BOARD OF COUNTY COMMISSIONERS

DATE: August 9, 2011
AGENDA ITEM NO. 27b

Consent Agenda ☐ **Regular Agenda** ☑ **Public Hearing** ☐

County Administrator's Signature:

Subject:

Approval of Final Agreement - Medical Benefits
Contract No. 101-0224-P (AM)

Department:

Human Resources / Purchasing

Staff Member Responsible:

Peggy Rowe / Joe Lauro

Recommended Action:

I RECOMMEND THE BOARD OF COUNTY COMMISSIONERS (BOARD) APPROVE THE FINAL NEGOTIATED AGREEMENT WITH THE HIGHEST RANKED FIRM, UNITED HEALTH CARE (UHC), TAMPA, FLORIDA.

IT IS FURTHER RECOMMENDED THAT AFTER PROPER EXECUTION OF THE AGREEMENT BY THE VENDOR, THE CHAIRMAN SIGN THE AGREEMENT AND THE CLERK ATTEST.

Summary Explanation/Background:

On May 24, 2011, the Board approved the ranking of three (3) firms pertaining to a contract for third party administrator services for the County's employee medical benefits Plan and authorized Buck Consultants (Buck), acting on behalf of Pinellas County, to negotiate a final contract with the firm who offered the most comprehensive and cost effective services.

A final agreement with the successful firm, UHC, has been negotiated by Buck and reviewed by County staff and is presented to the Board for consideration. Some of the key features offered by the new contract are listed below.

Key negotiation points:

1. Estimated savings utilizing the new contract compared to the current contract is $44,000.00 per year.

2. Enhancements or new services which were added as a result of negotiations and the cost had the concessions not been received:
   a. Administrative fees
      - Current fee: $33.12 Per Employee Per Month (PEPM) ($1,465,419 annual fees)
      - Initial offer: $33.12 ($1,465,419)
      - Final negotiated: $32.12 ($1,421,175)
        Based on estimated headcount of 3687, savings of $44,244 from initial offer. Fees noted above are estimated composite fees based on assumed enrollment. Actual fees vary by product ($32.04 PEPM Choice Plus, $35.39 PEPM Health Reimbursement Account (HRA), $33.33 PEPM Health Savings Account (HSA)

b. Stop loss fees:

UHC agreed to lower fee

- Current: $16.17 PEPM ($715,425 annual fees)
- Initial offer: $19.88 ($879,571)
- Final negotiated: $18.11 ($801,259)
- Based on estimated headcount of 3687, savings of $78,312 from initial offer.

c. Medicare Advantage Rates:

UHC agreed to lower rate

- Current: $345.80 ($2,601,799 annual premium)
- Initial offer: $441.50 ($3,321,846)
- Final negotiated: $397.67 ($2,992,069)
- Based on estimated headcount of 627, savings of $329,777 from initial offer :

d. Wellness Fund:

UHC agreed to an annual credit of $50,000 and agreed on credit being used for any items.

- UHC will still be offering the $50,000 wellness fund to the County, but will make it available prior to 1/1/12 as needed for any items the County may require before the beginning of the new policy year.
- It is not a requirement of the fund to be used for UHC services, products, etc.

e. Performance Guarantees:

UHC agreed to all of the standards requested in the performance guarantees, however utilizing percentage gradients instead of the flat percentage requested.

UHC will agreed to customer-specific performance guarantees:

- UHC is offering Case Management (CM) Enrollment performance guarantees.
- Disease Management (DM) Program Enrollment is guaranteed on a customer-specific basis.
- UHC agreed to a participation guarantee in the newly proposed Telephonic Coaching Program.
- The final metric added to the customer-specific clinical performance guarantee is an overall combined savings for CM and DM.

f. Telephonic Wellness Coaching:

UHC agreed to implement this program 10/1/11 and have submitted the appropriate paperwork to initiate the 90-day implementation.

g. Health Kiosks:

The Health Kiosk is a convenient and visible on-site solution that motivates employees to make healthy behavior changes. The Health Kiosk provides:

- Employees with easy access to their key biometric data.
- Employees the ability to track progress toward their health goals.
- Organizations the ability to assess the overall health status of their employee population with de-identified data.

UHC offered to provide two (2) kiosks at no cost to be installed prior to 1/1/12 .The kiosks do not feed to the incentive program at this time, but will feed to the Personal Health Record and Health Assessment

h. Incentive Tracking:

UHC agreed that Personal Rewards will be available to Pinellas County in 2013, or at whatever later date Pinellas decides to implement.

. UHC agreed that Telephonic Coaching is being offered 1/1/12 at no additional cost, as this is a prerequisite to Personal Rewards.

. UHC agreed to continue to provide for the cost associated with Telephonic Coaching (and the current level of costs for Health Rewards) once the County decides to migrate from Health Rewards to Personal Rewards.

UHC agreed that any costs, however, which may be over and above current Health Rewards and Telephonic Coaching costs will not be absorbed by UHC. There is a value to the program which is very personalized for each member, based on their health, age, sex status.

Fiscal Impact/Cost/Revenue Summary:

After Negotiation the Medical Plan Annual Cost including:

Administrative Fees	$ 34,421,000.00
First Year Claims	$ 33,000,000.00
First Year Estimated Administrative Fees	$ 1,421,000.00

Note: The approval of this item commits the County to administrative fees only. Claim costs are self-funded and subject to fluctuations in enrollment and medical costs incurred by members.

Exhibits/Attachments

1. Final Agreement

Commission Agenda Date: August 9, 2011

Item No. : 27b.

Final Agreement for

United Health Care for

Medical Benefits

Will be Distributed At Completion of Review

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 _____

Print Title _____

Date _____

ATTEST:
KEN BURKE

By _____
Deputy Clerk

APPROVED AS TO FORM:

Michelle Wallace
Office of the County Attorney

UHCASA05 (2/05)

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Section 1 - Definitions

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

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	$ 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. • 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.