physical therapy and speech and language therapy visit: • In-network: You pay nothing • Out-of-network: You pay nothing
Outpatient Substance Abuse	Group therapy visit: • In-network: $10 copay • Out-of-network: $10 copay Individual therapy visit: • In-network: $15 copay • Out-of-network: $15 copay
Outpatient Surgery	Ambulatory surgical center: • In-network: $25 copay • Out-of-network: $25 copay Outpatient hospital: • In-network: $25 copay • Out-of-network: $25 copay
Prosthetic Devices (braces, artificial limbs, etc.)	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost
Renal Dialysis	• In-network: 20% of the cost • Out-of-network: 20% of the cost
Urgently Needed Services	• $35 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services. See the "Inpatient Hospital Care" section of this booklet for other costs.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $0-$15 copay, depending on the service • Out-of-network: $0-$15 copay, depending on the service Eyeglasses or contact lenses after cataract surgery: • In-network: You pay nothing • Out-of-network: You pay nothing

	Additional benefit not covered by Original Medicare Routine eye exam (for up to 1 every year): • In-network: $15 copay • Out-of-network: $15 copay Benefit is combined in and out-of-network.
Preventive Care	• In-network: You pay nothing • Out-of-network: You pay nothing Our plan covers many preventive services, including but not limited to: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. **Additional benefit not covered by Original Medicare** Fitness program: $0 membership fee. SilverSneakers® Fitness program through network fitness centers. There is no visit or use fee for basic membership when you use network service providers. SilverSneakers® Steps at Home program is available for members living 15 miles away or more from a SilverSneakers fitness center. Member may select one of four kits that best fit their lifestyle and fitness level - general fitness, strength, walking or yoga. **Additional benefit not covered by Original Medicare**

	Nurseline℠: You may call the Nurseline, 24 hours a day, 7 days a week and speak to a registered nurse (RN) about your medical concerns and questions.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.
Inpatient Care	
Inpatient Hospital Care	Our plan covers an unlimited number of days for an inpatient hospital stay. ● In-network: ○ $50 copay per stay ● Out-of-network: ○ $50 copay per stay
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. ● In-network: ○ You pay nothing per day for days 1 through 20 ○ $25 copay per day for days 21 through 100 ● Out-of-network: ○ You pay nothing per day for days 1 through 20 ○ $25 copay per day for days 21 through 100
Prescription Drug Benefits	
How much do I pay?	For Part B drugs such as chemotherapy drugs: ● In-network: 20% of the cost ● Out-of-network: 20% of the cost Other Part B drugs: ● In-network: 20% of the cost ● Out-of-network: 20% of the cost Our plan covers Part D prescription drugs and the following charts below further explain your cost sharing.
Initial Coverage	You pay the following until total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. **Standard Retail Cost-Sharing**

Tier	One-month supply
Tier 1 (Preferred Generic)	$6 copay

Tier 2 (Preferred Brand, includes some Generics)	$15 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	$30 copay
Tier 4 (Specialty Tier)	$30 copay

Standard Mail Order Cost-Sharing

Tier	Three-month supply
Tier 1 (Preferred Generic)	$12 copay
Tier 2 (Preferred Brand, includes some Generics)	$30 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	$60 copay
Tier 4 (Specialty Tier)	$60 copay

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.

After you enter the coverage gap, we will continue to pay our share of the cost of your drugs and you pay your share of the cost. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Standard Retail Cost-Sharing

Tier	Drugs covered	One-month supply
Tier 1 (Preferred Generic)	All	$6 copay
Tier 2 (Preferred Brand, includes some Generics)	All	$15 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	All	$30 copay
Tier 4 (Specialty Tier)	All	$30 copay

Standard Mail Order Cost-Sharing

Tier	Drugs Covered	Three-month supply
Tier 1 (Preferred Generic)	All	$12 copay
Tier 2 (Preferred Brand, includes some Generics)	All	$30 copay
Tier 3 (Non-Preferred Brand, includes some Generics)	All	$60 copay
Tier 4 (Specialty Tier)	All	$60 copay

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:

- 5% of the cost, or
- $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copay for all other drugs.

Non-Formulary (drugs not covered under Medicare Part D)

Your plan sponsor has elected to offer additional coverage on some prescription drugs that are normally excluded from coverage on your Formulary. Please see the Additional Drug Coverage list for more information.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-714-0178. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-714-0178. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电1-877-714-0178。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電1-877-714-0178。 我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-714-0178. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-714-0178. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-714-0178 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-714-0178. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화1-877-714-0178번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-714-0178. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:
إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا.
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Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-714-0178 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-714-0178. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

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Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-714-0178. Ta usługa jest bezpłatna.

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NOTES

For more information, please contact Customer Service at:

Toll-Free **1-877-714-0178,** TTY **711**
8 a.m. to 8 p.m. local time, 7 days a week

www.UHCRetiree.com

If you are a member of a group sponsored plan (your coverage is provided through a former employer, union group or trust), please call the UnitedHealthcare Customer Service number on the back of your member ID card.

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UHEX16PP3696260_000

2016 Required INFORMATION

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Solutions for Caregivers assists in coordinating community and in-home resources. The final decision about your care arrangements must be made by you. In addition, the quality of a particular provider must be solely determined and monitored by you. Information provided to you about a particular provider does not imply and is in no way an endorsement of that particular provider by Solutions for Caregivers. The information on and the selection of a particular provider has been supplied by the provider and is subject to change without written consent of Solutions for Caregivers.

Drugs and prices may vary between pharmacies and are subject to change during the plan year. Prices are based on quantity filled at the pharmacy. Quantities may be limited by pharmacy based on their dispensing policy or by the plan based on Quantity Limit requirements; if prescription is in excess of a limit, co-pay amounts may be higher. Other pharmacies are available in our network. Members may use any pharmacy in the network, but may not receive Pharmacy Saver pricing. Pharmacies participating in the Pharmacy Saver program may not be available in all areas.

You are not required to use OptumRx to obtain a 90 or 100-day supply of your maintenance medications. If you have not used OptumRx home delivery, you must approve the first prescription order sent directly from your doctor to OptumRx before it can be filled. New prescriptions from OptumRx should arrive within ten business days from the date the completed order is received, and refill orders should arrive in about seven business days. Contact OptumRx anytime at 1-888-279-1828, TTY 711. OptumRx is an affiliate of UnitedHealthcare Insurance Company.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, co-payments and restrictions may apply.

Benefits, premium and/or co-payments/co-insurance may change each plan year.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan’s contract renewal with Medicare.

Drug LIST

UHEX16MP3700083_001

2016 DRUG LIST

This is an alphabetical partial list of Brand name and Generic drugs covered by the plan.

- **Brand name** drugs appear in **bold** type
- Generic drugs appear in plain type

Each drug is in one of four tiers, which is listed after the drug name.

- Each tier has a co-pay or co-insurance amount
- For a full description of the tiers, see the Summary of Benefits in this book

For more information or for a complete list of covered drugs, please call Customer Service. Our contact information is on the first page of this book.

This list was last updated August 1, 2015.

A

Acamprosate Calcium DR (Tablet Delayed-Release), T3
Acetaminophen/Codeine (Tablet), T1
Acetazolamide (Tablet), T2
Acetazolamide ER (Capsule Extended-Release 12 Hour), T3
Acyclovir (Tablet), T1
Adacel (Injection), T2
Adcirca (Tablet), T4
Advair Diskus (Aerosol Powder), T2
Advair HFA (Aerosol), T2
Aggrenox (Capsule Extended-Release 12 Hour), T3
Albenza (Tablet), T4
Alcohol Prep Pads, T2
Alendronate Sodium (Tablet), T1
Alfuzosin HCl ER (Tablet Extended-Release 24 Hour), T1
Allopurinol (Tablet), T1
Alprazolam (Tablet Immediate-Release), T1
Amantadine HCl (100mg Capsule, 50mg/5ml Syrup, 100mg Tablet), T2
Amiodarone HCl (200mg Tablet), T1
Amitiza (Capsule), T2
Amitriptyline HCl (Tablet), T3
Amlodipine Besylate (Tablet), T1
Amlodipine Besylate/ Benazepril HCl (Capsule), T1
Ammonium Lactate (12% Cream, 12% Lotion), T2
Amoxicillin (250mg Capsule, 500mg Capsule, 500mg Tablet, 875mg Tablet), T1
Amoxicillin/Clavulanate Potassium (Tablet Immediate-Release) (Generic Augmentin), T1
Amphetamine/ Dextroamphetamine (10mg Tablet Immediate-Release, 12.5mg Tablet Immediate-Release, 15mg Tablet Immediate-Release, 20mg Tablet Immediate-Release, 30mg Tablet Immediate-Release, 5mg Tablet Immediate-Release, 7.5mg Tablet Immediate-Release), T2
Amphetamine/ Dextroamphetamine ER (10mg Capsule Extended-Release 24 Hour, 15mg Capsule Extended-Release 24 Hour, 20mg Capsule Extended-Release 24 Hour, 25mg Capsule Extended-Release 24 Hour, 30mg Capsule Extended-Release 24 Hour, 5mg Capsule Extended-Release 24 Hour), T3
Anagrelide HCl (Capsule), T1
Anastrozole (Tablet), T1

Androderm (Patch 24 Hour), T2
Androgel (Packet), Androgel Pump (Gel), T2
Anoro Ellipta (Aerosol Powder), T2
Argatroban (Injection), T4
Atenolol (Tablet), T1
Atenolol/chlorthalidone (Tablet), T1
Atorvastatin Calcium (Tablet), T1
Atovaquone/Proguanil HCl (Tablet) (Generic Malarone), T2
Atripla (Tablet), T4
Atrovent HFA (Aerosol Solution), T3
Aubagio (Tablet), T4
Avastin (Injection), T4
Avonex (Injection), T4
Azathioprine (Tablet), T1
Azelastine HCl (0.05% Ophthalmic Solution), T3
Azelastine HCl (0.1% Nasal Solution), T2
Azelastine HCl (0.15% Nasal Solution), T2
Azilect (Tablet), T2
Azithromycin (100mg/5ml Suspension, 200mg/5ml Suspension, 250mg Tablet, 500mg Tablet, 600mg Tablet), T1
Azopt (Suspension), T2

B

Baclofen (Tablet), T1
Balsalazide Disodium (Capsule), T3
Belsomra (Tablet), T2
Benazepril HCl (Tablet), T1
Benazepril HCl/ Hydrochlorothiazide (Tablet), T1
Benicar (Tablet), T2
Benicar HCT (Tablet), T2
Benlysta (Injection), T4
Benztropine Mesylate (Tablet), T2
Betaseron (Injection), T4
Bethanechol Chloride (Tablet), T1
Bicalutamide (Tablet), T1
Bisoprolol Fumarate (Tablet), T2
Bisoprolol Fumarate/ Hydrochlorothiazide (Tablet), T2
Brimonidine Tartrate (0.15% Ophthalmic Solution), T2
Brimonidine Tartrate (0.2% Ophthalmic Solution), T2
Brintellix (Tablet), T3
Budesonide (3mg Capsule Extended-Release 24 Hour), T4
Bumetanide (Tablet), T1
Buprenorphine HCl (Tablet Sublingual), T3
Bupropion HCl (100mg Tablet Immediate-Release, 75mg Tablet Immediate-Release), Bupropion HCl SR (100mg Tablet Extended-Release 12 Hour, 150mg Tablet Extended-Release 12 Hour, 200mg Tablet Extended-Release 12 Hour), Bupropion HCl XL (150mg Tablet Extended-Release 24 Hour, 300mg Tablet Extended-Release 24 Hour), T1
Buspirone HCl (Tablet), T1
Butrans (Patch Weekly), T2
Bydureon (Injection), T2
Byetta (Injection), T3
Bystolic (Tablet), T2

C

Cabergoline (Tablet), T2
Calcitriol (Capsule), T1
Calcium Acetate (Capsule), T2
Captopril (Tablet), T1
Captopril/Hydrochlorothiazide (Tablet), T1
Carafate (Suspension), T3
Carbaglu (Tablet), T4
Carbamazepine (100mg/5ml Suspension, 200mg Tablet, 100mg Tablet Chewable), Carbamazepine ER (100mg Capsule Extended-Release 12 Hour, 200mg Capsule Extended-Release 12 Hour, 300mg Capsule Extended-Release 12 Hour, 200mg Tablet Extended-Release 12 Hour, 400mg Tablet Extended-Release 12 Hour), T2
Carbidopa (25mg Tablet), T4

Carbidopa/Levodopa (10mg-100mg Tablet Immediate-Release, 25mg-100mg Tablet Immediate-Release, 25mg-250mg Tablet Immediate-Release), Carbidopa/Levodopa ER (25mg-100mg Tablet Extended-Release, 50mg-200mg Tablet Extended-Release), Carbidopa/Levodopa ODT (10mg-100mg Tablet Dispersible, 25mg-100mg Tablet Dispersible, 25mg-250mg Tablet Dispersible), T1

Carboplatin (Injection), T2

Carvedilol (Tablet), T1

Cayston (Inhalation Solution), T4

Cefdinir (300mg Capsule, 125mg/5ml Suspension, 250mg/5ml Suspension), T2

Cefuroxime Axetil (Tablet), T1

Celecoxib (Capsule), T3

Cephalexin (250mg Capsule, 500mg Capsule, 750mg Capsule, 125mg/5ml Suspension, 250mg/5ml Suspension), T1

Chantix (Tablet), T3

Chlorhexidine Gluconate Oral Rinse (Solution), T1

Chlorthalidone (Tablet), T1

Cilostazol (Tablet), T1

Cimetidine (Oral Solution, Tablet), T1

Cinryze (Injection), T4

Ciprodex (Otic Suspension), T2

Ciprofloxacin HCl (Tablet Immediate-Release), T1

Citalopram Hydrobromide (Tablet), T1

Clindamycin HCl (Capsule Immediate-Release, Oral Solution), T1

Clonazepam (Tablet Immediate-Release), T1

Clonazepam ODT (Tablet Dispersible), T3

Clonidine HCl (Tablet Immediate-Release), T1

Clopidogrel (75mg Tablet), T1

Clozapine (Tablet Immediate-Release), T2

Clozapine ODT (Tablet Dispersible), T2

Colchicine (0.6mg Tablet) (Generic Colcrys), T2

Combigan (Ophthalmic Solution), T2

Combivent Respimat (Aerosol Solution), T2

Comtan (Tablet), T3

Copaxone (Injection), T4

Creon (Capsule Delayed-Release), T2

Crestor (Tablet), T2

Cromolyn Sodium (Ophthalmic Solution), T1

Cyclophosphamide (Capsule), T3

Cyproheptadine HCl (4mg Tablet), T3

D

Daliresp (Tablet), T3

Dapsone (Tablet), T2

Desmopressin Acetate (Tablet), T2

Dextroamphetamine Sulfate (Tablet Immediate-Release), Dextroamphetamine Sulfate ER (Capsule Extended-Release), T3

Dextrose 5%/NaCl (Injection), T2

Diazepam (1mg/ml Oral Solution), T1

Diazepam (Tablet Immediate-Release), Diazepam Intensol (5mg/ml Concentrate), T1

Diclofenac Potassium (Tablet), T1

Diclofenac Sodium DR (25mg Tablet Delayed-Release, 50mg Tablet Delayed-Release, 75mg Tablet Delayed-Release), Diclofenac Sodium ER (100mg Tablet Extended-Release 24 Hour), T1

Dicyclomine HCl (10mg Capsule, 20mg Tablet), T1

Digoxin (125mcg Tablet), T3

Digoxin (250mcg Tablet), T3

Dihydroergotamine Mesylate (Injection), T2

Diltiazem HCl (Tablet Immediate-Release), Diltiazem HCl ER (240mg Capsule Extended-Release, 300mg Capsule Extended-Release) (Generic Cardizem CD), (360mg Capsule Extended-Release) (Generic Tiazac), T1

Diphenoxylate/atropine (Tablet), T3

Disulfiram (Tablet), T2

Divalproex Sodium (125mg Capsule Sprinkle), Divalproex Sodium DR (125mg Tablet Delayed-Release, 250mg Tablet Delayed-Release, 500mg Tablet Delayed-Release), Divalproex Sodium ER (250mg Tablet Extended-Release 24 Hour, 500mg Tablet Extended-Release 24 Hour), T1

Donepezil HCl (10mg Tablet Immediate-Release, 23mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), Donepezil HCl ODT (10mg Tablet Dispersible, 5mg Tablet Dispersible), T1

Dorzolamide HCl/Timolol Maleate (Ophthalmic Solution), T1

Doxazosin Mesylate (Tablet), T1

Doxepin HCl (100mg Capsule, 10mg Capsule, 150mg Capsule, 25mg Capsule, 50mg Capsule, 75mg Capsule, 10mg/ml Concentrate), T3

Doxycycline Hyclate (Capsule Immediate-Release), T1

Dronabinol (10mg Capsule), T4

Dronabinol (2.5mg Capsule, 5mg Capsule), T3

Duloxetine HCl (Capsule Delayed-Release), T2

Durezol (Emulsion), T2

Dymista (Suspension), T3

E

Edarbi (Tablet), T3

Edarbyclor (Tablet), T3

Eliquis (Tablet), T2

Elmiron (Capsule), T3

Enalapril Maleate (Tablet), T1

Enalapril Maleate/ Hydrochlorothiazide (Tablet), T1

Enbrel (Injection), T4

Entacapone (Tablet), T3

Entecavir (Tablet), T4

EpiPen (Injection), T2

Eplerenone (Tablet), T2

Epzicom (Tablet), T4

Equetro (Capsule Extended-Release 12 Hour), T3

Erythromycin (Ophthalmic Ointment), T1

Erythromycin Base (Tablet), T3

Escitalopram Oxalate (Tablet), T1

Estradiol (0.5mg Tablet, 1mg Tablet, 2mg Tablet) (Generic Estrace), T3

Ethambutol HCl (Tablet), T2

Ethosuximide (250mg Capsule, 250mg/5ml Oral Solution), T2

Etoposide (Injection), T2

Exjade (Tablet Soluble), T4

F

Famotidine (Tablet), T1

Fareston (Tablet), T4

Farxiga (Tablet), T3

Fenofibrate (145mg Tablet, 48mg Tablet) (Generic Tricor), (160mg Tablet, 54mg Tablet) (Generic Lofibra), T1

Fentanyl (Patch 72 Hour), T3

Finasteride (5mg Tablet) (Generic Proscar), T1

Firazyr (Injection), T4

Flecainide Acetate (Tablet), T1

Flovent Diskus (Aerosol Powder), T2

Flovent HFA (Aerosol), T2

Fluconazole (Tablet), T1

Fluocinolone Acetonide (Otic Oil), T3

Fluphenazine HCl (Tablet), T1

Fluticasone Propionate (Suspension), T1

Furosemide (Tablet), T1

Fuzeon (Injection), T4

G

Gabapentin (100mg Capsule, 300mg Capsule, 400mg Capsule, 600mg Tablet, 800mg Tablet), T1

Gammagard Liquid (Injection), T4

Gemfibrozil (Tablet), T1

Gentamicin Sulfate (0.1% Cream, 0.1% Ointment, 0.3% Ophthalmic Ointment, 0.3% Ophthalmic Solution), T1

Gilenya (Capsule), T4

Gleevec (Tablet), T4

Glimepiride (Tablet), T1

Glipizide (10mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), Glipizide ER (10mg Tablet Extended-Release 24 Hour, 2.5mg Tablet Extended-Release 24 Hour, 5mg Tablet Extended-Release 24 Hour), T1

Glipizide/Metformin HCl (Tablet), T1

Glucagen Hypokit (Injection), T3
Glucagon Emergency Kit (Injection), T2

H

Haloperidol (Tablet), T1
Harvoni (Tablet), T4
Humalog Kwikpen (100unit/ml Injection), Humalog Mix 50/50 Kwikpen, Humalog Mix 75/25 Kwikpen, Humalog Mix 50/50 Vial, Humalog Mix 75/25 Vial, Humalog Vial (Injection), T2
Humira (Injection), T4
Humulin 70/30 Kwikpen, Humulin N Kwikpen, Humulin 70/30 Vial, Humulin N Vial, Humulin R Vial (Injection), Humulin R U-500 Vial (Concentrated Injection), T2
Hydralazine HCl (Tablet), T1
Hydrochlorothiazide (12.5mg Capsule, 12.5mg Tablet, 25mg Tablet, 50mg Tablet), T1
Hydrocodone/Acetaminophen (10mg-325mg Tablet, 2.5mg-325mg Tablet, 5mg-325mg Tablet, 7.5mg-325mg Tablet), T2
Hydromorphone HCl (Tablet Immediate-Release), T1
Hydroxychloroquine Sulfate (Tablet), T1
Hydroxyurea (Capsule), T1
Hydroxyzine HCl (10mg/5ml Oral Solution), T3

