Agenda item is more than 50 pages; may be viewed in Administration.

Agenda Item # 5F-1

PALM BEACH COUNTY
BOARD OF COUNTY COMMISSIONERS
AGENDA ITEM SUMMARY

Meeting Date: 10/18/11 **[ ] Consent** **[X] Regular**
[ ] Ordinance **[ ] Public Hearing**

Department:

Submitted By: Risk Management

Motion and Title: Staff recommends motion to approve:

A) The selection of Cigna Health and Life Insurance Company (CIGNA) for plan year 2012 following a Request for Proposal (RFP No. 11-057/LJ) for claims administration services for the County's self-insured health insurance plans; and
B) Administrative Services Only Agreement and associated performance guarantees with CIGNA for claims administration services for the County's self-funded health insurance plans for the period January 1, 2012 through December 31, 2012 (with four annual options to renew) totaling $2,421,070; and
C) Actuarial rates per coverage tier for plan year 2012; and
D) An effective date for the sunset of the PPO Plan which currently has only 16 participants remaining, hereby proposed to be December 31, 2012
E) A Fourth Amendment to Interlocal Agreement R2002 2287, extending its term for five (5) years for the period January 2, 2012 through December 31, 2016

Summary: Having completed the last remaining renewal option with CIGNA for expiring plan year 2011, staff issued an RFP for health plan administrative services, including stop loss insurance, disease management and mental health, for the County's self-funded health insurance plans on behalf of the employees of the Board, Supervisor of Elections, and Palm Tran, Inc. (collectively participating in the plan through the provisions of Interlocal Agreement R2002 2287). The selection committee chose CIGNA over four competing proposals on the basis that CIGNA offered the deepest discounts on medical and pharmaceutical costs and provided the least amount of provider network disruption. The new contract will include the services of a full time onsite wellness coordinator, fully funded by Cigna, and an increase in the wellness allowance provided by CIGNA from $30,000 per year to $50,000 per year. The total projected health plan and administrative expense for plan year 2012 is $65,722,423. Staff recommends that employee contributions and cost-sharing remain unchanged for plan year 2012, following significant changes that were collectively bargained and put in effect in the expiring plan year (2011). The total cost of the plan represents an increase of $4,390,678 over the actuary's projected cost of the expiring plan year. The amount of the increase has been reduced from an earlier actuarial estimate due to favorable claims experience in the current plan year following the implementation of the plan changes. This increase has been contemplated in the 2012 budget, and is necessary to secure the financial stability of the fund following three years with no increase in the County's portion of the plan's funding due to a higher than expected accumulation in the fund which was used to offset the County's costs in prior plan years. Sufficient funds have been budgeted to fund the program. Countywide (TKF)

Background and Policy Issues: (Continued on Page 3).

Attachments:
1. Letter from CIGNA confirming fees and Stop Loss premiums for plan year 2012.
2. Letter and attachment from Gallagher Benefit Services, Inc. illustrating Plan year 2012 cost projections and recommended actuarial rates for each plan and associated tier of coverage.
3. Administrative Services Only Agreement with CIGNA, including Performance Guarantees
4. Fourth Amendment of the Interlocal Agreement R2002 2287; 5) Disclosure of Ownership Interests

Recommended by: Nancy L. Bolton 10/4/11
Department Director **Date**

Approved by: 10/11/11
Assistant County Administrator **Date**

II. FISCAL IMPACT ANALYSIS

A. Five Year Summary of Fiscal Impact:

Fiscal Years	2012	2013	2014	2015	2016
Capital Expenditures					
Operating Costs	2,017,558	403,512			
External Revenues					
Program Income (County)					
In Kind Match (County)					
NET FISCAL IMPACT	$2,017,558	403,512			
# ADDITIONAL FTE POSITIONS (Cumulative)					

Is Item Included In Current Budget? Yes X No. _____

Budget Account No.: Fund 5012 **Dept** 700 **Unit** 7300 **Object** 4511 **Program Code** _____

