December 2, 2015

David Blasewitz
Director, HR Services Division
Pinellas County Board of Country Commissions
400 S. Ft. Harrison Avenue
Clearwater, FL 33756

RE: 2016 Financial Renewal under the Administrative Services Agreement ("ASA") United HealthCare Services, Inc. and Pinellas County Board of County Commissioners

Dear David Blasewitz:

This letter is confirmation of your Financial Renewal per the attached documents.

Please feel free to contact me at 973-849-1690 with any questions regarding the attachments. Please file this letter and its attachments with your ASA.

Thank you,

Regional Contract Manager

Attachments: A and B

EXHIBIT A

THE AMENDED FINANCIAL TERMS ARE AS FOLLOWS:

This Exhibit A shall not alter, vary, or affect any previously agreed to financial terms that are not amended by this Exhibit A.

Contract Number 214279
The following financial terms are effective for the period January 1, 2016 to December 31, 2016 unless otherwise identified.

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

The Standard Medical Service Fees are as stated below. These fees do not include state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan or United, including but not limited to those imposed pursuant to The Patient Protection and Affordable Care Act of 2010, as amended from time to time as these are the responsibility of the Plan.

The Standard Medical Fees are based upon an estimated minimum of 3,502 enrolled Employees.

- $33.71 per Employee per month covered under the "UnitedHealthcare *Choice Plus*" portion of the Plan.
- $35.05 per Employee per month covered under the "UnitedHealthcare *Choice Plus HSA*" portion of the Plan.*
- $33.71 per Employee per month covered under the "UnitedHealthcare *Options PPO Non-Differential*" portion of the Plan.

Average Contract Size: 1.86

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

Diabetes Prevention and Control Program

The following financial terms are effective for the period January 1, 2016 to December 31, 2016

Diabetes Prevention Program (DPP) Participating Member Fees Virtual Diabetes Prevention Program Included (if selected by Customer)			
Action	**Metric**	**Claim Payment**	**Cumulative Payment**
Member enrolls in program	Enrolled in a DPP class and attends at least one of the 16 sessions	$200	$200
Member participates in the program	Enrolled in a DPP class and attends at least four of the 16 sessions	$120	$320
Member completes the program	Enrolled in a DPP class and attends at least nine of the 16 sessions	$195	$515
Member completes the program and loses >=5% weight	Enrolled in a DPP class and attends at least nine of the 16 sessions and loses >= 5% within 60 days of class completion	$145	$660
-- OR --			
Member completes the program and loses >=9% weight	Enrolled in a DPP class and attends at least nine of the 16 sessions and loses >= 9% within 60 days of class completion	$180	$695
DPP Testing Event Fee			
Administration	Testing event administration fee per participant		$30
A1c test	Hemoglobin A1c test per participant		$15
Net Fees			$45
DPP At Home Lab Screening			
A1c Kit	Includes physician order, prefilled lab form and mailing		$20
A1c Results	Includes rehydration, analysis, results reporting and data load to portal		$25
Net Fees			$45

Diabetes Control Program (DCP) Participating Member Fees		
A1c <= 7.5%	If initially <= 7.5%, participant must maintain – *OR*– If initially > 7.5% , metric is achieved if: ▪ a reduction of at least 10% is achieved – *OR*– ▪ the final A1c measurement is <= 7.5%.	$90
LDL <= 100	If initially <= 100, participant must maintain – *OR*– If initially > 100, metric is achieved if: ▪ a reduction of at least 50% is achieved – *OR*– ▪ the final LDL measurement is <= 100	$90
Systolic Blood Pressure <= 130	If initially <= 130 , participant must maintain – *OR*– If initially > 130 (upper limit of 180), metric is achieved if: ▪ a reduction of at least 20% is achieved – *OR*– ▪ the final systolic blood pressure reading is <= 130	$90
Weight /BMI <= 25	If initially <= 25, participant must maintain – *OR*– If initially >25, metric is achieved if: ▪ reduction of at least >= 10% is achieved – *OR*– ▪ the final BMI measurement is <= 25	$90

1. There must be at least three measurements within the participant's program year 2. Two measurements that are at least 180 days apart must be in control per the stated guidelines 3. All measurements match a visit date		
DCP Consultation Participating Member Fees		
First Consultation with Pharmacist	One-time fee	$125
Follow-up Consultation with Pharmacist	Per consultation, four recommended per program per year	$89
DCP Lab Kit Fees		
Kit	Includes physician order, prefilled lab form and mailing	$20
A1c test	Includes rehydration, analysis, results reporting and communication to pharmacy partners	$15
Lipid panel	Includes rehydration, analysis, results reporting and communication to pharmacy partners	$25
Net Fees per Lab		$60
DCP Point of Care Lab Fees		
A1c test	Includes analysis and results reporting	$25
Lipid panel	Includes analysis and results reporting	$35
Net Fees per Lab		$60

Credit

Wellness Allowance

United will provide a wellness allowance so Customer may enhance Customer's medical benefits during the term of the Agreement. The wellness allowance may be used at Customer's discretion as Customer utilizes wellness programming and services from United. This credit is available during the first year.

$50,000 Wellness allowance in 2016

EXHIBIT B – PERFORMANCE GUARANTEES FOR HEALTH BENEFITS

The Standard Medical Service Fees (excluding Optional and Non-Standard Fees and that portion of the Standard Medical Service Fees attributable to Commission Funds, if applicable, as described in Exhibit B), (hereinafter referred to as "Fees") payable by Customer under this Agreement will be adjusted through a credit to its 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, 2016 and ending on December 31, 2016 (Each twelve month period is a "Guarantee Period"). With respect to the aspects of our performance addressed in this exhibit, these fee adjustments are Customer's exclusive financial remedies.

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

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

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

ID Cards			
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, passed a system load test and has been released to the ID card production area.		
Measurement	Percentage of cards issued		98%
	Issuance time frame, business days or less	business days	10
Criteria	Calculated on a pro-rated basis, based on the actual number of late cards as a percent of the total number of cards. ID card turnaround time guarantees are based on Our performance during the implementation process.		
Level	Customer specific		
Period	Initial implementation timeframe		
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		
Claim Operations			
Time to Process in 10 Days			
Definition	The percentage of all claims We receive 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		
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

Client Name: Pinellas County Board of County Commissioners
Contract Start Date: 1/1/2016
Contract End Date: 12/31/2016

Contingent on purchase of both Case and Disease Management programs

Metric	Definition	Guaranteed Result	Result Timeframe	$ Fees 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. • In the event that qualified, eligible members do not exist, the PG will be considered passing
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/Stratisfication 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	**<u>Case Management</u>** 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 comparing the medical cost trends for the participant and non-participants groups, during the intervention year. **<u>Disease Management</u>** 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	• 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 - 90% of savings - 50% of fees at risk 70 - 80% 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 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 • Requires a minimum membership of 3,000 for client specific results

					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).	
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Total Fees at Risk	**$ 20,000**