I

Ibandronate Sodium (Tablet), T2
Ibuprofen (100mg/5ml Suspension, 400mg Tablet, 600mg Tablet, 800mg Tablet), T1
Ilevro (Suspension), T2
Imiquimod (Cream), T3
Insulin Syringes, Needles, T2
Intelence (100mg Tablet, 200mg Tablet), T4
Invanz (Injection), T3
Invokamet (Tablet), T2
Invokana (Tablet), T2
Ipratropium Bromide (0.02% Inhalation Solution), T1
Ipratropium Bromide (0.03% Nasal Solution, 0.06% Nasal Solution), T1
Ipratropium Bromide/Albuterol Sulfate (Inhalation Solution), T1
Irbesartan (Tablet), T1
Irbesartan/Hydrochlorothiazide (Tablet), T1
Isentress (Tablet), T4
Isoniazid (Tablet), T2
Isosorbide Dinitrate (10mg Tablet Immediate-Release, 20mg Tablet Immediate-Release, 30mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), Isosorbide Dinitrate ER (40mg Tablet Extended-Release), T1
Isosorbide Mononitrate (10mg Tablet Immediate-Release, 20mg Tablet Immediate-Release), Isosorbide Mononitrate ER (120mg Tablet Extended-Release 24 Hour, 30mg Tablet Extended-Release 24 Hour, 60mg Tablet Extended-Release 24 Hour), T1
Ivermectin (Tablet), T2

J

Janumet (50mg-1000mg Tablet Immediate-Release, 50mg-500mg Tablet Immediate-Release), Janumet XR (100mg-1000mg Tablet Extended-Release 24 Hour, 50mg-1000mg Tablet Extended-Release 24 Hour, 50mg-500mg Tablet Extended-Release 24 Hour), T2
Januvia (Tablet), T2
Jardiance (Tablet), T2
Jentadueto (Tablet), T3

K

Kalydeco (Packet), T4
Kazano (Tablet), T3
Ketoconazole (2% Cream, 2% Shampoo, 200mg Tablet), T1
Ketorolac Tromethamine (Ophthalmic Solution), T2
Kionex (Powder), T2
Klor-Con 8 (Tablet Extended-Release), Klor-Con 10 (Tablet Extended-Release), T2
Klor-con M20 (Tablet Extended-Release), T1

Kombiglyze XR (Tablet Extended-Release 24 Hour), T2
Korlym (Tablet), T4

L

Labetalol HCl (Tablet), T1
Lactulose (Oral Solution), T1
Lamivudine (Tablet), T2
Lamotrigine (Tablet Immediate-Release), T1
Lamotrigine ODT (Tablet Dispersible), T3
Lantus Solostar (Injection), Lantus Vial (Injection), T2
Lastacaft (Ophthalmic Solution), T2
Latanoprost (Ophthalmic Solution), T1
Latuda (Tablet), T4
Leflunomide (Tablet), T1
Letrozole (Tablet), T1
Leucovorin Calcium (Tablet), T2
Leukeran (Tablet), T2
Levemir FlexTouch (Injection), Levemir Vial (Injection), T2
Levetiracetam (Tablet Immediate-Release), T1
Levocarnitine (Tablet), T2
Levocetirizine Dihydrochloride (Tablet), T1
Levofloxacin (Tablet), T1
Levothyroxine Sodium (Tablet), T1
Lialda (Tablet Delayed-Release), T2
Lidocaine (Gel, Ointment, 2% Viscous Solution), T2
Lidocaine/Prilocaine (Cream), T2
Lindane (1% Lotion, 1% Shampoo), T3
Linzess (Capsule), T2
Liothyronine Sodium (Tablet), T1
Lisinopril (Tablet), T1
Lisinopril/Hydrochlorothiazide (Tablet), T1
Lithium Carbonate (150mg Capsule Immediate-Release, 300mg Capsule Immediate-Release, 600mg Capsule Immediate-Release, 300mg Tablet Immediate-Release), Lithium Carbonate ER (300mg Tablet Extended-Release, 450mg Tablet Extended-Release), T1
Loperamide HCl (Capsule), T1
Lorazepam (0.5mg Tablet Immediate-Release, 1mg Tablet Immediate-Release, 2mg Tablet Immediate-Release), Lorazepam Intensol (2mg/ml Concentrate), T1
Losartan Potassium (Tablet), T1
Losartan Potassium/ Hydrochlorothiazide (Tablet), T1
Lotemax (0.5% Gel, 0.5% Ointment, 0.5% Suspension), T3
Lovastatin (Tablet), T1
Lumigan (Ophthalmic Solution), T2
Lupron Depot (Injection), Lupron Depot-PED (Injection), T4
Lyrica (Capsule), T2
Lysodren (Tablet), T4

M

Medroxyprogesterone Acetate (Tablet), T1
Meloxicam (Tablet), T1
Mercaptopurine (Tablet), T2
Meropenem (Injection), T2
Metformin HCl (1000mg Tablet Immediate-Release, 500mg Tablet Immediate-Release, 850mg Tablet Immediate-Release), Metformin HCl ER (500mg Tablet Extended-Release 24 Hour, 750mg Tablet Extended-Release 24 Hour) (Generic Glucophage XR), Metformin HCl ER (1000mg Tablet Extended-Release 24 Hour) (Generic Fortamet), T1
Methadone HCl (10mg/5ml Oral Solution, 5mg/5ml Oral Solution, 10mg Tablet, 5mg Tablet), T2
Methimazole (Tablet), T1
Methotrexate (Tablet), T1
Methscopolamine Bromide (Tablet), T3
Methyldopa (Tablet), T3
Methylphenidate HCl (Tablet Immediate-Release) (Generic Ritalin), T2
Methylprednisolone Dose Pack (Tablet), T1
Metoclopramide HCl (Tablet), T1
Metolazone (Tablet), T2
Metoprolol Succinate ER (Tablet Extended-Release 24 Hour), T1
Metoprolol Tartrate (Tablet Immediate-Release), T1
Metronidazole (Tablet Immediate-Release), T2
Midodrine HCl (Tablet), T2

Migergot (Suppository), T2
Minocycline HCl (Capsule Immediate-Release), T1
Minoxidil (Tablet), T1
Mirtazapine (15mg Tablet Immediate-Release, 30mg Tablet Immediate-Release, 45mg Tablet Immediate-Release, 7.5mg Tablet Immediate-Release), Mirtazapine ODT (15mg Tablet Dispersible, 30mg Tablet Dispersible, 45mg Tablet Dispersible), T1
Modafinil (Tablet), T3
Montelukast Sodium (4mg Packet, 10mg Tablet, 4mg Tablet Chewable, 5mg Tablet Chewable), T1
Morphine Sulfate ER (Tablet Extended-Release) (Generic MS Contin), T2
Multaq (Tablet), T2
Mupirocin (Ointment), T1
Myrbetriq (Tablet Extended-Release 24 Hour), T2

N

Naltrexone HCl (Tablet), T2
Namenda (10mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), T3
Namenda (10mg/5ml Oral Solution), Namenda XR (Capsule Extended-Release 24 Hour), T2
Naproxen (Tablet Immediate-Release), T1
Nasonex (Suspension), T3
Neomycin/Polymyxin/Hydrocortisone (Otic Solution, Otic Suspension), T2
Nesina (Tablet), T3
Nevanac (Suspension), T2
Niacin ER (Tablet Extended-Release), T2
Nicotrol Inhaler, T3
Nitrofurantoin Macrocrystals (50mg Capsule) (Generic Macrodantin), T3
Nitrofurantoin Monohydrate (100mg Capsule) (Generic Macrobid), T3
Nitrostat (Tablet Sublingual), T2
Norethindrone Acetate (Tablet), T1
Nortriptyline HCl (10mg Capsule, 25mg Capsule, 50mg Capsule, 75mg Capsule, 10mg/5ml Oral Solution), T1
Norvir (100mg Capsule, 80mg/ml Oral Solution, 100mg Tablet), T3
Nuedexta (Capsule), T3
Nutropin AQ (Injection), T4
Nuvigil (Tablet), T3
Nystatin (Cream, Ointment, Oral Suspension, Topical Powder), T1
Nystop (Powder), T1

O

Olanzapine (Tablet Immediate-Release), T1
Omega-3-Acid Ethyl Esters (Capsule) (Generic Lovaza), T3
Omeprazole (10mg Capsule Delayed-Release, 40mg Capsule Delayed-Release), T1
Omeprazole (20mg Capsule Delayed-Release), T1
Ondansetron (24mg Tablet Immediate-Release, 4mg Tablet Immediate-Release, 8mg Tablet Immediate-Release), Ondansetron ODT (4mg Tablet Dispersible, 8mg Tablet Dispersible), T1
Onglyza (Tablet), T2
Opana ER (Crush Resistant) (Tablet Extended-Release 12 Hour Abuse-Deterrent), T2
Opsumit (Tablet), T4
Orenitram (0.125mg Tablet Extended-Release), T3
Orenitram (0.25mg Tablet Extended-Release, 1mg Tablet Extended-Release), T4
Orenitram (2.5mg Tablet Extended-Release), T4
Oseni (Tablet), T3
Oxcarbazepine (Tablet), T2
Oxybutynin Chloride (5mg/5ml Syrup, 5mg Tablet), T1
Oxybutynin Chloride ER (Tablet Extended-Release 24 Hour), T2
Oxycodone HCl (Tablet Immediate-Release), T1
Oxycodone/Acetaminophen (10mg-325mg Tablet, 2.5mg-325mg Tablet, 5mg-325mg Tablet, 7.5mg-325mg Tablet), T2

P

Pantoprazole Sodium (Tablet Delayed-Release), T1
Pataday (Ophthalmic Solution), T2
Pegasys (Injection), T4
Penicillin V Potassium (Tablet), T1

T1 = Tier 1 T2 = Tier 2 T3 = Tier 3 T4 = Tier 4

Perforomist (Nebulized Solution), T3
Periogard (Solution), T1
Permethrin (Cream), T2
Phenytoin Sodium Extended (Capsule), T1
Pilocarpine HCl (Tablet), T2
Pioglitazone HCl (Tablet), T1
Pioglitazone HCl/Glimepiride (Tablet), T1
Pioglitazone HCl/Metformin HCl (Tablet), T1
Polyethylene Glycol 3350 (Powder) (Generic Miralax), T1
Pomalyst (Capsule), T4
Potassium Chloride ER (10meq Capsule Extended-Release, 8meq Capsule Extended-Release, 8meq Tablet Extended-Release), T2
Potassium Chloride ER (10meq Tablet Extended-Release, 20meq Tablet Extended-Release), T1
Potassium Citrate ER (Tablet Extended-Release), T2
Potiga (Tablet), T4
Pradaxa (Capsule), T2
Pramipexole Dihydrochloride (Tablet Immediate-Release), T2
Pravastatin Sodium (Tablet), T1
Prazosin HCl (Capsule), T1
Prednisolone Acetate (Suspension), T2
Prednisone (5mg/5ml Oral Solution, 10mg Tablet, 1mg Tablet, 2.5mg Tablet, 20mg Tablet, 50mg Tablet, 5mg Tablet), Prednisone Intensol (5mg/ml Concentrate), T1
Premarin (Vaginal Cream), T2
Prezista (100mg/ml Suspension, 150mg Tablet, 600mg Tablet, 800mg Tablet), T4
Pristiq (Tablet Extended-Release 24 Hour), T3
ProAir HFA (Aerosol Solution), ProAir RespiClick (Aerosol Powder), T2
Procrit (10000unit/ml Injection, 2000unit/ml Injection, 3000unit/ml Injection, 4000unit/ml Injection), T3
Procrit (20000unit/ml Injection, 40000unit/ml Injection), T4
Proctosol HC (Cream), T1
Proctozone-HC (Cream), T1
Progesterone (Capsule), T1
Prolensa (Ophthalmic Solution), T3
Promethazine HCl (12.5mg Tablet, 25mg Tablet, 50mg Tablet), T3
Propranolol HCl (10mg Tablet Immediate-Release, 20mg Tablet Immediate-Release, 40mg Tablet Immediate-Release, 60mg Tablet Immediate-Release, 80mg Tablet Immediate-Release), Propranolol HCl ER (120mg Capsule Extended-Release 24 Hour, 160mg Capsule Extended-Release 24 Hour, 60mg Capsule Extended-Release 24 Hour, 80mg Capsule Extended-Release 24 Hour), T1
Propylthiouracil (Tablet), T1
Pulmicort Flexhaler (Aerosol Powder), T3
Pyridostigmine Bromide (Tablet), T1

Q

Quetiapine Fumarate (Tablet Immediate-Release), T1
Quinapril HCl (Tablet), T1
Quinapril/Hydrochlorothiazide (Tablet), T1

R

Raloxifene HCl (Tablet), T2
Ramipril (Capsule), T1
Ranexa (Tablet Extended-Release 12 Hour), T2
Ranitidine HCl (Tablet), T1
Rapaflo (Capsule), T2
Rebif (Injection), T4
Renagel (Tablet), T2
Renvela (800mg Tablet), T2
Restasis (Emulsion), T2
Revlimid (Capsule), T4
Reyataz (150mg Capsule, 200mg Capsule, 300mg Capsule, 50mg Packet), T4
Ribavirin (200mg Capsule), T2
Ribavirin (200mg Tablet), T3
Rifabutin (Capsule), T3
Rifampin (Capsule), T2
Riluzole (Tablet), T2
Rimantadine HCl (Tablet), T2
Risperidone (Tablet), T1
Rituxan (Injection), T4
Rivastigmine Tartrate (Capsule Immediate-Release), T2
Rizatriptan Benzoate (10mg Tablet Immediate-Release, 5mg Tablet Immediate-Release), T2

Rizatriptan Benzoate ODT (10mg Tablet Dispersible, 5mg Tablet Dispersible), T3
Ropinirole HCl (Tablet Immediate-Release), T1
Rozerem (Tablet), T3

S

Santyl (Ointment), T3
Saphris (Tablet Sublingual), T3
Savella (Tablet), T2
Selegiline HCl (5mg Capsule, 5mg Tablet), T2
Selzentry (Tablet), T4
Sensipar (30mg Tablet), T2
Sensipar (60mg Tablet, 90mg Tablet), T4
Serevent Diskus (Aerosol Powder), T2
Seroquel XR (Tablet Extended-Release 24 Hour), T2
Sertraline HCl (Tablet), T1
Sildenafil (Tablet), T2
Silver Sulfadiazine (Cream), T2
Simvastatin (Tablet), T1
Sodium Fluoride (Tablet), T1
Sodium Polystyrene Sulfonate (Suspension), T2
Sotalol HCl (Tablet), Sotalol HCl AF (Tablet), T1
Sovaldi (Tablet), T4
Spiriva Handihaler (18mcg Capsule), Spiriva Respimat (2.5mcg/ACT Aerosol Solution), T2
Spironolactone (Tablet), T1
Strattera (Capsule), T3
Suboxone (Film), T3
Sucralfate (Tablet), T1
Sulfamethoxazole/ Trimethoprim (Tablet), Sulfamethoxazole/ Trimethoprim DS (Tablet), T1
Sulfasalazine (Tablet Immediate-Release), T1
Sulfazine EC (Tablet Delayed-Release), T1
Sumatriptan Succinate (Tablet), T2
Suprax (100mg/5ml Suspension, 200mg/5ml Suspension, 100mg Tablet Chewable, 200mg Tablet Chewable), T2
Suprax (400mg Capsule, 500mg/5ml Suspension), T2
Symbicort (Aerosol), T2
Symlinpen 120 (Injection), T4
Symlinpen 60 (Injection), T3
Synthroid (Tablet), T2

T

Tamiflu (30mg Capsule, 45mg Capsule, 75mg Capsule, 6mg/ml Suspension), T3
Tamoxifen Citrate (Tablet), T1
Tamsulosin HCl (Capsule), T1
Tarceva (Tablet), T4
Targretin (75mg Capsule, 1% Gel), T4
Tasigna (Capsule), T4
Tecfidera (Capsule Delayed-Release), T4
Telmisartan (Tablet), T1
Telmisartan/ Hydrochlorothiazide (Tablet), T1
Terazosin HCl (Capsule), T1
Terbinafine HCl (Tablet), T1
Testosterone Cypionate (Injection), T2
Theophylline (80mg/15ml Oral Solution), Theophylline CR (100mg Tablet Extended-Release, 200mg Tablet Extended-Release), Theophylline ER (300mg Tablet Extended-Release 12 Hour, 450mg Tablet Extended-Release 12 Hour, 400mg Tablet Extended-Release 24 Hour, 600mg Tablet Extended-Release 24 Hour), T1
Thymoglobulin (Injection), T4
Timolol Maleate (Ophthalmic Solution), T1
Tivicay (Tablet), T4
Tizanidine HCl (Tablet), T1
Tobramycin Sulfate (Ophthalmic Solution), T1
Tobramycin/Dexamethasone (Ophthalmic Suspension), T2
Topiramate (Tablet Immediate-Release), T1
Topotecan HCl (Injection), T4
Torsemide (Tablet), T1
Tracleer (Tablet), T4
Tradjenta (Tablet), T3
Tramadol HCl (Tablet Immediate-Release), T1
Tramadol HCl/ Acetaminophen (Tablet), T1
Tranexamic Acid (100mg/ml Injection, 650mg Tablet), T2
Transderm-Scop (Patch 72 Hour), T3
Travatan Z (Ophthalmic Solution), T2
Trazodone HCl (Tablet), T1
Tretinoin (Capsule), T4

Triamcinolone Acetonide (0.025% Cream, 0.1% Cream, 0.5% Cream, 0.025% Ointment, 0.1% Ointment, 0.5% Ointment), T2
Triamcinolone in Orabase (Paste), T2
Triamterene/ Hydrochlorothiazide (37.5mg-25mg Capsule, 50mg-25mg Capsule, 37.5mg-25mg Tablet, 75mg-50mg Tablet), T1
Tribenzor (Tablet), T2
Trihexyphenidyl HCl (Elixir), T3
Trulicity (Injection), T2
Truvada (Tablet), T4

U

Uloric (Tablet), T2
Ursodiol (300mg Capsule, 250mg Tablet, 500mg Tablet), T3

V

Valacyclovir HCl (Tablet), T2
Valganciclovir (Tablet), T4
Valsartan (Tablet), T1
Valsartan/ Hydrochlorothiazide (Tablet), T1
Verapamil HCl (120mg Tablet Immediate-Release, 40mg Tablet Immediate-Release, 80mg Tablet Immediate-Release), Verapamil HCl ER (120mg Tablet Extended-Release, 180mg Tablet Extended-Release, 240mg Tablet Extended-Release), T1
Versacloz (Suspension), T4
Vesicare (Tablet), T2
Victoza (Injection), T2
Virazole (Inhalation Solution), T4
Viread (40mg/gm Powder, 150mg Tablet, 200mg Tablet, 250mg Tablet, 300mg Tablet), T4
Voltaren (Gel), T3
Vytorin (Tablet), T3
Vyvanse (Capsule), T3

W

Warfarin Sodium (Tablet), T1
Welchol (3.75gm Packet, 625mg Tablet), T2

X

Xarelto (Tablet), T2
Xolair (Injection), T4

Z

Zafirlukast (Tablet), T2
Zenpep (Capsule Delayed-Release), T2
Zetia (Tablet), T2
Zirgan (Gel), T3
Zolpidem Tartrate (Tablet Immediate-Release), T3
Zonisamide (Capsule), T1
Zostavax (Injection), T3
Zytiga (Tablet), T4

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Additional DRUG COVERAGE

Bonus Drug List

Your plan sponsor (employer, union or trust) offers a bonus drug list. The prescription drugs in this list are covered in addition to the drugs in the plan's formulary (drug list).

The cost tier for each prescription drug is shown in the list.

Although you pay the same co-pay or co-insurance for these drugs as shown in your Summary of Benefits and Evidence of Coverage, the amounts you pay for these additional prescription drugs **do not apply to your Medicare Part D out-of-pocket costs**. Payments for these additional prescription drugs (made by you or the plan) are treated differently from payments made for other prescription drugs.

Coverage for the prescription drugs in the bonus drug list is in addition to your Part D drug coverage. Unlike your Part D drug coverage, you are unable to file an appeal or grievance for drugs in the bonus drug list. If you have questions, please contact Customer Service using the information on the cover of this book.

If you get Extra Help from Medicare to pay for your prescription drugs, it will not apply to the drugs in this bonus drug list.

This is not a complete list of the prescription drugs available to you or the restrictions and limitations that may apply through the bonus drug list. For a complete list, please contact Customer Service using the information on the cover of this book.