B. Recommended Sources of Funds/Summary of Fiscal Impact:

Est. Adm/Excess Ins. Fees ($43.30 per month *12)	$519.65
Est. Employees	4659
Est. Total Adm/Excess Ins. Fees	$2,421,070

C. Departmental Fiscal Review: Jessica Kolb 9/29/11

III. REVIEW COMMENTS

A. OFMB Fiscal and/or Contract Administration Comments:

10/5/11
OFMB 10/3/11 10/3/11

10/7/11
Contract Administration

B. Legal Sufficiency:

10/11/11
Assistant County Attorney

C. Other Department Review:

_____
Department Director

Background and Policy Issues:

During the RFP process responses from five carriers were evaluated based on administrative costs, provider and prescription drug discounts, provider networks and other criteria, and the selection committee ranked each proposer and voted to recommend that CIGNA remain the provider of Administrative Services for the HMO, POS and PPO plans and that no other competing plan be offered. CIGNA continues to offer the most competitive discounts and networks in Palm Beach County when compared to its peers.

The County has self-insured its triple-option health insurance plan (HMO, POS & PPO) since 2003. Annual claims experience has been consistent with, or in some years, more favorable than the numbers projected by the plan's actuary since the County became self-insured, with the exception of plan years 2006 and 2010 when actual experience exceeded the Actuary's projection. The plan's favorable claims experience for most of its self-insured years, coupled with the addition of interest income and prescription drug rebates contributing to the revenue received in the fund, allowed the plan to accumulate a fund balance that allowed the fund to remain in excess of the 60 days of claims "safe harbor" threshold established by the Office of Insurance Regulation for many years, resulting in no necessary increase in the Board's annual amount of funding since 2008. However, due to the higher than expected claims in plan year 2010, the fund fell below the 60 day safe harbor, and therefore it was necessary to increase the Board's amount of funding for the plan for 2012. This was contemplated in the Agenda item presented for the 2011 renewal, and in the 2012 budget process.

The benefit plan design changes for the HMO, POS, and prescription drug plans which went into effect in January of 2011 have proven cost effective and are showing a better than expected impact on monthly claims costs. For plan year 2012, it is estimated that employee premiums and out of pocket costs (co-payments, deductibles, etc.) will constitute 15% of the total amount of the plan's costs.

PPO rates are based on the true actuarial cost of claims, and have become cost prohibitive. With only 16 employees remaining in this plan, staff recommends that the plan be discontinued entirely at the end of the 2012 plan year. The plan was closed to new employees effective January 1, 2011.

The specific excess insurance cap (stop loss insurance) will remain at $550,000 for any one claimant in the current plan year. Since the County changed its insurance funding arrangement to self-insured, only two claims have reached and exceeded this threshold (with an additional claim expected to reach the threshold in the expiring plan year).

In conjunction with its administrative services, CIGNA will provide one full time wellness coordinator to serve the County in a dedicated, onsite role. The coordinator will, among other tasks, work with the County to improve its wellness program and facilitate the completion of Health Risk Assessments by County employees, which will provide customized data containing information that will be helpful in assisting the County with developing its wellness initiatives. Additionally, the wellness funding allowance offered by CIGNA will increase from $30,000 to $50,000 annually.

Dina D'Angelo
Sr. Client Manager

A HealthCare

September 26, 2011

1571 Sawgrass Corp Pkwy
Suite 140
Sunrise, Florida 33323
Telephone 954-514-6877
dina.dangelo@cigna.com

Nancy Bolton
Director, Risk Management
Palm Beach County Board of County Commissioners
100 Australian Avenue, Suite 200
West Palm Beach, FL 33406

Dear Nancy,

This letter is to confirm the renewal rates for the period January 1st, 2012 – December 31st, 2012.