Drug	Tier	Quantity Limits
Analgesics - drugs to treat pain, inflammation, and muscle and joint conditions		
Inflammation		
Choline & Magnesium Salicylates	1	
Salsalate	1	
Urinary Tract Pain		
Phenazopyridine	1	
Anesthetics - drugs for numbing		
Lidocaine Cream 3%	1	
Central nervous system agents - anxiolytics, sedatives, hypnotics		
Weight Loss		

Bold type = Brand name drug Plain type = Generic drug

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Drug	Tier	Quantity Limits
Phentermine	1	Maximum of 1 per day
Dermatological agents - drugs to treat skin conditions		
Sulfacetamide Sodium	1	
Dry Skin		
Urea 40% Cream	1	
Fungal Infections		
Alcortin A	3	
Gastrointestinal agents - drugs to treat bowel, intestine and stomach conditions		
Irritable Bowel		
Clidinium & Chlordiazepoxide	1	
Hyoscyamine Sulfate	1	
Levbid	3	
Irritable Bowel or Ulcers		
Donnatal	3	
Hemorrhoids		
Analpram-HC	3	
Hydrocortisone Acetate Suppository	1	
Lidocaine/Hydrocortisone Acetate	1	
Pramoxine/Hydrocortisone	1	
Genitourinary agents - drugs to treat bladder, genital and kidney conditions		
Erectile Dysfunction		
Cialis (10 mg, 20 mg)	3	Maximum of 6 tablets per 30 days
Edex	3	Maximum of 6 cartridges per 30 days
Levitra	3	Maximum of 6 tablets per 30 days
Viagra	3	Maximum of 6 tablets per 30 days
Urinary Tract Infection		

Bold type = Brand name drug Plain type = Generic drug

Drug	Tier	Quantity Limits
Urogesic Blue	3	
Ustell	1	
Hormonal agents - hormone replacement/modifying drugs		
Thyroid Supplement		
Armour Thyroid	3	
Nutritional supplements - drugs to treat vitamin & mineral deficiencies		
Cyanocobalamin (Vitamin B12) Injection	1	
Folgard Rx	3	
Folic Acid (Rx only)	1	
Mephyton	3	
Nephrocaps	3	
NephPlex Rx	3	
Rena-Vite Rx	1	
Renal Cap	1	
Vitamin D (Rx only)	1	
Zinc Sulfate	1	
Potassium Supplement		
Potassium Bicarbonate & Chloride Effervescent Tablet	1	
Otic agents - drugs to treat ear conditions		
Ear Pain		
Antipyrine/Benzocaine Otic Solution	1	
Respiratory tract agents - drugs to treat allergies, cough, cold and lung conditions		
Cough and Cold		
Benzonatate	1	
Bromfed DM Syrup	1	
Cheratussin AC	1	

Bold type = Brand name drug Plain type = Generic drug

Drug	Tier	Quantity Limits
Hydrocodone Polyst/Chlorphen CR Susp (generic for Tussionex)	1	
Hydrocodone/Homatropine	1	
Promethazine/Codeine Syrup	1	
Promethazine/Dextromethorphan Syrup	1	

Bold type = Brand name drug Plain type = Generic drug

The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan. Limitations, co-payments, and restrictions may apply.

Benefits, formulary, pharmacy network, provider network, premium and/or co-payments/co-insurance may change from time to time during each plan year. You will receive notice when necessary.

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in plan depends on the plan's contract renewal with Medicare.

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What's NEXT

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Here's what you can expect next

1 **UnitedHealthcare® will process your enrollment.**
And if there are any questions or we need additional information, we will be in touch.

2 **You will receive your member ID card.**
You will want to put this in your wallet to start using it as soon as your plan is effective. You may not need to use your red, white and blue Medicare card very often so be sure to put that somewhere safe.

3 **Review your Getting Started Guide and Plan Details.**
Once you're enrolled in the plan, you will receive a Getting Started Guide and Plan Details that give you more information on how your benefits work and how to get the most out of your plan.

4 **We'll give you a call.**
Soon after your enrollment, you will receive a call from us asking you to complete a short health survey. Medicare requires us to ask these questions, but you don't have to complete the survey. Your answers will help us connect you to additional programs and services that may better fit your needs.

5 **After your effective date, register online at the website listed below.**
Get easy, convenient access to all your plan information.

Give us a call if you have any questions.

We are always ready to help you but it may save time if you have some information handy when you call. Be sure to let the Customer Service representative know that you are calling about a group-sponsored plan. In addition, it is helpful to have:

- Your group number on the front of this book
- Medicare claim number and Medicare effective date — you can find this on your red, white and blue Medicare card
- Names and addresses for doctors, specialists, hospitals and your pharmacy
- List of current prescription drugs and dosages

Give us a call if you have any questions.

Toll-Free **1-877-714-0178,** TTY **711** 8 a.m. to 8 p.m. local time, 7 days a week

Learn more online at **www.UHCRetiree.com**

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Statements of Understanding

By electing enrollment in this plan, I agree to the following:

This is a Medicare Advantage plan and has a contract with the Federal government. This is not a Medicare Supplement plan. I need to keep my Medicare Part A and Part B, and I must continue to pay my Medicare Part B premium and, if applicable, Part A premiums, if not otherwise paid for by Medicaid or another third party. I understand I can be in only one Medicare Advantage or Prescription Drug plan at a time. My enrollment in this plan will automatically end my enrollment in another Medicare health plan. If I have prescription drug coverage, or if I get prescription drug coverage from somewhere other than this plan, I will inform you.

Enrollment in this plan is generally for the entire plan year. I may leave this plan only at certain times of the year or under special conditions.

If I choose to disenroll from this plan, which is sponsored by my former employer, union or trust group plan sponsor, I will be automatically transferred to Original Medicare. Also, if I choose to enroll in a different Medicare Advantage plan not offered by my plan sponsor, I will be automatically disenrolled from this plan provided through my plan sponsor.

This plan covers a specific service area. If I plan to move out of the area, I will call my plan sponsor or this plan to disenroll and get help finding a new plan in my area. I may not be covered under Medicare while out of the country, with the exception of limited coverage near the U.S. border. However, under this plan, when I am outside of the United States I am covered for emergency or urgently needed care. I have the right to appeal plan decisions about payment or services if I do not agree.

Upon enrollment, I will receive a Plan Details book that includes an Evidence of Coverage document. The Evidence of Coverage will have more information about services covered by this plan, as well as the terms and conditions. If a service is not listed in the Evidence of Coverage, it will not be paid for by Medicare or this plan without authorization.

My information, including my prescription drug event data, will be released to Medicare and other plans, only as necessary, for treatment, payment and healthcare operations. Medicare may also release my information for research and other purposes which follow all applicable Federal statutes and regulations.

If I do not have prescription drug coverage, I may have to pay a late enrollment penalty for Medicare's prescription drug coverage. This would apply if I did not sign up for and maintain creditable prescription drug coverage when I first became eligible for Medicare. If I have a late enrollment penalty from Medicare, I will receive a letter making me aware of the penalty and what the next steps are.

For members of the UnitedHealthcare® Group Medicare Advantage (HMO) plan only

I understand that beginning on the date my UnitedHealthcare Group Medicare Advantage (HMO) coverage begins; I must get all of my health care from UnitedHealthcare Group Medicare Advantage (HMO), except for emergency or urgently needed services or out-of-area dialysis services.

UnitedHealthcare®

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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UnitedHealthcare®

Give us a call if you have any questions:

1-877-714-0178, TTY **711**
8 a.m. to 8 p.m. local time, 7 days a week

www.UHCRetiree.com

Plans are insured through UnitedHealthcare Insurance Company or one of its affiliated companies, a Medicare Advantage organization with a Medicare contract and a Medicare-approved Part D sponsor. Enrollment in the plan depends on the plan's contract renewal with Medicare.

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This is an advertisement.
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Pinellas County PURCHASING

Joe Lauro, CPPO/CPPB
Director

March 21, 2015

TO:	ALL INTERESTED BIDDERS
INVITATION TO BID:	PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS
BID NUMBER:	156-0174-P(JA)
PHASE II BID SUMITTAL DATE:	April 19, 2016 @ 3:00 p.m. EST

ADDENDUM NO. 2

Following is additional information, clarifications, questions or responses relative to referenced Request for Proposal (RFP):

The following Proposers have met the prequalification requirements to submit their Proposal, per the requirements in Section B, #3 on page 9 of 52, and Section E, Paragraph D. Phase II – Scope of Work, page 19 of 52, of the Request for Proposal, in alphabetical order.

1. Aetna Life Insurance Company
2. Cigna Health and Life Insurance Company
3. Blue Cross and Blue Shield of FL D/B/A Florida Blue
4. Humana Insurance Company
5. United Healthcare Services, Inc.

In addition to the items that must be returned to the County, as outlined on page 21 of 52, Proposers are directed to the following online proposal questionnaire that must be completed as part of the Proposal, due at the same date and time as the hard copy submittal:

http://www.proposaltech.com/

Phase II Bid submittals are due no later than 3:00 p.m. on April 19, 2016 at 3:00 p.m. EST.

Sincerely,

Joe Lauro

Joseph Lauro, CPPO/CPPB
Director of Purchasing

PLEASE ADDRESS REPLY TO:
400 South Ft. Harrison, Sixth Floor
Clearwater, Florida 33756
Phone: (727) 464-3311
FAX: (727) 464-3925
Website: www.pinellascounty.org/purchase

Joe Lauro, CPPO/CPPB
Director

March 3, 2016

TO: ALL INTERESTED BIDDERS

REQUEST FOR PROPOSAL: PERSONNEL SERVICES - GROUP MEDICAL BENEFITS

PROPOSAL NUMBER: 156-0174-P(JA)

RFP SUBMITTAL DATE: Pre-qualification Portion due: March 8, 2016 at 3:00 P.M.

ADDENDUM NO. 1

Following is additional information, clarifications, questions or responses relative to referenced Bid (ITB):

QUESTIONS/ANSWERS:

1. **Question: To ensure we are including everything that is needed for Phase I, please confirm that the list below is accurate. If anything else is required of Phase I, please list.**

   Answer: Per the Request for Proposal, Section E – Scope of Work, page 21 of 52, the chart shown therein indicates the list of all submittals required for Phase I.

2. **Question: Please confirm the naming convention of this group is "Pinellas County Board of County Commissioners" or "the County". If different, please list.**

   Answer: The naming convention of this group is "Pinellas County Unified Personnel System" or "County."

3. **Question: "…request clarification of the submission requirements for Phase I. Will the Phase I questionnaire require submission of: 1 original, 1 copy, and 6 USBs/CDs?"**

   Answer: Per the Request for Proposal, Section B – Special Conditions, page 11 of 52, all requested documentation required to be submitted for Phase I shall be submitted in one (1) original paper document, one (1) paper copy, and six (6) electronic media copies.

4. **Question: Regarding Phase I – Pre-qualification Questionnaire, #8 – If proposer does not currently participate in the UDDA initiative, but does submit discount data to a recognized third party entity focused on evaluating vendors' health plan network discounts, will the Pinellas County Unified Personnel System and its representatives consider accepting such third party validation?**

PLEASE ADDRESS REPLY TO:
400 South Ft. Harrison, Sixth Floor
Clearwater, Florida 33756
Phone: (727) 464-3311
FAX: (727) 464-3925
Website: www.pinellascounty.org/purchase

Answer: Yes, acceptance will be considered if the proposer does not currently participate in the UDDA initiative.

5. **Question: Regarding Phase I – Prequalification Questionnaire, #9 – If proposer's actuarially approved network discount data is submitted to a recognized third party entity for evaluation, will Towers Watson actuaries be willing to accept and review such data, and the Pinellas County Unified Personnel System consider accepting such third party validation?**

   Answer: Yes, acceptance will be considered. If selected to move forward to Phase II, Towers Watson personnel will coordinate with the proposer(s) for submission of data to provide discount analysis to the County.

6. **Question: Insurance – Proposal submittals should include, the Proposer's current Certificate(s) of Insurance in accordance with the insurance requirements listed below. If Proposer does not currently meet insurance requirements, proposer/bidder/quoter shall also include verification from their broker or agent that any required insurance not provided at that time of submittal will be in place within 10 days after award recommendation. Do we need to submit the certificates with Phase I?**

   Answer: Insurance certificates will not be a required submittal for Phase I.

7. **Question: How important is minority vendor spending?**

   Answer: Minority vendor spending is not part of the criteria used in this RFP.

8. **Question: On page 17, in the Background section there is a group referred to as "The UPS". Can you please confirm who or what the UPS is? If this is a typo, please confirm the background information applies to the County.**

   Answer: The UPS is the acronym for the Pinellas County Unified Personnel System.

9. **Question: Is this RFP open to broker services to facilitate the marketing and administration of medical benefits? Or are you specifically looking for a medical carrier to work with your current agent/broker? If you are open to broker bids, please clarify if the answers to Section C of Phase I should be answered from the perspective of available medical carriers we currently work with and/or if answered no from the broker perspective would eliminate us from Phase I consideration.**

   Answer: No. This RFP is for medical administration services, not broker services.

10. **Question: If alternate plans are quoted, will the group need to see dollar values?**

11. **Question: Item #3 in Section B – Special Conditions states, "The County's health and welfare consultant will be calculating the costs to determine the Compensation rating." Please provide additional information on what exactly the "compensation rating" is.**

12. **Question: Does the County currently have a wellness fund in place? Communication fund? Integration funds? If so, can you provide information on how much dollars are set aside for each? Also, what services or purposes these funds are used for?**

13. **Question: The RFP references claims data analysis can you please provide additional information on who provides this services and integration currently in place?**

14. **Question: The RFP asks for an onsite representative and an onsite coach. Will these individuals be working directly with Human Resources or in the onsite clinic?**

15. **Question: Can you please provide additional information on current onsite offering? Is there an onsite clinic currently in place? If not, when is it anticipated? Is this where the requested registered nurse will be used or an additional registered nurse being requested?**

16. **Question: Please provide additional information on integration of products.**

17. **Question: What is the cost for integrating with Truven? What kind is file is required?**

Answer: If selected to move forward to Phase II, please re-submit questions 10 through 17 during the Phase II question period.

All other specification conditions remain the same.

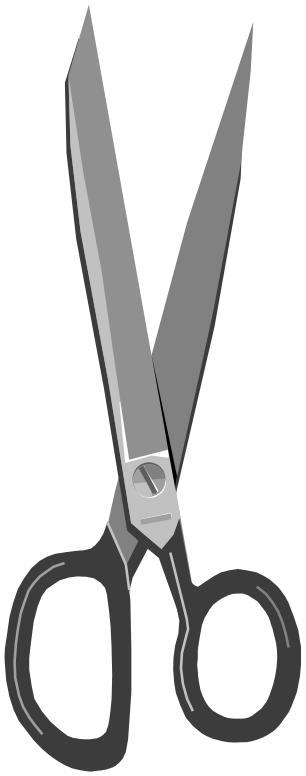
Please remember to acknowledge receipt of this Addendum in the RFP, Section G, Page 24 of 52 as Addendum No. 1 and return with completed bid packages.

Sincerely,

Joe Lauro

Director of Purchasing

Cut along the outer border and affix this label to your sealed proposal envelope to identify it as a "Sealed Proposal". Be sure to include the name of the company submitting the proposal where requested.



SEALED PROPOSAL • DO NOT OPEN

SEALED PROPOSAL NO.: **156-0174-P(JA)**

PROPOSAL TITLE: **PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS**

DUE DATE/TIME:

PHASE I – March 8, 2016 @ 3:00 p.m.

PHASE II – April 19, 2016 @ 3:00 p.m.

SUBMITTED BY: _____
(Name of Company)

DELIVER TO: PURCHASING DEPARTMENT
Board of County Commissioners
Annex Building –6th Floor
400 South Fort Harrison Avenue
Clearwater, FL 33756

Please Note:

From time to time, addenda may be issued to this proposal. Any such addenda will be posted on the same Web site, www.pinellascounty.org/purchase/Current_Bids1.htm, from which you obtained this proposal. Before submitting your proposal you should check the Web site to download any addenda that may have been issued. Please remember to sign and return Addenda Acknowledgement Form with completed proposal package if applicable.

SUBMIT TO:	REQUEST FOR PROPOSAL
PINELLAS COUNTY BOARD OF COUNTY COMMISSIONERS 400 S. FT. HARRISON AVENUE ANNEX BUILDING – 6TH FLOOR CLEARWATER, FL 33756	
ISSUE DATE: **February 24, 2016**	***PROPOSAL SUBMITTALS RECEIVED AFTER SUBMITTAL DATE & TIME WILL NOT BE CONSIDERED***
TITLE: **PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS**	RFP NUMBER: **156-0174-P(JA)**
SUBMITTAL DUE: **PHASE I – March 8, 2016 @3:00 P.M.** **PHASE II – April 19, 2016 @ 3:00 P.M.** ***AND MAY NOT BE WITHDRAWN FOR 120 DAYS FROM DATE LISTED ABOVE.***	PRE-PROPOSAL DATE & LOCATION: **NOT APPLICABLE**
DEADLINE FOR PHASE I WRITTEN QUESTIONS: March 2, 2016 by 3:00 P.M. **DEADLINE FOR PHASE II WRITTEN QUESTIONS: April 7, 2016 by 3:00 P.M.** **SUBMIT QUESTIONS TO: Jeanne Armstrong AT jarmstrong@pinellascounty.org** **Phone: 727/464-5323 Fax: 727/464-3925**	
THE MISSION OF PINELLAS COUNTY Pinellas County Government is committed to progressive public policy, superior public service, courteous public contact, judicious exercise of authority and sound management of public resources to meet the needs and concerns of our citizens today and tomorrow.	Joe Lauro Director of Purchasing

PROPOSER MUST COMPLETE THE FOLLOWING

NO CHANGES REQUESTED BY A PROPOSER WILL BE CONSIDERED AFTER THE RFP OPENING DATE AS ADVERTISED. BY SIGNING THIS PROPOSAL FORM YOU ARE ATTESTING TO YOUR AWARENESS OF THIS POLICY AND ARE AGREEING TO ALL OTHER PROPOSAL TERMS AND CONDITIONS, INCLUDING ALL INSURANCE REQUIREMENTS.

PROPOSER (COMPANY NAME): _____ **D/B/A** _____

MAILING ADDRESS: _____ **CITY / STATE / ZIP** _____

COMPANY EMAIL ADDRESS: _____

PHN: (__)_____ **FAX**: (__)_____

***REMIT TO NAME:** _____
(As Shown On Company Invoice)

_____**FEIN#**_____

CONTACT NAME: _____

Proper Corporate Identity is needed when you submit your proposal, specifically how your firm is registered with the Florida Division of Corporations. Please visit www.sunbiz.org for this information.

PRINT NAME: _____

EMAIL ADDRESS: _____

I HEREBY AGREE TO ABIDE BY ALL TERMS AND CONDITIONS OF THIS RFP, INCLUDING ALL INSURANCE REQUIREMENTS & CERTIFY I AM AUTHORIZED TO SIGN THIS RFP FOR THE PROPOSER.

AUTHORIZED SIGNATURE: _____

PRINT NAME/TITLE: _____

THIS FORM MUST BE RETURNED WITH YOUR RESPONSE

SECTION A – GENERAL CONDITIONS

1. **SUBMISSION OF PROPOSAL:**

(a) Proposals will be opened immediately after the proposal submittal date and time (3:00 PM) by the Pinellas County Purchasing Department, 400 South Fort Harrison Avenue, Annex Building, 6th Floor, Clearwater, FL 33756. The public may attend the proposal opening, but may not immediately review any proposals submitted. The names of respondents only will be read aloud at the time of opening. Pursuant to Florida Statute, Section 119.071(1)(b)2, all proposals submitted shall be subject to review as public records 30 days from opening, or earlier if an intended decision is reached before the 30-day period expires. Late proposals will not be accepted.

(b) Proposals and changes thereto shall be enclosed in sealed envelopes or packages, addressed to the Purchasing Department, Pinellas County. The name and address of the firms, the date and hour of the proposal submittal, and the title shall be placed on the outside of the envelope.

(c) Proposer is advised that exceptions to any terms and conditions contained in this RFP or the Services Agreement must be stated with specificity in its response to the RFP as provided herein and in Section A, paragraph 21. Proposer is deemed to have accepted and to be bound by the RFP and Services Agreement terms and conditions that Proposer does not take exception to in its response. The County reserves the right to modify or add terms and conditions based upon the exceptions stated by the Proposer, or to declare any terms and conditions non-negotiable, as determined by the County in its sole discretion.

2. **WRITTEN REQUESTS FOR INTERPRETATIONS/CLARIFICATIONS:**

No oral interpretations will be made to any firms as to the meaning of specifications, the Services Agreement, or any other contract documents. All questions pertaining to the terms and conditions or scope of work of this proposal must be sent in writing (email or fax) to the Purchasing Department and received no later than the deadline specified in RFP. Responses to questions may be handled as an addendum if the response would provide clarification to requirements of the proposal. All such addenda shall become part of the RFP documents. The County will not be responsible for any other explanation or interpretation of the proposed RFP. The Purchasing Department will be unable to respond to questions received after the specified deadline.

3. **DESCRIPTION OF SUPPLIES/SERVICES:**

Any manufacturer's names, trade names, brand name, or catalog numbers used in specifications are for the purpose of describing and establishing general quality levels. SUCH REFERENCES ARE NOT INTENDED TO BE RESTRICTIVE. Proposals will be considered for all brands that meet the quality of the specifications listed for any items.

4. **ALTERNATES:**

Unless otherwise provided in this Request for Proposal, ALTERNATES may be included in the plans, specifications, and/or proposals. When included, the Proposer shall indicate on the proposal the cost of said alternate and sum to be deducted or added to the Proposal. Such alternates may or may not be accepted by the County. If approved, it is at the County's discretion to accept said alternate(s) in any sequence or combination therein.

5. **RIGHTS OF PINELLAS COUNTY IN REQUEST FOR PROPOSAL PROCESS:**

In addition to all other rights of the County under Florida law, the County specifically reserves the following:

a) the right to rank firms and negotiate with the most qualified firm.

b) the right to select the proposal that it believes will serve the best interest of Pinellas County.

c) the right to reject any or all responses, or parts thereof, to disqualify any and all responses, and/or determine any response to be non-responsive.

d) the right to cancel the entire Request for Proposal.

e) the right to remedy or waive technical or immaterial errors in the Request for Proposal or in proposals submitted.

f) the right to request any necessary clarifications or proposal data without changing the terms of the proposal.

g) the right to require the Proposer to perform the services required on the basis of the original proposals without negotiation.

SECTION A – GENERAL CONDITIONS

6. **EVALUATION CRITERIA:**
The evaluation criteria define the factors that will be used by the Evaluation Committee to evaluate and score responsive, responsible and qualified proposals. Proposers shall include sufficient information to allow the Evaluation Committee to thoroughly evaluate and score their proposals. Each proposal submitted shall be evaluated and ranked by an evaluation committee. The contract will be awarded to the most qualified proposer, per the evaluation criteria listed in Section E of the RFP.

7. **COSTS INCURRED BY PROPOSERS:**
All expenses involved with the preparation and submission of proposals to the County and any oral presentations, or any work performed in connection therewith, shall be borne solely by the Proposer(s). No payment will be made for any responses received, or for any other effort required of, or made by, the Proposer(s) prior to contract commencement unless otherwise specified in Section E of this RFP.

8. **ORAL PRESENTATION:**
An oral presentation may be requested of any firm, at the Evaluation Committee's discretion. If an oral presentation is requested the written evaluation process shall be utilized to short list proposals. If required as part of the evaluation process, the oral presentation shall be scored as specified in Section E of the RFP. The most qualified firm as determined by evaluation process shall proceed with the contracting process.

9. **CONFLICT OF INTEREST:**

a) The Proposer represents that it presently has no interest and shall acquire no interest, either direct or indirect, which would conflict in any manner with the performance of services required hereunder. The Proposer further represents that no person having any such interest shall be employed by Proposer during the agreement term and any extensions. In addition, the Proposer shall not offer gifts or gratuities to County Employees as County Employees are not permitted to accept gifts or gratuities. By signing this proposal document, the Proposer acknowledges that no gifts or gratuities have been offered to County Employees or anyone else involved in this competitive proposal process.

b) The Proposer shall promptly notify the County's representative, in writing, by certified mail, of all potential conflicts of interest for any prospective business association, interest, or other circumstance, which may influence or appear to influence the Contractor's judgment or quality of services being provided hereunder. Such written notification shall identify the prospective business association, interest or circumstance, the nature of work that the Proposer may undertake and request an opinion of the County as to whether the association, interest or circumstance would, in the opinion of the County, constitute a conflict of interest if entered into by the Proposer. The County agrees to notify the Proposer of its opinion, by certified mail, within thirty days of receipt of notification from the Proposer.

c) It is essential to government procurement that the process be open, equitable and ethical. To this end, if potential unethical practices including but not limited to collusion, receipt or solicitation of gifts and conflicts of interest (direct/indirect) etc. are observed or perceived, please report such activity to:

Pinellas County Clerk of Circuit Court – Division of Inspector General

Phone – **(727) 45FRAUD** (453-7283)
Fax – 727-464-8386

10. **WITHDRAWAL OF PROPOSAL:**
A proposal may be withdrawn prior to the time set for the proposal submittal, based on a written request from an authorized representative of the firm; however, a proposal may not be withdrawn after the time set for the proposal submittal for a period of time as specified on page one (1) of this RFP.

11. **LATE PROPOSAL OR MODIFICATIONS:**
Proposals and modifications received after the time set for the proposal submittal will not be considered; however, modifications in writing received prior to the time set for the proposal submittal will be accepted. **Late proposals will not be accepted and shall be rejected. The time clock stamp located in Pinellas County Purchasing Department shall be the official time stamp.**

SECTION A – GENERAL CONDITIONS

12. **PROPOSALS FROM RELATED PARTIES / MULTIPLE PROPOSALS RECEIVED FROM ONE VENDOR:**
Where two (2) or more related parties each submit a proposal or multiple proposals are received from one (1) vendor, for any contract, such proposals shall be judged non-responsive. Related parties mean proposers or the principles thereof, which have a direct or indirect ownership interest in another proposer for the same contract or in which a parent company or the principles thereof of one (1) proposer have a direct or indirect ownership interest in another bidder or proposer for the same contract.

13. **JOINT VENTURES:**
All proposers intending to submit a proposal as a Joint Venture are required to have filed proper documents with the Florida Department of State, the Division of Professions, Construction Industry Licensing Board and any other state or local licensing Agency prior to submitting the proposal (see Section 489.119 Florida Statutes).

Joint Venture Firms must provide an affidavit attesting to the formulation of a joint venture and provide either proof of incorporation as a joint venture or a copy of the formal joint venture Agreement between all joint venture parties, indicating their respective roles, responsibilities and levels of participation for the project.

14. **PROVISION FOR OTHER AGENCIES:**
Unless otherwise stipulated by the proposer, the proposer agrees to make available to all Government agencies, departments, and municipalities the proposal prices submitted in accordance with said proposal terms and conditions therein, should any said governmental entity desire to buy under this proposal. Eligible Users shall mean all state of Florida agencies, the legislative and judicial branches, political subdivisions (counties, local district school boards, community colleges, municipalities, special districts, or other public agencies or authorities), which may desire to purchase under the terms and conditions of the contract.

15. **COLLUSION:**
The proposer, by signing this proposal, agrees to the following: "Proposer certifies that its proposal is made without previous understanding, agreement, or connection with any person, firm or corporation making a proposal for the same item(s) and is in all respects fair, without outside control, collusion, fraud, or otherwise illegal action".

16. **PUBLIC ENTITY CRIME AND SCRUTINIZED COMPANIES:**
Contractor is directed to the Florida Public Entity Crime Act, Fla. Stat. 287.133, and Fla. Stat. 287.135 regarding Scrutinized Companies, and Contractor agrees that its bid and, if awarded, its performance of the agreement will comply with all applicable laws including those referenced herein. Contractor represents and certifies that Contractor is and will at all times remain eligible to bid for and perform the services subject to the requirements of these, and other applicable, laws. Contractor agrees that any contract awarded to Contractor will be subject to termination by the County if Contractor fails to comply or to maintain such compliance.

17. **VARIANCE FROM STANDARD TERMS & CONDITIONS:**
All standard terms and conditions stated in Section A apply to this RFP and may be incorporated into the Services Agreement as deemed necessary by the County, except as specifically stated in the subsequent sections of the document, which take precedence over Section A.

18. **ADA REQUIREMENT FOR PUBLIC NOTICES:**
Persons with disabilities requiring reasonable accommodation to participate in any proceeding or event related to this RFP, should call 727/464-4062 (voice/tdd) fax 727/464-4157, not later than seven days prior to the proceeding or event.

19. **PROCUREMENT POLICY FOR RECYCLED MATERIALS:**
Pinellas County wishes to encourage its proposer to use recycled products in fulfilling contractual obligations to the County and that such a policy will serve as a model for other public entities and private sector companies.

When awarding a purchase of five thousand dollars ($5,000) or less, or recommending a purchase in excess of five thousand dollars ($5,000) for products, materials, or services, the Director of Purchasing may allow a preference to a responsive proposer who certifies that their product or material contains the greatest percentage of postconsumer material. If they are submitting a proposal on paper products they must certify that their materials and/or products contain at least the content recommended by the EPA guidelines.

On all proposals over fifty thousand dollars ($50,000), or as required by law, the Director of Purchasing shall require vendors to specify which products have recycled materials, what percentage or amount is postconsumer material, and to provide certification of the percentages of recycled materials used in the manufacture of goods and commodities procured by the County.

SECTION A – GENERAL CONDITIONS

Price preference is not the preferred practice the County wishes to employ in meeting the goals of this resolution. If a price preference is deemed to serve the best interest of the County and further supports the purchase of recycled materials, the Director of Purchasing will make a recommendation that a price preference be allowed up to an amount not to exceed 10% above the lowest complying proposal received.

DEFINITIONS:

Recovered Materials: Materials that have recycling potential, can be recycled, and have been diverted or removed from the solid waste stream for sale, use or reuse, by separation, collection, or processing.

Recycled Materials: Materials that contain recovered materials. This term may include internally generated scrap that is commonly used in industrial or manufacturing processes, waste or scrap purchased from another manufacturer and used in the same or a closely related product.

Postconsumer Materials: Materials which have been used by a business or a consumer and have served their intended end use, and have been separated or diverted from the solid waste stream for the purpose of recycling, such as; newspaper, aluminum, glass containers, plastic containers, office paper, corrugated boxes, pallets or other items which can be used in the remanufacturing process.

20. **ADDITIONAL REQUIREMENTS:**
The County reserves the right to request additional services from the Contractor if provided in the Services Agreement.

21. **SERVICES AGREEMENT:**
In addition to being subject to all terms and conditions in this RFP, all responses are subject to the terms and conditions in the Services Agreement attached to the RFP. Additional or modified terms and conditions in the Services Agreement may be necessary depending on the responses to the RFP, including any exceptions stated by the Proposer as required by Section A, paragraph 1(c) of this RFP. However, the County objects to and shall not be bound by any additional or modified terms and conditions that are in conflict with the terms and conditions in the Services Agreement, or are not acceptable to, or have been declared to be non-negotiable by the County, as determined in its sole discretion.

22. **INTEGRITY OF REQUEST FOR PROPOSAL (RFP) DOCUMENTS:**
Proposers shall use the original RFP Form(s) provided by the Purchasing Department and enter information only in the spaces where a response is requested. Proposers may use an attachment as an *addendum* to the RFP Form(s) if sufficient space is not available on the original form for the proposer to enter a complete response. **Any modifications or alterations to the original RFP documents by the proposer, whether intentional or otherwise, will constitute grounds for rejection of a RFP.** Any such modifications or alterations a proposer wishes to propose must be clearly stated in the proposer's RFP response and presented in the form of an addendum to the original RFP documents.

23. **PUBLIC RECORDS/TRADE SECRETS:**
Pinellas County Government is subject to the Florida Public Records law (Chapter 119, Florida Statutes), and all documents, materials, and data submitted to any solicitation as part of the response are governed by the disclosure, exemption and confidentiality provisions relating to public records in Florida Statutes. Except for materials that are "trade secrets" or "confidential" as defined by applicable Florida law, ownership of all documents, materials, and data submitted in response to the solicitation shall belong exclusively to the County.

To the extent that Proposer desires to maintain the confidentiality of materials that constitute trade secrets pursuant to Florida law, trade secret material submitted must be identified by some distinct method that the materials that constitute a trade secret, and Proposer shall provide an additional copy of the proposal that redacts all designated trade secrets. By submitting materials that are designated as trade secrets and signature of the Proposer on its Proposal, Proposer acknowledges and agrees:

(i) that after notice from the County that a public records request has been made for the materials designated as a trade secret, the Proposer shall be solely responsible for defending its determination that submitted material is a trade secret that is not subject to disclosure at its sole cost, which action shall be taken immediately, but no later than 10 calendar days from the date of notification or Proposer will be deemed to have waived the trade secret designation of the materials;

(ii) that to the extent that the proposal with trade secret materials is evaluated, the County and it officials, employees, agents, and representatives in any way involved in processing, evaluating, negotiating contract terms, approving any contract based on the proposal, or engaging in any other activity relating to the competitive selection process are hereby granted full rights to access, view, consider, and discuss the materials designated as trade secrets through the final contract award;

(iii) to indemnify and hold the County, and its officials, employees, agents and representatives harmless from any actions, damages (including attorney's fees and costs), or claims arising from or related to the designation of trade secrets by the Proposer, including actions or claims arising from the County's non-disclosure of the trade secret materials.

(iv) that information and data it manages as part of the services may be public record in accordance with Chapter 119, Florida Statues and Pinellas County public record policies. Proposer agrees, prior to providing goods/services, it will implement policies and procedures, which are subject to approval by the County, to maintain, produce, secure and retain public records in accordance with applicable laws, regulations, and County Policies including but not limited to Section 119.0701, Florida Statues.

Notwithstanding any other provision in the solicitation, the classification as trade secret of the entire proposal document, line item and/or total proposal prices, the work, services, project, goods, and/or products to be provided by Proposer, or any information, data, or materials that may be part of or incorporated into a contract between the County and the Proposer is not acceptable to the County and will result in a determination that the proposal is nonresponsive; the classification as trade secret of any other portion of a proposal document may result in a determination that the proposal is non-responsive.

24. **LOBBYING:**

Lobbying shall be prohibited on all county competitive selection processes, and contract awards pursuant to this division, including but not limited to requests for proposals, requests for quotations, requests for qualifications, bids or the award of purchasing contracts of any type. The purpose of this prohibition is to protect the integrity of the procurement process by shielding it from undue influences prior to the contract award or the competitive selection process is otherwise concluded. However, nothing herein shall prohibit a prospective bidder/proposer/protestor from contacting the purchasing department or the county attorney's office to address situations such as clarification and/or questions related to the procurement process.

Lobbying of evaluation committee members, county government employees, or elected/appointed officials, or advisory board members regarding request for proposals, requests for quotations, requests for qualifications, bids, or purchasing contracts, by the bidder/proposer any member of the bidder's/proposer'ss staff, any agent or representative of the bidder/proposer, or any person employed by any legal entity affiliated with or representing a bidder/proposer/protestor, is strictly prohibited from the date of the advertisement, or on a date otherwise established by the board of county commissioners, until either an award is final or the competitive selection process is otherwise concluded. Any lobbying activities in violation of this section or on behalf of a bidder/proposer shall result in the disqualification or rejection of the proposal, quotation, statement of qualification, bid or contract.

For purposes of this provision, lobbying shall mean influencing or attempting to influence action or non-action, and/or attempting to obtain the goodwill of persons specified herein relating to the selection, ranking, or contract award in connection with any request for proposal, request for quotation, requests for qualification, bid or purchasing contract through direct or indirect oral or written communication. The final award of a purchasing contract shall be the effective date of the purchasing contract.

Any evaluation committee member, county government employee or elected/appointed official, or advisory board member who has been lobbied shall immediately report the lobbying activity to the director of purchasing.

25. **PROTEST PROCEDURE:**

As per Section 2-162 of County Code:

(a) *Right to protest*. Any prospective bidder or proposer who is aggrieved by the contents of the bid or proposal package, or any bidder or proposer who is aggrieved in connection with the recommended award on a bid or proposal solicitation, may file a written protest to the director of purchasing as provided herein. This right to protest is strictly limited to those procurements of goods or services solicitated through invitations to bid or requests for proposals, including solicitations pursuant to § 287.055, Florida Statutes, the "Consultants' Competitive Negotiation Act." No other actions or recommendations in connection with a solicitation can be protested, including: (i) requests for quotations or requests for qualifications; (ii) rejection of some, all or parts of bids or proposals; (iii) disqualification of bidders or proposers as non-responsive or nonresponsible; or (iv) recommended awards less than the mandatory bid or proposal amount. Protests failing to comply with the provisions of this section 2-162 shall not be reviewed.

(b) *Posting*. The purchasing department shall post the recommended award on the departmental website no less than five (5) full business days after the decision to recommend the award is made.

(c) *Requirements to protest*.

(1) If the protest relates to the content of the bid/proposal package, a formal written protest must be filed no later than 5:00 p.m. on the fifth full business day after issuance of the bid/proposal package.

(2) If the protest relates to the recommended award of a bid or proposal, a formal written protest must be filed no later than 5:00 p.m., on the fifth full business day after posting of the award recommendation.

(3) The formal written protest shall identify the protesting party and the solicitation involved; include a statement of the grounds on which the protest is based; refer to the statutes, laws, ordinances or other legal authorities which the protesting party deems applicable to such grounds; and specifically request the relief to which the protesting party deems itself entitled by application of such authorities to such grounds.

(4) A formal written protest is considered filed with the county when the purchasing department receives it. Accordingly, a protest is not timely filed unless it is received within the time specified above by the purchasing department. Failure to file a formal written protest within the time period specified shall constitute a waiver of the right to protest and result in relinquishment of all rights to protest by the bidder/proposer.

(d) *Rights of interested parties*. Bidders or proposers, other than the protestor, which would be directly affected by the favorable resolution of a protest relating to a recommended award, shall have the right to provide written documentation related to the protested solicitation. Said interested parties shall be solely responsible for determining whether a protest has been filed. Any documentation submitted by an interested party must be filed with the director of purchasing no later than 5:00 p.m. on the fifth full business day after the purchasing department posts notification that a protest has been filed. Any interested party submitting documentation shall bear all costs, including legal representation, relating to the submission.

(e) *Sole remedy*. These procedures shall be the sole remedy for challenging the content of the bid or proposal package or the recommended award.

(f) *Lobbying*. Protestors, and interested parties as defined subsection (d), and anyone acting on their behalf, are prohibited from attempts to influence, persuade, or promote a bid or proposal protest through any other channels or means, and contacting any Pinellas County official, employee, advisory board member, or representative to discuss any matter relating in any way to the solicitation being protested, other than the purchasing department's or county attorney's office employees. The prohibitions provided for herein shall begin with the filing of the protest and end upon the final disposition of the protest; provided however, at all times protestors shall be subject to the procurement lobbying prohibitions in section 2-189 of this code. Failure to adhere to the prohibitions herein shall result in the rejection of the protest without further consideration.

(g) *Time limits*. The time limits in which protests must be filed as specified herein may be altered by specific provisions in the bid/request for proposal.

(h) *Authority to resolve*. The director of purchasing shall resolve the protest in accordance with the documentation and applicable legal authorities and shall issue a written decision to the protestor no later than 5:00 p.m. on the tenth full business day after the filing thereof.

(i) *Review of purchasing director's decision*.

(1) The protesting party may request a review of the purchasing director's decision to the county administrator by delivering written request for review of the decision to the director of purchasing by 5:00 p.m. on the fifth full business day after the date of the written decision. The written notice shall include any materials, statements, and arguments which the bidder/proposer deems relevant to the issues raised in the request to review the decision of the purchasing director.

(2) The county administrator shall issue a decision in writing stating the reason for the action with a copy furnished to the protesting party no later than 5:00 p.m., on the seventh full business day after receipt of the request for review. The decision shall be final and conclusive as to the county unless a party commences action in a court of competent jurisdiction.

(j) *Stay of procurement during protests*. There shall be no stay of procurement during protests.

SECTION A – GENERAL CONDITIONS

26. **ADDITIONAL REQUIREMENTS:**

If you are a Service Organization subject to SSAE 16, Reporting on Controls at a Service Organization, a copy of your Services Organization Control (SOC) Report should be submitted annually to the Finance Division over the term of the contract. This report will also be shared with the County's external audit firm, when requested.

SECTION B – SPECIAL CONDITIONS

Proposal Title: PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS

Proposal Number: 156-0174-P(JA)

1. **INTENT:**
In accordance with attached specifications, it is the intent of the Pinellas County Unified Personnel System ("County") to establish a contract for Employee Group Medical Plan Administrative Services through a two-step solicitation process. It is the intent to award to one vendor.

2. **PHASE I – PRE-QUALIFICATION PROCESS**:
Interested proposers must complete the pre-qualification questionnaire located in Section E. Do **NOT** include pricing with the pre-qualification submission.