Administrative Fee

Network	$16.12 per employee per month
Network Point of Service	$16.12 per employee per month
PPO	$16.12 per employee per month

Access Fee (inclusive of Disease Management fee)

Network	$17.49 per employee per month
Network POS	$17.49 per employee per month
PPO	$15.90 per employee per month

Specific Stop Loss @ $550,000

Network	$9.55 per employee per month
Network Point of Service	$9.55 per employee per month
PPO	$9.55 per employee per month

HIPAA $ .15 per employee per month

Sincerely,

Dina D'Angelo
Dina D'Angelo
Sr. Client Manager

Proud National Sponsor of the March of Dimes WalkAmerica®... the Walk that Saves Babies

Gallagher Benefit Services, Inc.
A Subsidiary of Arthur J. Gallagher & Co.

September 21, 2011

Ms. Nancy Bolton
Director, Risk Management
Palm Beach County
100 Australian Ave., Ste 200
West Palm Beach, FL 33406

Re: 2012 Health Plan Projections

Dear Nancy:

I have reviewed the County's claim experience under your health plan through July 2011. I project the total 2012 expense, based on an average enrollment of 4,659 employees (which is the current enrollment) and the final fixed costs as negotiated with CIGNA, to be as follows:

Expected Claims	$63,301,353
ASO/Access Fees	$1,887,149
Reinsurance Premiums	$533,921
Total Projected 2012 Expense	**$65,722,423**

The funding rates on the attached exhibit generate expected revenue equal to this expense. Provided experience is in line with our expectations, this will keep the plan's Fund Balance at its current level, and that level is consistent with the Office of Insurance Regulation's (OIR) safe harbor threshold. The plan changes that the Board approved for 2011 have been successful in reducing the cost of the plan, as we now project the operating loss for 2011 will be approximately $1.1 million less than we had projected ($1.8 million instead of $2.9 million), and that improvement is over and above the significant savings assumed in the original projection.

For your reference, I have attached a copy of the 2011 and recommended 2012 funding rates, showing the annualized funding produced for both years. The 2012 rates represent an overall increase of 16%, with no change in the employee portion of the rates. As noted above, the County has intentionally set the rates below the expected cost of the plan in recent years in order to reduce the Fund Balance. Because of that, it is now necessary to increase the rates by more than prevailing medical inflation of 10% to 11% in order to get the funding high enough to cover the plan's expenses and prevent further erosion of the Fund Balance.

Anticipated pharmacy rebates and investment income allocated to the fund may add close to $1 million to the fund in 2012 and that will provide a margin to protect against higher than expected claims without having the plan's Fund Balance fall below the OIR safe harbor.

One Boca Place
2255 Glades Road, Suite 400E
Boca Raton, FL 33431
561.995.6706
Fax 561.995.6708
www.ajg.com

Nancy, please let me know if you have any questions about this or need any additional information.

Sincerely,

Glen R. Volk, FSA, MAAA
Consulting Actuary

cc: Jeff Angello

Palm Beach County Board of County Commissioners
2012 Funding Illustrations Based on Breakeven Funding With No Changes to Employee Rates

Based on Current Total Enrollment

		2011 Monthly Funding Rates				2012 Monthly Funding Rates			
Plan	Tier	Enrollees	Total	County	Employee	Enrollees	Total	County	Employee
HMO	EE	1,975	$ 564.44	$ 539.44	$ 25.00	1,975	$ 654.93	$ 629.93	$ 25.00
	EE + 1	1,060	$ 1,171.06	$ 1,005.98	$ 165.08	1,060	$ 1,358.79	$ 1,193.71	$ 165.08
	Family	1,245	$ 1,604.54	$ 1,325.67	$ 278.87	1,245	$ 1,861.76	$ 1,582.89	$ 278.87
	Subtotal	4,280	$ 52,244,939	$ 45,386,303	$ 6,858,635	4,280	$ 60,620,344	$ 53,761,709	$ 6,858,635
POS	EE	231	$ 626.09	$ 571.09	$ 55.00	231	$ 726.46	$ 671.46	$ 55.00
	EE + 1	86	$ 1,278.91	$ 1,009.54	$ 269.37	86	$ 1,483.93	$ 1,214.56	$ 269.37
	Family	46	$ 1,751.85	$ 1,340.92	$ 410.93	46	$ 2,032.69	$ 1,621.76	$ 410.93
	Subtotal	363	$ 4,022,378	$ 3,365,095	$ 657,283	363	$ 4,667,208	$ 4,009,925	$ 657,283
PPO	EE	13	$ 1,579.78	$ 1,279.78	$ 300.00	13	$ 1,833.04	$ 1,533.04	$ 300.00
	EE + 1	3	$ 3,564.79	$ 2,350.79	$ 1,214.00	3	$ 4,136.26	$ 2,922.26	$ 1,214.00
	Family	-	$ 4,999.57	$ 3,001.57	$ 1,998.00	-	$ 5,801.05	$ 3,803.05	$ 1,998.00
	Subtotal	16	$ 374,778	$ 284,274	$ 90,504	16	$ 434,860	$ 344,356	$ 90,504
Total All Plans		4,659	$ 56,642,095	$ 49,035,672	$ 7,606,423	4,659	$ 65,722,412	$ 58,115,989	$ 7,606,423
Annual 2012 Increase in $							$ 9,080,317	$ 9,080,317	$ -