Upon review of the pre-qualification submittals by the County and County's health and welfare consultant, an Addendum to the RFP will be issued qualifying selected Proposers to move to Phase II.

3. **PHASE II – PROPOSAL**:
Only those qualified proposers listed on the Addendum from Phase I shall submit proposals and pricing. Proposals received from non-qualified proposers will be deemed non-responsive.

The County's health and welfare consultant will be calculating the costs to determine the Compensation rating.

Qualified Proposers for Phase II shall address the information required in Section E of this RFP, in addition to the online Questionnaire (instructions for which shall be submitted via Addendum).

In addition, Proposers are required to provide the following information in a sealed envelope by the date and time indicated for Phase II on page 1 of this RFP.

a) A separate statement describing the Proposer's qualifications and experience in providing the same or similar services as outlined in the RFP Scope of Work. This description should include the names of the person(s) who will provide the services, including any subcontractors, their qualifications, and the years of experience in performing this type of work/services.

b) A separate written narrative describing the methods and/or manner in which the Proposer proposes to satisfy the requirements of the Scope of Work set out in Section E.

c) A separate proposed Statement of Work (Proposer's Statement of Work) that enumerates and defines the work/services that Proposer will provide to the County to complete the Scope of Work in this RFP, including each task, deliverable, and/or goods or products comprising the services Proposer will provide, as well as a proposed completion schedule for each task or deliverable, if applicable. The Proposer's Statement of Work shall be in a form that can be incorporated into the Services Agreement as an Exhibit at the County's option.

d) Financial information as requested in online questionnaire for Phase II to determine compensation formulation. The County's health and welfare consultant will be calculating the costs to determine the compensation rating.

e) Any exceptions to any section of this RFP. In addition to being subject to all terms and conditions in this RFP, all responses are subject to the terms and conditions in the Services Agreement attached to the RFP. Additional or modified terms and conditions in the Services Agreement may be necessary depending upon the responses to the RFP, including any exceptions stated by the Proposer as required by Section A, paragraph 1(d) of this RFP. However, the County objects to and shall not be bound by any additional or modified terms and conditions that are in conflict with the terms and conditions in the Services Agreement, or are not acceptable to, or have been declared to be non-negotiable by the County, as determined in its sole discretion.

SECTION B – SPECIAL CONDITIONS

4. **TERM OF SERVICES AGREEMENT:**
Duration of the contract shall be for the period of sixty (60) months beginning January 1, 2017 and ending December 31, 2021.

5. **FEES AND EXPENSES:**
The agreed to compensation will include all standard day-to-day administrative, overhead and internal expenses; including, but not limited to:

- costs of bonds and insurance premiums as required by this RFP
- support
- office supplies
- safety equipment
- consumables
- other consulting services
- special presentations
- regular and certified postage
- computer/software
- equipment and usage
- telephone charges
- emails
- electronic data transmission fees
- standard copier usage
- fax charges
- travel, per diem and lodging charges, unless otherwise agreed to by the County in the Services Agreement

Travel and lodging expenses will be included in the lump sum proposal and will be paid in accordance with Florida Statute 112.061.

6. **TIME LINE**:

Following is a listing of actions and anticipated dates; the County reserves the right to change the dates, if necessary.

Date	
2/24/2016	Advertising & Publishing Phase I of RFP
3/2/2016	Deadline for Questions/Clarifications Phase I
3/8/2016	Phase I Proposals due in Purchasing by 3:00 p.m. Public bid opening to follow immediately.
Wk of 3/14/16	Addendum released naming contractors eligible for Phase II
Wk of 3/21/16	Advertising & Publishing Phase II of RFP
4/7/2016	Deadline for Questions/Clarifications Phase II
4/19/2016	Phase II Proposals due in Purchasing by 3:00 p.m. Public bid opening to follow immediately.
6/2/2016	Evaluation of the RFP
6/17/2016	Invitation letter to contractors advising oral presentation date/time
Wk of 7/11/2016	Oral Presentations
7/15/2016	Recommendation due to Purchasing from Human Resources
9/27/2016	Submit recommendation to Board for Award of Contract

7. **PROPOSAL SUBMITTAL COPIES:**
Proposals shall be submitted in one (1) original paper document, one (1) paper copy, and six (6) electronic media copies CDs/DVDs or Travel Drives in PDF format. The preferred method is PDF conversion from the Proposer's source files (to minimize file size and maximize quality and accessibility) rather than scanning so that the County can open, print, read and save the pdf file you have created. To ensure consistency, the electronic copy should be ONE file document and in the same order as the paper original. If this is not possible, the electronic copy files should be in the same order as the paper copy, with a directory listing of the files.

Please note the evaluation committee will use the electronic media copies to review your submittal. Failure to include all information in the electronic media copies may have an impact on your evaluation scores.

SECTION B – SPECIAL CONDITIONS

Instructions for Providing Files in PDF Format to Pinellas County Government

Why does Pinellas County Government want all the documents as PDF files?

Answer- It's much more efficient to go paperless, and PDF is a universal file format that fits perfectly into government workflow processes.

How do I convert my files to PDF format?

Answer- If you have a program such as Adobe Acrobat, creating a PDF of any file is a simple print function. Rather than printing to a traditional printer, the file converts to a PDF format copy of your original. Any program (such as Word, PowerPoint, Excel, etc.) can be converted this way by simply selecting the print command and choosing PDF as the printer.

Should I scan everything and save as PDF?

Answer- Not unless you are scanning with OCR (optical character recognition). Scanning will create unnecessarily large files because a scan is just a picture of a page rather than actual page text. Furthermore, the result of scanning is that your pages will not look nearly as "clean" or professional as simply using the print to PDF method from the program from which the file originates. Additionally, since scan pages are pictures of text, not really text, they may not be considered accessible* under Federal ADA guidelines (*unless the scans are OCR.)

SECTION C – LIMITATION ON LIABILITY, INDEMNIFICATION, AND INSURANCE REQUIREMENTS

1. LIMITATIONS ON LIABILITY. By submitting a Proposal, the Proposer acknowledges and agrees that the services will be provided without any limitation on Proposer's liability. The County objects to and shall not be bound by any term or provision that purports to limit the Proposer's liability to any specified amount in the performance of the services. Proposer shall state any exceptions to this provision in its response, including specifying the proposed limits of liability in the stated exception to be included in the Services Agreement. Proposer is deemed to have accepted and agreed to provide the services without any limitation on Proposer's liability that Proposer does not take exception to in its response. Notwithstanding any exceptions by Proposer, the County reserves the right to declare its prohibition on any limitation on Proposer's liability as non-negotiable, to disqualify any Proposal that includes exceptions to this prohibition on any limitation on Proposer's liability, and to proceed with another responsive, responsible proposal, as determined by the County in its sole discretion.

2. INDEMNIFICATION. By submitting a Proposal, the Proposer acknowledges and agrees to be bound by and subject to the County's indemnification provisions as set out in the Services Agreement. The County objects to and shall not be bound by any term or provision that purports to modify or amend the Proposer's indemnification obligations in the Services Agreement, or requires the County to indemnify and/or hold the Proposer harmless in any way related to the services. Proposer shall state any exceptions to this provision in the response, including specifying the proposed revisions to the Services Agreement indemnification provisions, or the proposed indemnification from the County to the Proposer to be included in the Services Agreement. Proposer is deemed to have accepted and agreed to provide the services subject to the Services Agreement indemnification provisions that Proposer does not take exception to in its response. Notwithstanding any exceptions by Proposer, the County reserves the right to declare its indemnification requirements as non-negotiable, to disqualify any Proposal that includes exceptions to this paragraph, and to proceed with another responsive, responsible proposal, as determined by the County in its sole discretion.

3. INSURANCE:

   a) Proposal submittals should include, the Proposers current Certificate(s) of Insurance in accordance with the insurance requirements listed below. If Proposer does not currently meet insurance requirements, proposer/bidder/quoter shall also include verification from their broker or agent that any required insurance not provided at that time of submittal will be in place within 10 days after award recommendation.

   b) Within 10 days of **contract award** and prior to commencement of work, Proposer shall email certificate that is compliant with the insurance requirements to CertsOnly-Portland@ebix.com. If certificate received with proposal was a compliant certificate no further action may be necessary. It is imperative that proposer include the unique identifier, which will be supplied by the County's Purchasing Department. The Certificate(s) of Insurance shall be signed by authorized representatives of the insurance companies shown on the Certificate(s). **A copy of the endorsement(s) referenced in paragraph 3.(d) for Additional Insured shall be attached to the certificate(s) referenced in this paragraph.**

   c) No work shall commence at any project site unless and until the required Certificate(s) of Insurance are received and approved by the County. Approval by the County of any Certificate(s) of Insurance does not constitute verification by the County that the insurance requirements have been satisfied or that the insurance policy shown on the Certificate(s) of Insurance is in compliance with the requirements of the Agreement. County reserves the right to require a certified copy of the entire insurance policy, including endorsement(s), at any time during the RFP and/or contract period.

   d) All policies providing liability coverage(s), other than professional liability and workers compensation policies, obtained by the Proposer and any subcontractors to meet the requirements of the Agreement shall be endorsed to include Pinellas County Board of County Commissioners as an Additional Insured.

   e) If any insurance provided pursuant to the Agreement expires prior to the completion of the Work, renewal Certificate(s) of Insurance and endorsement(s) shall be furnished by the Proposer to the County at least thirty (30) days prior to the expiration date.

(1) Proposer shall also notify County within twenty-four (24) hours after receipt, of any notices of expiration, cancellation, nonrenewal or adverse material change in coverage received by said Proposer from its insurer. Notice shall be given by certified mail to: Pinellas County, c/o Ebix BPO, PO Box 257, Portland, MI, 48875-0257; be sure to include your organization's unique identifier, which will be provided upon notice of award. Nothing contained herein shall absolve Proposer of this requirement to provide notice.

(2) Should the Proposer, at any time, not maintain the insurance coverages required herein, the County may terminate the Agreement, or at its sole discretion may purchase such coverages necessary for the protection of the County and charge the Proposer for such purchase or offset the cost against amounts due to proposer for services completed. The County shall be under no obligation to purchase such insurance, nor shall it be responsible for the coverages purchased or the insurance company or companies used. The decision of the County to purchase such insurance shall in no way be construed to be a waiver of any of its rights under the Agreement.

f) The County reserves the right, but not the duty, to review and request a copy of the Contractor's most recent annual report or audited financial statement when a self-insured retention (SIR) or deductible exceeds $50,000.

g) If subcontracting is allowed under this RFP, the Prime Proposer shall obtain and maintain, at all times during its performance of the Agreement, insurance of the types and in the amounts set forth; and require any subcontractors to obtain and maintain, at all times during its performance of the Agreement, insurance limits as it may apply to the portion of the Work performed by the subcontractor; *but in no event will the insurance limits be less than $500,000 for Workers' Compensation/Employers' Liability, and $1,000,000 for General Liability and Auto Liability if required below.*

(1) All subcontracts between Proposer and its subcontractors shall be in writing and are subject to the County's prior written approval. Further, all subcontracts shall (1) require each subcontractor to be bound to Proposer to the same extent Proposer is bound to the County by the terms of the Contract Documents, as those terms may apply to the portion of the Work to be performed by the subcontractor; (2) provide for the assignment of the subcontracts from Proposer to the County at the election of Owner upon termination of the Contract; (3) provide that County will be an additional indemnified party of the subcontract; (4) provide that the County will be an additional insured on all insurance policies required to be provided by the subcontractor except workers compensation and professional liability; (5) provide waiver of subrogation in favor of the County and other insurance terms and/or conditions as outlined below; (6) assign all warranties directly to the County; and (7) identify the County as an intended third-party beneficiary of the subcontract. Proposer shall make available to each proposed subcontractor, prior to the execution of the subcontract, copies of the Contract Documents to which the subcontractor will be bound by this Section C and identify to the subcontractor any terms and conditions of the proposed subcontract which may be at variance with the Contract Documents.

h) Each insurance policy and/or certificate shall include the following terms and/or conditions:

(1) The Named Insured on the Certificate of Insurance and insurance policy must match the entity's name that responded to the solicitation and/or is signing the agreement with the County. If Proposer is a Joint Venture per Section A. titled Joint Venture of this RFP, Certificate of Insurance and Named Insured must show Joint Venture Legal Entity name and the Joint Venture must comply with the requirements of Section C with regard to limits, terms and conditions, including completed operations coverage.

(2) Companies issuing the insurance policy, or policies, shall have no recourse against County for payment of premiums or assessments for any deductibles which all are at the sole responsibility and risk of Contractor.

(3) The term "County" or "Pinellas County" shall include all Authorities, Boards, Bureaus, Commissions, Divisions, Departments and Constitutional offices of County and individual members, employees thereof in their official capacities, and/or while acting on behalf of Pinellas County.

(4) The policy clause "Other Insurance" shall not apply to any insurance coverage currently held by County or any such future coverage, or to County's Self-Insured Retentions of whatever nature.

(5) All policies shall be written on a primary, non-contributory basis.

(6) Any Certificate(s) of Insurance evidencing coverage provided by a leasing company for either workers compensation or commercial general liability shall have a list of covered employees certified by the leasing company attached to the Certificate(s) of Insurance. The County shall have the right, but not the obligation to determine that the Proposer is only using employees named on such list to perform work for the County. Should employees not named be utilized by Proposer, the County, at its option may stop work without penalty to the County until proof of coverage or removal of the employee by the contractor occurs, or alternatively find the Proposer to be in default and take such other protective measures as necessary.

(7) Insurance policies, other than Professional Liability, shall include waivers of subrogation in favor of Pinellas County from both the Proposer and subcontractor(s).

i) The minimum insurance requirements and limits for this Agreement, which shall remain in effect throughout its duration and for two (2) years beyond final acceptance for projects with a Completed Operations exposure, are as follows:

(i) Workers' Compensation Insurance

Limit	Florida Statutory
Employers' Liability Limits	
Per Employee	$ 500,000
Per Employee Disease	$ 500,000
Policy Limit Disease	$ 500,000

(ii) Commercial General Liability Insurance including, but not limited to, Independent Contractor, Contractual Liability Premises/Operations, Products/Completed Operations, and Personal Injury.

Limits

Combined Single Limit Per Occurrence	$ 1,000,000
Products/Completed Operations Aggregate	$ 1,000,000
Personal Injury and Advertising Injury	$ 1,000,000
General Aggregate	$ 2,000,000

(iii) Professional Liability (Errors and Omissions) Insurance with at least minimum limits as follows. If "claims made" coverage is provided, "tail coverage" extending three (3) years beyond completion and acceptance of the project with proof of "tail coverage" to be submitted with the invoice for final payment. In lieu of "tail coverage", Proposer may submit annually to the County, for a three (3) year period, a current certificate of insurance providing "claims made" insurance with prior acts coverage in force with a retroactive date no later than commencement date of this contract.

Limits

Each Occurrence or Claim	$5,000,000
General Aggregate	$5,000,000

For acceptance of Professional Liability coverage included within another policy required herein, a statement notifying the certificate holder must be included on the certificate of insurance and the total amount of said coverage per occurrence must be greater than or equal to the amount of Professional Liability and other coverage combined.

SECTION C – LIMITATION ON LIABILITY, INDEMNIFICATION, AND INSURANCE REQUIREMENTS

(iv) Cyber Risk Liability (Network Security/Privacy Liability) Insurance including cloud computing and mobile devices, for protection of private or confidential information whether electronic or non-electronic, network security and privacy; privacy against liability for system attacks, digital asset loss, denial or loss of service, introduction, implantation or spread of malicious software code, security breach, unauthorized access and use; including regulatory action expenses; and notification and credit monitoring expenses with at least minimum limits as follows:

Limits

Each Occurrence	$5,000,000
General Aggregate	$5,000,000

For acceptance of Cyber Risk Liability coverage included within another policy required herein, a statement notifying the certificate holder must be included on the certificate of insurance and the total amount of said coverage per occurrence must be greater than or equal to the amount of Cyber Risk Liability and other coverage combined.

(v) Property Insurance Proposer will be responsible for all damage to its own property, equipment and/or materials.

SECTION D – VENDOR REFERENCES

Proposal Title: PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS

Proposal Number: 156-0174-P(JA)

THE FOLLOWING INFORMATION IS REQUIRED IN ORDER THAT YOUR PROPOSAL MAY BE REVIEWED AND PROPERLY EVALUATED.

COMPANY NAME: _____

LENGTH OF TIME COMPANY HAS BEEN IN BUSINESS: _____

BUSINESS ADDRESS: _____

HOW LONG IN PRESENT LOCATION: _____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

TOTAL NUMBER OF CURRENT EMPLOYEES: _____ FULL TIME _____ PART TIME

NUMBER OF EMPLOYEES YOU PLAN TO USE TO SERVICE THIS CONTRACT: _____

All references will be contacted by a County Designee via email, fax, mail or phone call to obtain answers to questions, as applicable before an evaluation decision is made.

Proposers must have experience in work of the same or similar nature, and must provide references that will satisfy the County. Proposer must furnish a reference list of at least four (4) customers for whom they have performed similar services.

LOCAL COMMERCIAL AND/OR GOVERNMENTAL REFERENCES THAT YOU HAVE PREVIOUSLY PERFORMED SIMILAR CONTRACT SERVICES FOR:

1.
COMPANY: _____
ADDRESS: _____
TELEPHONE/FAX: _____
CONTACT: _____
CONTACT EMAIL;_____
COMPANY EMAIL ADDRESS: _____

2.
COMPANY: _____
ADDRESS: _____
TELEPHONE/FAX: _____
CONTACT: _____
CONTACT EMAIL:_____
COMPANY EMAIL ADDRESS: _____

3.
COMPANY: _____
ADDRESS: _____
TELEPHONE/FAX: _____
CONTACT: _____
CONTACT EMAIL:_____
COMPANY EMAIL ADDRESS: _____

4.
COMPANY: _____
ADDRESS: _____
TELEPHONE/FAX: _____
CONTACT: _____
CONTACT EMAIL:_____
COMPANY EMAIL ADDRESS: _____

SECTION E – SCOPE OF WORK

Proposal Title: PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS

Proposal Number: 156-0174-P(JA)

A. OBJECTIVE:

Establish a contract to provide third party administration services for the County sponsored and self insured employee health plan.

The County's benefit plans, including the health plan for which third party administration services are sought in this RFP, are highly visible within the organization, and costs are monitored closely. The County has high service expectations for its vendors, and Human Resources (HR) representatives are proactive in working with employees to resolve claims problems, answer questions, etc. Therefore, HR seeks to partner with an organization which is dedicated to providing excellent service to employees, HR representatives and the benefits team. Accurate, consistent, timely and comprehensive management reporting is also a critically important aspect of this service commitment, as is hands-on, day-to-day client service and support via an onsite registered nurse.

B. BACKGROUND:

The UPS is a public personnel board authorized under Florida law to provide common human resources programs including, but not limited to, health and welfare benefits. It is made up of eleven different members or appointing authorities, including County Administrator, Tax Collector, Clerk of the Court, Property Appraiser and Supervisor of Elections. The UPS reports to its own Board, comprised of citizens chosen by Appointing Authorities, an Employee Advisory Council and the UPS Board itself. The UPS serves as a central point of contact for all human resource programs.

The UPS consists of approximately 3,000 active employees and 1,800 retirees. All permanent employees who work a minimum of twenty (20) hours per week are eligible to participate.

Options within the current group health plan include:

- Employee only
- Employee + Spouse
- Employee + Child(ren)
- Family

Two medical plans are currently offered to active employees and non-Medicare eligible retirees under the group health plan, including:

- Choice Plus POS
- Choice Plus HSA

Both plans provide: both in-network and out-of-network benefits; offer the same network of hospitals and doctors; are open access (can use any network doctor, do not have to choose a PCP and do not need a referral to see a specialist); additionally they cover the same benefits and have the same exclusions.

Retirees: Approximately forty-five (45) Medicare Eligible individuals are enrolled in the traditional indemnity plan which coordinates with Medicare. This plan is no longer open to newly Medicare eligible individuals. All other Medicare-eligible individuals (approximately 1700) are enrolled in a fully-insured Medicare Advantage plan. Non-Medicare family members receive benefits matching the Choice Plus (POS) plan.

Following are other coverages afforded participants in the group health plan at no additional premium (carved out of the medical plan). These plans are not included within this RFP.

- Prescription Drug plan
- Employee Assistance program
- Mental Health benefits
- Vision Care program

SECTION E – SCOPE OF WORK

C. PHASE I – PRE-QUALIFICATION QUESTIONNAIRE

For each item below, check one box to indicate where your firm meets or does not meet each minimum qualification:

#	MINIMUM REQUIREMENT	Meets	Does Not Meet
1	Proposer is a full-service health plan insurer and administrator that provides the Scope of Services outlined in this prequalification package	☐	☐
2	Proposer currently provides health insurance, administrative and health management services as outlined in the Scope of Services to at least five employer groups with more than 4,000 employees	☐	☐
3	Proposer currently accepts electronic eligibility files *Examples of acceptable electronic eligibility files and transfer methods include:* • *Electronic file transfers via secure site* • *Files in client layout agreed upon and HIPAA EDI compliant*	☐	☐
4	Proposer currently has a customer service center to address member specific benefit questions *Examples of acceptable customer service centers include:* • *Customer service with live member service representatives* • *Interactive voice response units* • *Full service (24/7)* • *Voice mail services if not full service* • *Web-based services*	☐	☐
5	Proposer currently administers or offers on a fully integrated basis, clinical management programs including review of cases, outreach and member interaction with disease management nurses *Examples of clinical management programs include:* • *Cancer* • *Asthma* • *COPD* • *Diabetes* • *Arthritis* • *Hypertension* • *Bariatric*	☐	☐
6	Proposer currently tracks and administers incentive plans on behalf of plan sponsors.	☐	☐

SECTION E – SCOPE OF WORK

7	Proposer currently administers a three-tiered network that includes higher value/richer benefits for members that utilize higher quality and/or otherwise designated providers, in addition to the in- and out-of-network benefit tiers.	☐	☐
8	Proposer currently participates in the Uniform Discount Data Specification (UDDS) initiative driven by a national industry workgroup comprised of vendors, consulting and brokerage firms. This initiative ensures a consistent approach and standardized methodology for evaluating vendors' health plan network discounts.	☐	☐
9	Proposer acknowledges that all data utilized in the UDDS is reviewed and approved by actuaries at both Towers Watson and the submitting health plan proposer, and that the results of the network discount evaluation accurately represent proposer's network discounts.	☐	☐

D. **PHASE II - SCOPE OF WORK:**

Provide a project approach for medical plan administration and health plan management services through PPO/HMO plans and including Stop Loss Coverage, concisely addressing and responding to the items as listed below.

1. Access to national and local contracted networks of physicians, hospitals and ancillary providers;
2. claims processing;
3. utilization review of claims and cases;
4. case management;
5. clinical programs supporting members with chronic or complex conditions, and to control costs;
6. wellness programs;
7. nurse line;
8. customer service representatives to respond to members' inquiries;
9. enrollment services and materials (i.e. id cards, enrollment forms, plan documents, provider directors, claims forms)
10. vendor integration and data sharing with pharmacy benefit manager and behavioral health administrator;
11. partner with the carve-out vendor counterparts to produce positive outcomes and an integrated member experience;
12. integration with onsite clinic;
13. partnering with the County and onsite wellness staff to provide any additional resources;
14. examples of successful integration experience with other vendors;
15. detailed management of clinical reporting and ad-hoc reporting;
16. online claims and benefit plan information access for members;
17. online reporting and eligibility access for plan sponsor;
18. data sharing with data aggregation vendor (Truven).
19. Describe administrative and operation capabilities as well as comprehensive health management capabilities and approach, including Return on Investment Methodology and performance guarantees.
20. details on providing an onsite registered nurse to assist with member engagement and strategic initiatives. (The representative should have a member services background and be familiar with wellness programming, consumerism, etc.);

The following should be addressed within the Statement of Work:

21. Partnering with the County to help manage healthcare costs and improve the overall health status of employees and their families;
22. describe how Proposer will work with the County to administer, streamline and/or modify the current incentive programs as well as assist with the development of future programs;

23. provide examples of leading edge initiatives that have been developed or are in development that would support the County in creating member engagement towards positive health outcomes. Concise case studies are strongly encouraged;
24. provide a detailed implementation plan including providing a smooth implementation of benefits and services to employees.

E. PHASE II QUESTIONNAIRE:

Proposers will be directed to website via addendum for submission of the Phase II questionnaire, financial information and any other requested information.

F. EVALUATION CRITERIA:

Criteria used by the County to evaluate and score responsive and qualified proposals. Proposers shall include sufficient information to allow the County to thoroughly evaluate and score their proposals. Each proposal submitted shall be evaluated and ranked by an evaluation committee. The contract will be awarded to the most qualified proposer, per the following evaluation criteria:

1. Project Approach (350 Points)

A separate written narrative describing the methods and/or manner in which the Proposer proposes to satisfy the requirements of the Scope of Work, specifically addressing the questions in Section D. Include each task, deliverable, and/or goods or products comprising the services Proposer will provide, as well as a proposed completion schedule for each task or deliverable,

2. Administrative/Operational Capabilities (200 Points)

Capabilities and operations to provide the administrative services as outlined in the Scope of Work.

3. Total Cost (250 Points)

Required information and documentation as requested within the online questionnaire will be reviewed by the County's health and benefit consultant to obtain overall compensation costs.

4. Network Adequacy (150 Points)

Address Proposer's network capability in providing members' access to providers and facilities.

5. No Exceptions to RFP (50 Points)

Proposer is advised that exceptions to any terms and conditions contained in this RFP or the Services Agreement must be stated with specificity in its response to the RFP. The points available under this criterion may be deducted if the Proposer takes exception to any language to this RFP package.

6. ITEMS TO BE RETURNED WITH PROPOSAL:

Proposal Organization: Proposers are expected to organize their proposals in such a manner as to facilitate the evaluation process. Proposals should be keyed or indexed to correspond with this Request for Proposal. Responses should be correlated to the specific submittal, Criterion, section or paragraph number of the request for proposal being addressed. Evaluators will make a reasonable effort to locate information in the proposals; however failure to follow this suggested format may make location of critical submittal information difficult, possibly resulting in a loss of appropriate point credit.

SECTION E – SCOPE OF WORK

To be submitted to the County as noted on Page 1 of the RFP

Phase I		
a)	Page 1	Proposal Signature Page
b)	Section B	Proposal Submittal Copies
c)	Section D	Vendor References
d)	Section E	Vendor pre-qualification questionnaire
e)	Section F	ePayables Form
f)	Section F	W-9 Form
g)	Section G	Addendum Acknowledgement Form (If Applicable)
h)	Section H	Statement of No Submittal (If Applicable)

To be submitted to County as noted on Page 1 of the RFP:

Phase II		
i)	Page 1	Proposal Signature Page
j)	Section B	Item 2 Proposal Requirements
k)	Section G	Addendum Acknowledgement Form

To be submitted to County's health and welfare consultant per Section B:

- Phase II – online proposal submittal

SECTION F ELECTRONIC PAYMENT

Electronic Payment (ePayables)

The Pinellas County Board of County Commissioners (County) offers a credit card payment process (ePayables) through Bank of America. Pinellas County does not charge vendors to participate in the program; however, there may be a charge by the company that processes your credit card transactions. For more information please visit Pinellas County purchasing website at www.pinellascounty.org/purchase.

Would your company accept to participate in the ePayables credit card program?

☐ Yes ☐ No

Company Name

Authorized Signature (for payment acceptance)

Printed Signature/Title/Department

Phone Number

W-9 REQUEST FOR TAXPAYER ID NUMBER AND CERTIFICATION

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any)
Exemption from FATCA reporting code (if any)

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
___ – ___ – ____

Employer identification number
__ – _____

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

Cat. No. 10231X Form **W-9** (Rev. 8-2013)

SECTION G – ADDENDA ACKNOWLEDGMENT FORM

Proposal Title: PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS

Proposal No: 156-0174-P(JA)

PLEASE ACKNOWLEDGE RECEIPT OF ADDENDA FOR THIS RFP BY SIGNING AND DATING BELOW:

ADDENDA NO.	SIGNATURE/PRINTED NAME	DATE RECEIVED

Note: Prior to submitting the response to this solicitation, it is the responsibility of the firm submitting a response to confirm if any addenda have been issued. If such document(s) has been issued, acknowledge receipt by signature and date in section above and return Addenda Acknowledgement Form with RFP. Failure to do so may result in being considered non-responsive.

Information regarding Addenda issued is available on the Purchasing Department section of the County's website at, www.pinellascounty.org/purchase/Current_Bids1.htm , listed under category 'Current Bids'.

SECTION H – NO BID STATEMENT

NOTE: If you do not intend to submit a proposal on this requirement, please return this form immediately. ***Thank you.***

Pinellas County Purchasing Department
400 South Fort Harrison Avenue, 6th Floor
Clearwater, Florida 33756

We, the undersigned have declined to submit a proposal for RFP No. **156-0174-P(JA)** for **PERSONNEL SERVICES – EMPLOYEE MEDICAL BENEFITS.**

_____ Specifications too "tight", i.e., geared toward one brand or manufacturer only (explain below).
_____ Insufficient time to respond to the Request for Proposal.
_____ We do not offer this product or service.
_____ Our schedule would not permit us to perform.
_____ Unable to meet specifications.
_____ Unable to meet Bond requirement.
_____ Specifications unclear (explain below).
_____ Unable to Meet Insurance Requirements.
_____ Remove Us from Your "Notification List" Altogether
_____ Other (specify below).

REMARKS:

_____

_____

_____

_____

We understand that if the "No Proposal" letter is not executed and returned our name may be deleted from the Bidders List of Pinellas County.

COMPANY NAME: _____

DATE: _____

SIGNATURE: _____

TYPED NAME OF ABOVE: _____

TELEPHONE: _____

FAX: _____

EMAIL: _____

SERVICES AGREEMENT

THIS SERVICES AGREEMENT ("Agreement") is made as of this _____ day of_____, 20_____ ("Effective Date"), by and between Pinellas County, a political subdivision of the State of Florida ("County"), and _____, _____("Contractor") (individually, "Party," collectively, "Parties").

W I T N E S S E T H:

WHEREAS, the County requested proposals pursuant to _____("RFP") for _____ services; and

WHEREAS, based upon the County's assessment of Contractor's proposal, the County selected the Contractor to provide the Services as defined herein; and

WHEREAS, Contractor represents that it has the experience and expertise to perform the Services as set forth in this Agreement.

NOW, THEREFORE, in consideration of the above recitals, the mutual covenants, agreements, terms and conditions herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged, the Parties agree as follows:

1. Definitions.

A. "**Agreement**" means this Agreement, including all Exhibits, which are expressly incorporated herein by reference, and any amendments thereto.

B. "**County Confidential Information**" means any County information deemed confidential and/or exempt from Section 119.07, Florida Statutes, and Section 24(a), Article 1 of the Florida Constitution, or other applicable law, including, but not limited to, data or information referenced in _____, and any other information designated in writing by the County as County Confidential Information.

C. "**Contractor Confidential Information**" means any Contractor information that constitutes a trade secret pursuant to Chapter 688, Florida Statutes, and is designated in this Agreement or in writing as a trade secret by Contractor (unless otherwise determined to be a public record by applicable Florida law). Notwithstanding the foregoing, Contractor Confidential Information does not include information that: (i) becomes public other than as a result of a disclosure by the County in breach of the Agreement; (ii) becomes available to the County on a non-confidential basis from a source other than Contractor, which is not prohibited from disclosing such information by obligation to Contractor; (iii) is known by the County prior to its receipt from Contractor without any obligation or confidentiality with respect thereto; or (iv) is developed by the County independently of any disclosures made by Contractor.

D. "**Contractor Personnel**" means all employees of Contractor, and all employees of subcontractors of Contractor, including, but not limited to temporary and/or leased employees, who are providing the Services at any time during the project term.

E. "**Services**" means the work, duties and obligations to be carried out and performed safely by Contractor under this Agreement, as described throughout this Agreement and as specifically described in Exhibit A ("Statement of Work") attached hereto and incorporated herein by reference. As used in this Agreement, Services shall include any component task, subtask, service, or function inherent, necessary, or a customary part of the Services, but not specifically described in this Agreement, and shall include the provision of all standard day-to-day administrative, overhead, and internal expenses, including costs of bonds and insurance as required herein, labor, materials, equipment, safety equipment, products, office supplies, consumables, tools, postage, computer hardware/software, telephone charges, copier usage, fax charges, travel, lodging, and per diem and all other costs required to perform Services except as otherwise specifically provided in this Agreement.

2. Conditions Precedent. This Agreement, and the Parties' rights and obligations herein, are contingent upon and subject to the Contractor securing and/or providing the performance security, if required in Section 3, and the insurance coverage(s) required in Section 13, within ten (10) days of the Effective Date. No Services shall be performed by the Contractor and the County shall not incur any obligations of any type until Contractor satisfies these conditions. Unless waived in writing by the County, in the event the Contractor fails to satisfy the conditions precedent within the time required herein, the Agreement shall be deemed not to have been entered into and shall be null and void.

3. Services.

A. Services. The County retains Contractor, and Contractor agrees to provide the Services. All Services shall be performed to the satisfaction of the County, and shall be subject to the provisions and terms contained herein and the Exhibits attached hereto.

B. Services Requiring Prior Approval. Contractor shall not commence work on any Services requiring prior written authorization in the Statement of Work without approval from _____.

C. Additional Services. From the Effective Date and for the duration of the project, the County may elect to have Contractor perform Services that are not specifically described in the Statement of Work attached hereto but are related to the Services ("Additional Services"), in which event Contractor shall perform such Additional Services for the compensation specified in the Statement of Work attached hereto. Contractor shall commence performing the applicable Additional Services promptly upon receipt of written approval as provided herein.

D. De-scoping of Services. The County reserves the right, in its sole discretion, to de-scope Services upon written notification to the Contractor by the County. Upon issuance and receipt of the notification, the Contractor and the County shall enter into a written amendment reducing the appropriate Services Fee for the impacted Services by a sum equal to the amount associated with the de-scoped Services as defined in the payment schedule in this Agreement, if applicable, or as determined by mutual written consent of both Parties based upon the scope of work performed prior to issuance of notification.

E. Independent Contractor Status and Compliance with the Immigration Reform and Control Act. Contractor is and shall remain an independent contractor and is neither agent, employee, partner, nor joint venturer of County. Contractor acknowledges that it is responsible for complying with the provisions of the Immigration Reform and Control Act of 1986 located at 8 U.S.C. 1324, et seq, and regulations relating thereto, as either may be amended from time to time. Failure to comply with the above provisions shall be considered a material breach of the Agreement.

F. Non-Exclusive Services. This is a non-exclusive Agreement. During the term of this Agreement, and any extensions thereof, the County reserves the right to contract for another provider for similar services as it determines necessary in its sole discretion.

G. Project Monitoring. During the term of the Agreement, Contractor shall cooperate with the County, either directly or through its representatives, in monitoring Contractor's progress and performance of this Agreement.

H. Supplemental Terms. [Additional terms appropriate in the County's discretion to define the relationship and services, and which are not inconsistent with the other standard terms contained herein, may be included as an Exhibit]

4. Term of Agreement.

A. Initial Term. The term of this Agreement shall commence on (select appropriate box):

☐ the Effective Date; or

☐ _____, 20____,

☐ and shall remain in full force and effect for_____

B. Term Extension. (Select appropriate box.)

☐ The term of this Agreement may not be extended. All Services shall be completed by the expiration of the initial term as defined in 4.A.

☐ The Parties may extend the term of this Agreement for ___ ( ) additional _____ ( ) month period(s) pursuant to the same terms, conditions, and pricing set forth in the Agreement by mutually executing an amendment to this Agreement, as provided herein.

5. Compensation and Method of Payment.

A. Services Fee. As total compensation for the Services, the County shall pay the Contractor the sums as provided in this Section 5 ("Services Fee"), pursuant to the terms and conditions as provided in this Agreement. It is acknowledged and agreed by Contractor that this compensation constitutes a limitation upon County's obligation to compensate Contractor for such Services required by this Agreement, but does not constitute a limitation upon Contractor's obligation to perform all of the Services required by this Agreement. In no event will the Services Fee paid exceed the not-to-exceed sums set out in subsections 5.B. and C., unless the Parties agree to increase this sum by written amendment as authorized in Section 21 of the Agreement.

B. ☐ The County agrees to pay the Contractor the not-to-exceed sum of $_____,

☐ For Services completed and accepted as provided in Section 15 herein if applicable, payable [***INSERT APPROPRIATE OPTIONS AND DELETE THE REMAINING OPTIONS***] [in equal monthly payments of $___ beginning on the first day of the month commencing on ___, 20____, upon submittal of an invoice as required herein.]

☐ on a fixed-fee basis for the deliverables as set out in Exhibit _____, payable upon submittal of an invoice as required herein.

☐ at the following hourly rates (select appropriate box):

☐ the hourly rate of $_____; or

☐ [***DESCRIBE PAYMENT TERMS***] _____
_____

C. Travel Expenses. (Select appropriate box.)

☐ The Services Fee includes all travel, lodging and per diem expenses incurred by Contractor in performing the Services.

☐ The County shall reimburse the Contractor the sum of not-to-exceed $_____ for the travel expenses incurred in accordance with County Travel Policy, and as approved in writing in advance by _____.

D. Taxes. Contractor acknowledges that the County is not subject to any state or federal sales, use, transportation and certain excise taxes.

E. Payments. Contractor shall submit invoices for payments due as provided herein and authorized reimbursable expenses incurred with such documentation as required by County. Invoices shall be submitted to (select appropriate box):

☐ to the designated person as set out in Section 18 herein;

☐ as provided in Exhibit ___ attached hereto.

For time and materials Services, all Contractor Personnel shall maintain logs of time worked, and each invoice shall state the date and number of hours worked for Services authorized to be billed on a time and materials basis. All payments shall be made in accordance with the requirements of Section 218.70 et seq., Florida Statutes, "The Local Government Prompt Payment Act." The County may dispute any payments invoiced by Contractor in accordance with the County's Invoice Payments Dispute Resolution Process established in accordance with Section 218.76, Florida Statutes, and any such disputes shall be resolved in accordance with the County's Dispute Resolution Process.

6. Personnel.

A. Qualified Personnel. Contractor agrees that each person performing Services in connection with this Agreement shall have the qualifications and shall fulfill the requirements set forth in this Agreement.

B. Approval and Replacement of Personnel. The County shall have the right to approve all Contractor Personnel assigned to provide the Services, which approval shall not be unreasonably withheld. Prior to commencing the Services, the Contractor shall provide at least ten (10) days written notice of the names and qualifications of the Contractor Personnel assigned to perform Services pursuant to the Agreement. Thereafter, during the term of this Agreement, the Contractor shall promptly and as required by the County provide written notice of the names and qualifications of any additional Contractor Personnel assigned to perform Services. The County, on a reasonable basis, shall have the right to require the removal and replacement of any of the Contractor Personnel performing Services, at any time during the term of the Agreement. The County will notify Contractor in writing in the event the County requires such action. Contractor shall accomplish any such removal within forty-eight (48) hours after receipt of notice from the County and shall promptly replace such person with another person, acceptable to the County, with sufficient knowledge and expertise to perform the Services assigned to such individual in accordance with this Agreement. In situations where individual Contractor Personnel are prohibited by applicable law from providing Services, removal and replacement of such Contractor Personnel shall be immediate and not subject to such forty-eight (48) hour replacement timeframe and the provisions of Section 7. A.1. shall apply if minimum required staffing is not maintained.

7. Termination.

A. Contractor Default Provisions and Remedies of County.

1. Events of Default. Any of the following shall constitute a "Contractor Event of Default" hereunder: (i) Contractor fails to maintain the staffing necessary to perform the Services as required in the Agreement, fails to perform the Services as specified in the Agreement, or fails to complete the Services within the completion dates as specified in the Agreement; (ii) Contractor breaches Section 9 (Confidential Information); (iii) Contractor fails to gain acceptance of a deliverable per Section 15, if applicable, for two (2) consecutive iterations; or (iv) Contractor fails to perform or observe any of the other material provisions of this Agreement.

2. Cure Provisions. Upon the occurrence of a Contractor Event of Default as set out above, the County shall provide written notice of such Contractor Event of Default to Contractor ("Notice to Cure"), and Contractor shall have thirty (30) calendar days after the date of a Notice to Cure to correct, cure, and/or remedy the Contractor Event of Default described in the written notice.

3. Termination for Cause by the County. In the event that Contractor fails to cure a Contractor Event of Default as authorized herein, or upon the occurrence of a Contractor Event of Default as specified in Section 7.A.1.(iii), the County may terminate this Agreement in whole or in part, effective upon receipt by Contractor of written notice of termination pursuant to this provision, and may pursue such remedies at law or in equity as may be available to the County.

B. County Default Provisions and Remedies of Contractor.

1. Events of Default. Any of the following shall constitute a "County Event of Default" hereunder: (i) the County fails to make timely undisputed payments as described in this Agreement; (ii) the County breaches Section 9 (Confidential Information); or (iii) the County fails to perform any of the other material provisions of this Agreement.

2. Cure Provisions. Upon the occurrence of a County Event of Default as set out above, Contractor shall provide written notice of such County Event of Default to the County ("Notice to Cure"), and the County shall have thirty (30) calendar days after the date of a Notice to Cure to correct, cure, and/or remedy the County Event of Default described in the written notice.

3. Termination for Cause by Contractor. In the event the County fails to cure a County Event of Default as authorized herein, Contractor may terminate this Agreement in whole or in part effective on receipt by the County of written notice of termination pursuant to this provision, and may pursue such remedies at law or in equity as may be available to the Contractor.

C. Termination for Convenience. Notwithstanding any other provision herein, the County may terminate this Agreement, without cause, by giving thirty (30) days advance written notice to the Contractor of its election to terminate this Agreement pursuant to this provision.

8. Time is of the Essence. Time is of the essence with respect to all provisions of this Agreement that specify a time for performance, including the Services as described in Exhibits attached hereto; provided, however, that the foregoing shall not be construed to limit a Party's cure period allowed in the Agreement.

9. Confidential Information and Public Records.

A. County Confidential Information. Contractor shall not disclose to any third party County Confidential Information that Contractor, through its Contractor Personnel, has access to or has received from the County pursuant to its performance of Services pursuant to the Agreement, unless approved in writing by the County Contract Manager. All such County Confidential Information will be held in trust and confidence from the date of disclosure by the County, and discussions involving such County Confidential Information shall be limited to Contractor Personnel as is necessary to complete the Services.

B. Contractor Confidential Information. All Contractor Confidential Information received by the County from Contractor will be held in trust and confidence from the date of disclosure by Contractor and discussions involving such Contractor Confidential Information shall be limited to the members of the County's staff and the County's subcontractors who require such information in the performance of this Agreement. The County acknowledges and agrees to respect the copyrights, registrations, trade secrets and other proprietary rights of Contractor in the Contractor Confidential Information during and after the term of the Agreement and shall at all times maintain the confidentiality of the Contractor Confidential Information provided to the County, subject to federal law and the laws of the State of Florida related to public records disclosure. Contractor shall be solely responsible for taking any and all action it deems necessary to protect its Contractor Confidential Information except as provided herein. Contractor acknowledges that the County is subject to public records legislation, including but not limited to Chapter 119, Florida Statutes, and the Florida Rules of Judicial Administration, and that any of the County's obligations under this Section may be superseded by its obligations under any requirements of said laws.

C. Public Records. Contractor 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. Contractor 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 Contractor agrees to charge the County, 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.

10. Audit. Contractor 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 119, Florida Statutes. In addition, County reserves the right to examine and/or audit such records.

11. Service Organizations. As a Service Organization subject to SSAE 16, Reporting on Controls at a Service Organization, a copy of your Services Organization Control (SOC) Report should be submitted annually to the Finance Division over the term of the contract. This report will also be shared with the County's external audit firm, when requested.

12. Compliance with Laws. The laws of the State of Florida apply to any purchase made under this Request for Proposal. Proposers shall comply with all local, state, and federal directives, orders and laws as applicable to this proposal and subsequent contract(s) including but not limited to Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973, Equal Employment Opportunity (EEO), Minority Business Enterprise (MBE), and OSHA as applicable to this contract.

13. Public Entities Crimes. Contractor is directed to the Florida Public Entities Crime Act, Section 287.133, Florida Statutes, and represents to County that Contractor is qualified to transact business with public entities in Florida.

14. Liability and Insurance.

A. Insurance. Contractor shall comply with the insurance requirements set out in Exhibit _____, attached hereto and incorporated herein by reference.

B. **Indemnification.** Contractor agrees to indemnify, pay the cost of defense, including attorney's fees, and hold harmless the County, its officers, employees and agents from all damages, suits, actions or claims, including reasonable attorney's fees incurred by the County, of any character brought on account of any injuries or damages received or sustained by any person, persons, or property, or in any way relating to or arising from the Agreement; or on account of any act or omission, neglect or misconduct of Contractor; or by, or on account of, any claim or amounts recovered under the Workers' Compensation Law or of any other laws, regulations, ordinance, order or decree; or arising from or by reason of any actual or claimed trademark, patent or copyright infringement or litigation based thereon; except only such injury or damage as shall have been occasioned by the sole negligence of the County.

C. **Liability.** Neither the County nor Contractor shall make any express or implied agreements, guaranties or representations, or incur any debt, in the name of or on behalf of the other Party. Neither the County nor Contractor shall be obligated by or have any liability under any agreements or representations made by the other that are not expressly authorized hereunder. The County shall have no liability or obligation for any damages to any person or property directly or indirectly arising out of the operation by Contractor of its business, whether caused by Contractor's negligence or willful action or failure to act.

D. **Contractor's Taxes.** The County will have no liability for any sales, service, value added, use, excise, gross receipts, property, workers' compensation, unemployment compensation, withholding or other taxes, whether levied upon Contractor or Contractor's assets, or upon the County in connection with Services performed or business conducted by Contractor. Payment of all such taxes and liabilities shall be the responsibility of Contractor.

15. County's Funding. The Agreement is not a general obligation of the County. 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 fiscal year in which this Agreement is executed. No liability shall be incurred by the County, or any department, beyond the monies budgeted and available for this purpose. If funds are not appropriated by the County for any or all of this Agreement, the County shall not be obligated to pay any sums provided pursuant to this Agreement beyond the portion for which funds are appropriated. The County agrees to promptly notify Contractor in writing of such failure of appropriation, and upon receipt of such notice, this Agreement, and all rights and obligations contained herein, shall terminate without liability or penalty to the County.

16. Acceptance of Services. For all Services deliverables that require County acceptance as provided in the Statement of Work, the County, through the _____ or designee, will have ten (10) calendar days to review the deliverable(s) after receipt or completion of same by Contractor, and either accept or reject the deliverable(s) by written notice to *[Proposer]*_____. If a deliverable is rejected, the written notice from the County will specify any required changes, deficiencies, and/or additions necessary. Contractor shall then have seven (7) calendar days to revise the deliverable(s) to resubmit and/or complete the deliverable(s) for review and approval by the County, who will then have seven (7) calendar days to review and approve, or reject the deliverable(s); provided however, that Contractor shall not be responsible for any delays in the overall project schedule that result from the County's failure to timely approve or reject deliverable(s) as provided herein. Upon final acceptance of the deliverable(s), the County will accept the deliverable(s) in writing.

17. Subcontracting/Assignment.

A. Subcontracting. Contractor is fully responsible for completion of the Services required by this Agreement and for completion of all subcontractor work, if authorized as provided herein. Contractor shall not subcontract any work under this Agreement to any subcontractor other than the subcontractors specified in the proposal and previously approved by the County, without the prior written consent of the County, which shall be determined by the County in its sole discretion.

B. Assignment. (Select appropriate box.)

☐ This Agreement, and any rights or obligations hereunder, shall not be assigned, transferred or delegated to any other person or entity. Any purported assignment in violation of this section shall be null and void.

☐ This Agreement, and all rights or obligations hereunder, shall not be assigned, transferred, or delegated in whole or in part, including by acquisition of assets, merger, consolidation, dissolution, operation of law, change in effective control of the Contractor, or any other assignment, transfer, or delegation of rights or obligations, without the prior written consent of the County. The Contractor shall provide written notice to the County within fifteen (15) calendar days of any action or occurrence assigning the Agreement or any rights or obligations hereunder as described in this section. In the event the County does not consent to the assignment, as determined in its sole discretion, the purported assignment in violation of this section shall be null and void, and the County may elect to terminate this Agreement by providing written notice of its election to terminate pursuant to this provision upon fifteen (15) days notice to Contractor.

18. Survival. The following provisions shall survive the expiration or termination of the Term of this Agreement: 7, 9, 10, 13, 20, 23 (others which by their nature would survive) and ___.

19. Notices. All notices, authorizations, and requests in connection with this Agreement shall be deemed given on the day they are: (1) deposited in the U.S. mail, postage prepaid, certified or registered, return receipt requested; or (2) sent by air express courier (e.g., Federal Express, Airborne, etc.), charges prepaid, return receipt requested; or (iii) sent via email and addressed as set forth below, which designated person(s) may be amended by either Party by giving written notice to the other Party:

For County:	For Contractor:
Attn:_____	Attn:_____
_____	_____
_____	_____
_____	_____

with a copy to:
Purchasing Director
Pinellas County Purchasing Department
400 South Fort Harrison Avenue
Clearwater, FL 33756

20. Conflict of Interest.

A. The Contractor represents that it presently has no interest and shall acquire no interest, either direct or indirect, which would conflict in any manner with the performance of the Services required hereunder, and that no person having any such interest shall be employed by Contractor during the agreement term and any extensions; and during the term of this Agreement, Contractor shall not _____.

B. The Contractor shall promptly notify the County in writing of any business association, interest, or other circumstance which constitutes a conflict of interest as provided herein. If the Contractor is in doubt as to whether a prospective business association, interest, or other circumstance constitutes a conflict of interest, the Contract may identify the prospective business association, interest or circumstance, the nature of work that the Contractor may undertake and request an opinion as to whether the business association, interest or circumstance constitutes a conflict of interest if entered into by the Contractor. The County agrees to notify the Contractor of its opinion within (10) calendar days of receipt of notification by the Contractor, which shall be binding on the Contractor.

21. Right to Ownership. All work created, originated and/or prepared by Contractor in performing Services pursuant to the Agreement, including _____ and other documentation or improvements related thereto, to the extent that such work, products, documentation, materials or information are described in or required by the Services (collectively, the "Work Product") shall be County's property when completed and accepted, if acceptance is required in this Agreement, and the County has made payment of the sums due therefore. The ideas, concepts, know-how or techniques developed during the course of this Agreement by the Contractor or jointly by Contractor and the County may be used by the County without obligation of notice or accounting to the Contractor. Any data, information or other materials furnished by the County for use by Contractor under this Agreement shall remain the sole property of the County.

22. Amendment. This Agreement may be amended by mutual written agreement of the Parties hereto.

23. Severability. The terms and conditions of this Agreement shall be deemed to be severable. Consequently, if any clause, term, or condition hereof shall be held to be illegal or void, such determination shall not affect the validity or legality of the remaining terms and conditions, and notwithstanding any such determination, this Agreement shall continue in full force and effect unless the particular clause, term, or condition held to be illegal or void renders the balance of the Agreement impossible to perform.

24. Applicable Law and Venue. This Agreement shall be governed by and construed in accordance with the laws of the State of Florida (without regard to principles of conflicts of laws). The Parties agree that all actions or proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state or federal (if permitted by law and a Party elects to file an action in federal court) courts located in or for Pinellas County, Florida. This choice of venue is intended by the Parties to be mandatory and not permissive in nature, and to preclude the possibility of litigation between the Parties with respect to, or arising out of, this Agreement in any jurisdiction other than that specified in this section. Each Party waives any right it may have to assert the doctrine of *forum non conveniens* or similar doctrine or to object to venue with respect to any proceeding brought in accordance with this section.

25. Waiver. No waiver by either Party of any breach or violation of any covenant, term, condition, or provision of this Agreement or of the provisions of any ordinance or law, shall be construed to waive any other term, covenant, condition, provisions, ordinance or law, or of any subsequent breach or violation of the same.

26. Due Authority. Each Party to this Agreement represents and warrants that: (i) it has the full right and authority and has obtained all necessary approvals to enter into this Agreement; (ii) each person executing this Agreement on behalf of the Party is authorized to do so; (iii) this Agreement constitutes a valid and legally binding obligation of the Party, enforceable in accordance with its terms.

27. No Third Party Beneficiary. The Parties hereto acknowledge and agree that there are no third party beneficiaries to this Agreement. Persons or entities not a party to this Agreement may not claim any benefit from this Agreement or as third party beneficiaries hereto.

28. Entire Agreement. This Agreement constitutes the entire Agreement between the Parties and supersedes all prior negotiations, representations or agreements either oral or written.

(Signature Page Follows)

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement the day and year first written.

PINELLAS COUNTY, FLORIDA
by and through its _____

By:_____

[ADD CONTRACTOR'S NAME BELOW]
_____

By:_____
Name: _____
Title: _____

[Corporate Seal]

ATTEST:

By: _____
(Attesting Witness' name/title)

[INSERT ATTEST BOX BELOW FOR BOARD OF COUNTY COMMISSIONER AGREEMENTS]
[SUBJECT TO CHANGE]
ATTEST:
KEN BURKE, CLERK OF COURT

By:_____
Deputy Clerk

APPROVED AS TO FORM

By:_____
Office of the County Attorney

EXHIBIT A

STATEMENT OF WORK

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(Document to be Provided Prior to Agreement Execution)

EXHIBIT B

INSURANCE REQUIREMENTS

1. LIMITATIONS ON LIABILITY. By submitting a Proposal, the Proposer acknowledges and agrees that the services will be provided without any limitation on Proposer's liability. The County objects to and shall not be bound by any term or provision that purports to limit the Proposer's liability to any specified amount in the performance of the services. Proposer shall state any exceptions to this provision in its response, including specifying the proposed limits of liability in the stated exception to be included in the Services Agreement. Proposer is deemed to have accepted and agreed to provide the services without any limitation on Proposer's liability that Proposer does not take exception to in its response. Notwithstanding any exceptions by Proposer, the County reserves the right to declare its prohibition on any limitation on Proposer's liability as non-negotiable, to disqualify any Proposal that includes exceptions to this prohibition on any limitation on Proposer's liability, and to proceed with another responsive, responsible proposal, as determined by the County in its sole discretion.

2. INDEMNIFICATION. By submitting a Proposal, the Proposer acknowledges and agrees to be bound by and subject to the County's indemnification provisions as set out in the Services Agreement. The County objects to and shall not be bound by any term or provision that purports to modify or amend the Proposer's indemnification obligations in the Services Agreement, or requires the County to indemnify and/or hold the Proposer harmless in any way related to the services. Proposer shall state any exceptions to this provision in the response, including specifying the proposed revisions to the Services Agreement indemnification provisions, or the proposed indemnification from the County to the Proposer to be included in the Services Agreement. Proposer is deemed to have accepted and agreed to provide the services subject to the Services Agreement indemnification provisions that Proposer does not take exception to in its response. Notwithstanding any exceptions by Proposer, the County reserves the right to declare its indemnification requirements as non-negotiable, to disqualify any Proposal that includes exceptions to this paragraph, and to proceed with another responsive, responsible proposal, as determined by the County in its sole discretion.

3. INSURANCE:

   a) Proposal submittals should include, the Proposers current Certificate(s) of Insurance in accordance with the insurance requirements listed below. If Proposer does not currently meet insurance requirements, proposer/bidder/quoter shall also include verification from their broker or agent that any required insurance not provided at that time of submittal will be in place within 10 days after award recommendation.

   b) Within 10 days of **contract award** and prior to commencement of work, Proposer shall email certificate that is compliant with the insurance requirements to CertsOnly-Portland@ebix.com. If certificate received with proposal was a compliant certificate no further action may be necessary. It is imperative that proposer include the unique identifier, which will be supplied by the County's Purchasing Department. The Certificate(s) of Insurance shall be signed by authorized representatives of the insurance companies shown on the Certificate(s). **A copy of the endorsement(s) referenced in paragraph 3.(d) for Additional Insured shall be attached to the certificate(s) referenced in this paragraph.**

   c) No work shall commence at any project site unless and until the required Certificate(s) of Insurance are received and approved by the County. Approval by the County of any Certificate(s) of Insurance does not constitute verification by the County that the insurance requirements have been satisfied or that the insurance policy shown on the Certificate(s) of Insurance is in compliance with the requirements of the Agreement. County reserves the right to require a certified copy of the entire insurance policy, including endorsement(s), at any time during the RFP and/or contract period.

d) All policies providing liability coverage(s), other than professional liability and workers compensation policies, obtained by the Proposer and any subcontractors to meet the requirements of the Agreement shall be endorsed to include Pinellas County Board of County Commissioners as an Additional Insured.

e) If any insurance provided pursuant to the Agreement expires prior to the completion of the Work, renewal Certificate(s) of Insurance and endorsement(s) shall be furnished by the Proposer to the County at least thirty (30) days prior to the expiration date.

(1) Proposer shall also notify County within twenty-four (24) hours after receipt, of any notices of expiration, cancellation, nonrenewal or adverse material change in coverage received by said Proposer from its insurer. Notice shall be given by certified mail to: Pinellas County, c/o Ebix BPO, PO Box 257, Portland, MI, 48875-0257; be sure to include your organization's unique identifier, which will be provided upon notice of award. Nothing contained herein shall absolve Proposer of this requirement to provide notice.

(2) Should the Proposer, at any time, not maintain the insurance coverages required herein, the County may terminate the Agreement, or at its sole discretion may purchase such coverages necessary for the protection of the County and charge the Proposer for such purchase or offset the cost against amounts due to proposer for services completed. The County shall be under no obligation to purchase such insurance, nor shall it be responsible for the coverages purchased or the insurance company or companies used. The decision of the County to purchase such insurance shall in no way be construed to be a waiver of any of its rights under the Agreement.

f) The County reserves the right, but not the duty, to review and request a copy of the Contractor's most recent annual report or audited financial statement when a self-insured retention (SIR) or deductible exceeds $50,000.

g) If subcontracting is allowed under this RFP, the Prime Proposer shall obtain and maintain, at all times during its performance of the Agreement, insurance of the types and in the amounts set forth; and require any subcontractors to obtain and maintain, at all times during its performance of the Agreement, insurance limits as it may apply to the portion of the Work performed by the subcontractor; *but in no event will the insurance limits be less than $500,000 for Workers' Compensation/Employers' Liability, and $1,000,000 for General Liability and Auto Liability if required below.*

All subcontracts between Proposer and its subcontractors shall be in writing and are subject to the County's prior written approval. Further, all subcontracts shall (1) require each subcontractor to be bound to Proposer to the same extent Proposer is bound to the County by the terms of the Contract Documents, as those terms may apply to the portion of the Work to be performed by the subcontractor; (2) provide for the assignment of the subcontracts from Proposer to the County at the election of Owner upon termination of the Contract; (3) provide that County will be an additional indemnified party of the subcontract; (4) provide that the County will be an additional insured on all insurance policies required to be provided by the subcontractor except workers compensation and professional liability; (5) provide waiver of subrogation in favor of the County and other insurance terms and/or conditions as outlined below; (6) assign all warranties directly to the County; and (7) identify the County as an intended third-party beneficiary of the subcontract. Proposer shall make available to each proposed subcontractor, prior to the execution of the subcontract, copies of the Contract Documents to which the subcontractor will be bound by this Section C and identify to the subcontractor any terms and conditions of the proposed subcontract which may be at variance with the Contract Documents.

EXHIBIT B

INSURANCE REQUIREMENTS

h) Each insurance policy and/or certificate shall include the following terms and/or conditions:

(1) The Named Insured on the Certificate of Insurance and insurance policy must match the entity's name that responded to the solicitation and/or is signing the agreement with the County. If Proposer is a Joint Venture per Section A. titled Joint Venture of this RFP, Certificate of Insurance and Named Insured must show Joint Venture Legal Entity name and the Joint Venture must comply with the requirements of Section C with regard to limits, terms and conditions, including completed operations coverage.

(2) Companies issuing the insurance policy, or policies, shall have no recourse against County for payment of premiums or assessments for any deductibles which all are at the sole responsibility and risk of Contractor.

(3) The term "County" or "Pinellas County" shall include all Authorities, Boards, Bureaus, Commissions, Divisions, Departments and Constitutional offices of County and individual members, employees thereof in their official capacities, and/or while acting on behalf of Pinellas County.

(4) The policy clause "Other Insurance" shall not apply to any insurance coverage currently held by County or any such future coverage, or to County's Self-Insured Retentions of whatever nature.

(5) All policies shall be written on a primary, non-contributory basis.

(6) Any Certificate(s) of Insurance evidencing coverage provided by a leasing company for either workers compensation or commercial general liability shall have a list of covered employees certified by the leasing company attached to the Certificate(s) of Insurance. The County shall have the right, but not the obligation to determine that the Proposer is only using employees named on such list to perform work for the County. Should employees not named be utilized by Proposer, the County, at its option may stop work without penalty to the County until proof of coverage or removal of the employee by the contractor occurs, or alternatively find the Proposer to be in default and take such other protective measures as necessary.

(7) Insurance policies, other than Professional Liability, shall include waivers of subrogation in favor of Pinellas County from both the Proposer and subcontractor(s).

(8) The minimum insurance requirements and limits for this Agreement, which shall remain in effect throughout its duration and for two (2) years beyond final acceptance for projects with a Completed Operations exposure, are as follows:

(i) Workers' Compensation Insurance

Limit	Florida Statutory
Employers' Liability Limits	
Per Employee	$ 500,000
Per Employee Disease	$ 500,000
Policy Limit Disease	$ 500,000

(ii) Commercial General Liability Insurance including, but not limited to, Independent Contractor, Contractual Liability Premises/Operations, Products/Completed Operations, and Personal Injury.

EXHIBIT B

INSURANCE REQUIREMENTS

Limits

Combined Single Limit Per Occurrence	$ 1,000,000
Products/Completed Operations Aggregate	$ 1,000,000
Personal Injury and Advertising Injury	$ 1,000,000
General Aggregate	$ 2,000,000

(iii) Professional Liability (Errors and Omissions) Insurance with at least minimum limits as follows. If "claims made" coverage is provided, "tail coverage" extending three (3) years beyond completion and acceptance of the project with proof of "tail coverage" to be submitted with the invoice for final payment. In lieu of "tail coverage", Proposer may submit annually to the County, for a three (3) year period, a current certificate of insurance providing "claims made" insurance with prior acts coverage in force with a retroactive date no later than commencement date of this contract.

Limits

Each Occurrence or Claim	$5,000,000
General Aggregate	$5,000,000

For acceptance of Professional Liability coverage included within another policy required herein, a statement notifying the certificate holder must be included on the certificate of insurance and the total amount of said coverage per occurrence must be greater than or equal to the amount of Professional Liability and other coverage combined.

(iv) Cyber Risk Liability (Network Security/Privacy Liability) Insurance including cloud computing and mobile devices, for protection of private or confidential information whether electronic or non-electronic, network security and privacy; privacy against liability for system attacks, digital asset loss, denial or loss of service, introduction, implantation or spread of malicious software code, security breach, unauthorized access and use; including regulatory action expenses; and notification and credit monitoring expenses with at least minimum limits as follows:

Limits

Each Occurrence	$5,000,000
General Aggregate	$5,000,000

For acceptance of Cyber Risk Liability coverage included within another policy required herein, a statement notifying the certificate holder must be included on the certificate of insurance and the total amount of said coverage per occurrence must be greater than or equal to the amount of Cyber Risk Liability and other coverage combined.

(v) Property Insurance Proposer will be responsible for all damage to its own property, equipment and/or materials.

EXHIBIT C

PAYMENT SCHEDULE

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(Document to be Provided Prior to Agreement Execution)

EXHIBIT D

PAYMENT/INVOICES

PAYMENT/INVOICES:
SUPPLIER shall submit invoices for payment due as provided herein with such documentation as required by Pinellas County and all payments shall be made in accordance with the requirements of Section 218.70 *et. seq,* Florida Statutes, "The Local Government Prompt Payment Act." Invoices shall be submitted to the address below unless instructed otherwise on the purchase order, or if no purchase order, by the ordering department:

Finance Division Accounts Payable
Pinellas County Board of County Commissioners
P. O. Box 2438
Clearwater, FL 33757

Each invoice shall include, at a minimum, the Supplier's name, contact information and the standard purchase order number. In order to expedite payment, it is recommended the Supplier also include the information shown in below. The County may dispute any payments invoiced by SUPPLIER in accordance with the County's Dispute Resolution Process for Invoiced Payments, established in accordance with Section 218.76, Florida Statutes, and any such disputes shall be resolved in accordance with the County's Dispute Resolution Process.

INVOICE INFORMATION:

Supplier Information Company name, mailing address, phone number, contact name and email address as provided on the PO

Remit To Billing address to which you are requesting payment be sent

Invoice Date Creation date of the invoice

Invoice Number Company tracking number

Shipping Address Address where goods and/or services were delivered

Ordering Department Name of ordering department, including name and phone number of contact person

PO Number Standard purchase order number

Ship Date Date the goods/services were sent/provided

Quantity Quantity of goods or services billed

Description Description of services or goods delivered

Unit Price Unit price for the quantity of goods/services delivered

Line Total Amount due by line item

Invoice Total Sum of all of the line totals for the invoice

Pinellas County offers a credit card payment process (ePayables) through Bank of America. Pinellas County does not charge vendors to participate in the program; however, there may be a charge by the company that processes your credit card transactions. For more information please visit Pinellas County purchasing website at www.pinellascounty.org/purchase.

EXHIBIT E

DISPUTE RESOLUTION FOR PINELLAS COUNTY BOARD OF COUNTY COMMISSIONERS IN MATTERS OF INVOICE PAYMENTS:

Payment of invoices for work performed for Pinellas County Board of County Commissioners (County) is made, by standard, in arrears in accordance with Section 218.70, et. seq., Florida Statutes, the Local Government Prompt Payment Act.

If a dispute should arise as a result of non-payment of a payment request or invoice the following Dispute Resolution process shall apply:

A. Pinellas County shall notify a vendor in writing within ten (10) days after receipt of an improper invoice, that the invoice is improper. The notice should indicate what steps the vendor should undertake to correct the invoice and resubmit a proper invoice to the County. The steps taken by the vendor shall be that of initially contacting the requesting department to validate their invoice and receive a sign off from that entity that would indicate that the invoice in question is in keeping with the terms and conditions of the agreement. Once sign off is obtained, the vendor should then resubmit the invoice as a "Corrected Invoice" to the requesting department which will initiate the payment timeline.

1.) Requesting department for this purpose is defined as the County department for whom the work is performed.

2.) Proper invoice for this purpose is defined as an invoice submitted for work performed that meets prior agreed upon terms or conditions to the satisfaction of Pinellas County.

B. Should a dispute result between the vendor and the County about payment of a payment request or an invoice then the vendor should submit their dissatisfaction in writing to the Requesting Department. Each Requesting Department shall assign a representative who shall act as a "Dispute Manager" to resolve the issue at departmental level.

C. The Dispute Manager shall first initiate procedures to investigate the dispute and document the steps taken to resolve the issue in accordance with section 218.76 Florida Statutes. Such procedures shall be commenced no later than forty-five (45) days after the date on which the payment request or invoice was received by Pinellas County, and shall not extend beyond sixty (60) days after the date on which the payment request or invoice was received by Pinellas County.

D. The Dispute Manager should investigate and ascertain that the work, for which the payment request or invoice has been submitted, was performed to Pinellas County's satisfaction and duly accepted by the Proper Authority. Proper Authority for this purpose is defined as the Pinellas County representative who is designated as the approving authority for the work performed in the contractual document. The Dispute Manager shall perform the required investigation and arrive at a solution before or at the sixty (60) days timeframe for resolution of the dispute, per section 218.76, Florida Statutes. The County Administrator or his or her designee shall be the final arbiter in resolving the issue before it becomes a legal matter. The County Administrator or his or her designee will issue their decision in writing.

E. Pinellas County Dispute Resolution Procedures shall not be subject to Chapter 120 of the Florida Statutes. The procedures shall also, per section 218.76, Florida Statutes, not be intended as an administrative proceeding which would prohibit a court from ruling again on any action resulting from the dispute.

EXHIBIT E

DISPUTE RESOLUTION FOR PINELLAS COUNTY BOARD OF COUNTY COMMISSIONERS IN MATTERS OF INVOICE PAYMENTS:

F. Should the dispute be resolved in the County's favor interest charges begin to accrue fifteen (15) days after the final decision made by the County. Should the dispute be resolved in the vendor's favor the County shall pay interest as of the original date the payment was due.

G. For any legal action to recover any fees due because of the application of sections 218.70 et. seq., Florida Statutes, an award shall be made to cover court costs and reasonable attorney fees, including those fees incurred as a result of an appeal, to the prevailing party If it is found that the non-prevailing party held back any payment that was the reason for the dispute without having any reasonable lawful basis or fact to dispute the prevailing party's claim to those amounts.

EXHIBIT F

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Agreement ("Agreement") is entered into by and between _____, ("Business Associate") and Pinellas County and _____ ("Covered Entity").

RECITALS

WHEREAS, Business Associate performs functions, activities, or services for, or on behalf of Covered Entity, and Business Associate receives, has access to or creates Health Information in order to perform such functions, activities or services;

WHEREAS, Covered Entity is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations promulgated thereunder ("HIPAA"), including but not limited to, the Standards for Privacy of Individually Identifiable Health Information and the Security Standards for the Protection of Electronic Protected Health Information found at 45 Code of Federal Regulations Parts 160, 162 and 164;

WHEREAS, the Health Information Technology for Economic and Clinical Health Act ("HITECH"), part of the American Recovery and Reinvestment Act of 2009 ("ARRA"), amended provisions of HIPAA widening the scope of privacy and security protections available under HIPAA, increases the potential for legal liability and provides for more enforcement; and

WHEREAS, HIPAA requires Covered Entity to enter into a contract with Business Associate to provide for the protection of the privacy and security of Health Information, and HIPAA prohibits the disclosure to or use of Health Information by Business Associate if such a contract is not in place; and

WHEREAS, on March 26, 2013, the Department of Health and Human Services ("HHS") HIPAA Omnibus Final Rule became effective, modifying the requirements for Business Associates and Business Associates Agreements.

AGREEMENT

NOW, THEREFORE, in consideration of the foregoing which are hereby acknowledged and incorporated herein, and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties agree as follows:

ARTICLE I
DEFINITIONS

1.1 Catch-all definition: The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

EXHIBIT F

HIPAA BUSINESS ASSOCIATE AGREEMENT

1.2 "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Business Associate].

1.3 "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Pinellas County ____.

1.4 "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

1.5 "Privacy Regulations" means the Standards for Privacy of Covered Individually Identifiable Health Information, 45 Code of Federal Regulations Parts 160 and 164, promulgated under HIPAA.

1.6 "Services" means the services provided by Business Associate pursuant to the Underlying Agreement(s), or if no such agreement(s) are in effect, the services Business Associate performs with respect to the Covered Entity.

1.7 "Underlying Agreement" means the _____ Agreement executed by the Covered Entity and Business Associate, if any.

ARTICLE II
OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

2.1 Business Associate agrees to:

- 2.1.1 Not Use or Disclose Protected Health Information other than as permitted or required by the Agreement or as required by law;
- 2.1.2 Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information, to prevent use or disclosure of Protected Health Information other than as provided for by the Agreement;
- 2.1.3 Report to Covered Entity any Use or Disclosure of Protected Health Information not provided for by the Agreement of which it becomes aware, including breaches of unsecured Protected Health Information as required at 45 CFR 164.410, and any security incident of which it becomes aware;
  - 2.1.3.1 The initial report shall be made by telephone call to the Covered Entity within forty-eight (48) hours from the time the Business Associate becomes aware of the non-permitted Use or Disclosure, followed by a written report to covered Entity no later than five (5) calendar days from the date the Business Associate becomes aware of the non-permitted Use or Disclosure; and
  - 2.1.3.2 Business Associate will handle breach notifications to individuals, the HHS Office for Civil Rights (OCR), and potentially the media, on

behalf of the Covered Entity only when so directed by the Covered Entity or required by law.

2.1.4 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information;

2.1.5 Make available protected health information in a designated record set to the Covered Entity as necessary to satisfy Covered Entity's obligations under 45 CFR 164.524;

2.1.5.1 Requests received by the Business Associate directly from an individual seeking access to protected health information in a designated record set will be forwarded to the Covered Entity within two (2) business days to allow the Covered Entity to process the request.

2.1.6 Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

2.1.6.1 Requests for amendment that the Business Associate receives directly from the individual will be forwarded to the Covered Entity within two (2) business days to allow the Covered Entity to process the request.

2.1.6.2 Business Associate shall to incorporate any amendments to the information in the designated record set within two (2) business days.

2.1.7 Maintain and make available the information required to provide an accounting of disclosures to the Covered Entity within two (2) business days, as necessary to satisfy Covered Entity's obligations under 45 CFR 164.528 regardless of whether the business associate received the request for an accounting of disclosures directly from the individual, or the Covered Entity made the Business Associate aware of such a request received by the Covered Entity;

2.1.7.1 For each Disclosure that requires an accounting, Business Associate shall track the information required by the Privacy Regulations, and shall securely maintain the information for six (6) years from the date of the Disclosure.

2.1.8 To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

2.1.9 Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

2.2 Initial Effective Date of Performance. The obligations created under this Agreement shall become effective immediately upon execution of this Agreement or the agreement to which it is appended.

2.3 Permitted Uses and Disclosures of Protected Health Information.

2.3 Business Associate may only:

2.3.1.1 Use and Disclose Protected Health Information as necessary to perform Services for, or on behalf of Covered Entity **(insert description of services)** in accordance with the Underlying Agreement;

2.3.1.2 Use Protected Health Information to create aggregated or de-identified information (in accordance with the requirements of the Privacy Regulations);

2.3.1.3 Use or Disclose Protected Health Information (including aggregated or de-identified information) as otherwise directed by Covered Entity consistent with covered entity's minimum necessary policies and procedures, provided that Covered Entity shall not request Business Associate to Use or Disclose Protected Health Information in a manner that would not be permissible if done by Covered Entity;

2.3.1.4 Use or Disclose Protected Health Information as required by law;

2.3.1.5 Business Associate shall not Use Health Information for any other purpose, except that if necessary, Business Associate may Use Health Information for the proper management and administration of Business Associate or to carry out its legal responsibilities; provided that any Use or Disclosure described herein will not violate the Privacy Regulations or Florida law if done by Covered Entity.

2.3.1.6 Except as otherwise limited in this Agreement, Business Associate may Disclose Health Information for the proper management and administration of the Business Associate, provided that with respect to any such Disclosure either (a) the Disclosure is required by law (within the meaning of the Privacy Regulations) or (b) the Disclosure would not otherwise violate Florida law and Business Associate obtains reasonable written assurances from the person to whom the information is to be Disclosed that such person will hold the information in confidence and will not Use or further Disclose such information except as required by law or for the purpose(s) for which it was Disclosed by Business Associate to such person, and that such person will notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

2.4 Adequate Safeguards for Health Information. Business Associate warrants that it shall implement and maintain appropriate safeguards to prevent the Use or Disclosure of Health Information in any manner other than as permitted by this Agreement.

2.5 Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of Health

Information by Business Associate in violation of the requirements of this Agreement.

ARTICLE III
OBLIGATIONS OF COVERED ENTITY

3.1 Privacy Notice. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices to the extent such limitation(s) may affect Business Associate's Use or Disclosure of Health Information.

ARTICLE IV
TERM AND TERMINATION

4.1 Term. Subject to the provisions of Sections 4.2 and 4.3, the term of this Agreement shall be the term of the Underlying Agreement(s).

4.2 Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Agreement by the Business Associate, Covered Entity shall either:

a. notify Business Associate of the breach in writing, and provide an opportunity to cure the breach or end the violation within ten (10) business days of such notification; provided that if Business Associate fails to cure the breach or end the violation within such time period to the satisfaction of Covered Entity, Covered Entity shall have the right to immediately terminate this Agreement and the Underlying Agreement(s) upon written notice to Business Associate;

b. upon written notice to Business Associate, immediately terminate this Agreement and the Underlying Agreement(s) if Covered Entity determines that such breach cannot be cured; or

c. if Covered Entity determines that neither termination nor cure is feasible, the Covered Entity shall report the violation to the Secretary.

4.3 Termination for Breach of Section 5.2. Covered Entity may terminate the Underlying Agreement(s) and this Agreement upon thirty (30) days written notice in the event (a) Business Associate does not promptly enter into negotiations to amend this Agreement when requested by Covered Entity pursuant to Section 5.2 or (b) Business Associate does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of Health Information that the Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA.

4.4 Disposition of Health Information Upon Termination or Expiration. Upon termination or expiration of this Agreement, Business Associate shall either return or destroy, in Covered Entity's sole discretion and in accordance with any instructions by Covered Entity, all Protected Health Information in the possession or control of Business Associate and its agents and subcontractors. In such event, Business Associate shall retain no copies of such Protected Health Information. However, if the Business Associate determines that neither return nor destruction of Protected Health Information is feasible, Business Associate shall

notify Covered Entity of the conditions that make return or destruction infeasible, and may retain Protected Health Information provided that Business Associate (a) continues to comply with the provisions of this Agreement for as long as it retains Protected Health Information, and (b) further limits Uses and Disclosures of Protected Health Information to those purposes that make the return or destruction of Protected Health Information infeasible.

4.5 Survival. The obligations of Business Associate under this Article IV shall survive the termination of this Agreement.

ARTICLE V
MISCELLANEOUS

5.1 Indemnification. Notwithstanding anything to the contrary in the Underlying Agreement(s), at Business Associate's expense, Business Associate agrees to indemnify, defend and hold harmless Covered Entity and Covered Entity's employees, directors, officers, subcontractors or agents (the "Indemnities") against all damages, losses, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) and all liability to third parties arising from any breach of this Agreement by Business Associate or its employees, directors, officers, subcontractors, agents or other members of Business Associate's workforce. Business Associate's obligation to indemnify the Indemnitees shall survive the expiration or termination of this Agreement for any reason.

5.2 Amendment to Comply with Law. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA and other applicable laws relating to the security or confidentiality of Health Information. The parties understand and agree that Covered Entity must receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all Health Information that it receives or creates on behalf of Covered Entity. Upon Covered Entity's request, Business Associate agrees to promptly enter into negotiations with Covered Entity, concerning the terms of any amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA or other applicable laws.

5.3 Relationship to Underlying Agreement(s) Provisions. In the event that a provision of this Agreement is contrary to a provision of an Underlying Agreement(s), the provision of this Agreement shall control. Otherwise, this Agreement shall be construed under, and in accordance with, the terms of such Underlying Agreement(s), and shall be considered an amendment of and supplement to such Underlying Agreement(s).

5.4 Modification of Agreement. No alteration, amendment, or modification of the terms of this Agreement shall be valid or effective unless in writing and signed by Business Associate and Covered Entity.

5.5 Non-Waiver. A failure of any party to enforce at any time any term, provision or condition of this Agreement, or to exercise any right or option herein, shall in no way operate as

a waiver thereof, nor shall any single or partial exercise preclude any other right or option herein. In no way whatsoever shall a waiver of any term, provision or condition of this Agreement be valid unless in writing, signed by the waiving party, and only to the extent set forth in such writing.

5.6 Agreement Drafted By All Parties. This Agreement is the result of arm's length negotiations between the parties and shall be construed to have been drafted by all parties such that any ambiguities in this Agreement shall not be construed against either party.

5.7 Severability. If any provision of this Agreement is found to be invalid or unenforceable by any court, such provision shall be ineffective only to the extent that it is in contravention of applicable laws without invalidating the remaining provisions hereof.

5.8 Section Headings. The section headings contained herein are for convenience in reference and are not intended to define or limit the scope of any provision of this Agreement.

5.9 No Third Party Beneficiaries. There are no third party beneficiaries to this Agreement.

5.10 Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and will become effective and binding upon the parties as of the effective date at such time as all the signatories hereto have signed a counterpart of this Agreement.

5.11 Notices. Any notices required or permitted to be given hereunder by either party to the other shall be given in writing: (1) by personal delivery; (2) by electronic facsimile with confirmation sent by United States first class registered or certified mail, postage prepaid, return receipt requested; (3) by bonded courier or by a nationally recognized overnight delivery service; or (4) by United States first class registered or certified mail, postage prepaid, return receipt requested, in each case, addressed to:

If to Business Associate:

If to Covered Entity: _____
_____
_____

or to such other addresses as the parties may request in writing by notice given pursuant to this Section 5.12. Notices shall be deemed received on the earliest of personal delivery; upon delivery by electronic facsimile with confirmation from the transmitting machine that the transmission was completed; twenty-four (24) hours following deposit with a bonded courier or overnight delivery service; or seventy-two (72) hours following deposit in the U.S. Mail as required herein.

EXHIBIT F

HIPAA BUSINESS ASSOCIATE AGREEMENT

5.12 Applicable Law and Venue. This Agreement shall be governed by and construed in accordance with the internal laws of the State of Florida (without regard to principles of conflicts of laws). The parties agree that all actions or proceedings arising in connection with this Agreement shall be tried and litigated exclusively in the state courts located in Pinellas County, Florida or federal court (if permitted by law and a party elects to file an action in federal court) in the Tampa Division of the Middle District of Florida. This choice of venue is intended by the parties to be mandatory and not permissive in nature, and to preclude the possibility of litigation between the parties with respect to, or arising out of, this Agreement in any jurisdiction other than that specified in this Section 5.12. Each party waives any right it may have to assert the doctrine of *forum non conveniens* or similar doctrine or to object to venue with respect to any proceeding brought in accordance with this Section 5.12.

5.13 Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Regulations.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective as of the date stated above.

COVERED ENTITY	**BUSINESS ASSOCIATE**
By:_____	By:_____
Print Name:_____	Print Name:_____
Title:_____	Title:_____
Dated:_____	Dated:_____

Approved as to form subject to proper execution

By: _____
Office of the County Attorney