Attachment 3

Administrative Services Only Agreement

By and Between

Palm Beach County Board of County Commissioners
"Employer"

And

CIGNA Health and Life Insurance Company
"CHLIC"

Effective Date: January 1, 2012

Table of Contents

THIS AGREEMENT, effective January 1, 2012 (the "**Effective Date**") is by and between Palm Beach County Board of County Commissioners ("**Employer**") and CIGNA Health and Life Insurance Company ("**CHLIC**"). This Agreement replaces any and all prior agreements between the parties with respect to the subject matter hereof.

RECITALS:

WHEREAS, Employer, as Plan sponsor, has adopted the benefit described in Exhibit A, as may be amended, ("**Plan**") for certain of its employees/members and their eligible dependents (collectively "**Members**"); and

WHEREAS, the employees of the Palm Beach County Board of County Commissioners, Palm Tran, Inc. and the Supervisor of Elections participate in the Plan under the provisions of Interlocal Agreement #2002 2287 as amended; and

WHEREAS, Employer has requested CHLIC to furnish certain administration services in connection with the Plan 3212040

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is hereby agreed as follows:

Definitions

Applicable Law – means the state, federal and international laws and regulations that apply. Applicable Law includes but is not limited to the Employee Retirement Income Security Act of 1974, as amended and the rules and regulations thereunder ("**ERISA**"), the Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations thereunder ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

Agreement – this entire document including the Schedule of Financial Charges and all Exhibits.

Bank Account – a benefit plan account with a bank designated by CHLIC; established and maintained by Employer in its or a nominee's name.

ERISA – the Employee Retirement Income Security Act of 1974, as amended and related regulations.

Extra-Contractual Benefits – Payments which Employer has instructed CHLIC to make for health care services and/or products that CHLIC has determined are not covered under the Plan

Member – a person eligible for and enrolled in the Plan as an employee or dependent.

Participant/Participating Members – Member(s) who is (are) participating in a specific program and/or product available to Members under the Plan.

Participating Providers – providers of health care services and/or products, who/which contract directly or indirectly with CHLIC to provide services and/or products to Members.

Plan Benefits – Amounts payable for covered health care services and products under the terms of the Plan.

Party/Parties – refers to Employer and CHLIC, each a "Party" and collectively, the "Parties".

Plan Year – the twelve (12) month period, beginning on the Effective Date and, thereafter, each subsequent

twelve (12) month period.

Run-Out Claims – claims for Plan Benefits relating to health care services and products that are incurred prior to termination of this Agreement; termination of a Plan benefit option or eligible Members, as applicable.

Section 1. Term and Termination of Agreement

The initial term of this Agreement shall be the twelve (12) months commencing on the Effective Date hereof; thereafter, this Agreement, (subject to CHLIC's right to revise charges as provided in Section 8.a.), shall automatically renew for successive terms of twelve (12) months unless, at least sixty (60) days prior to the end of the then current term the Employer gives written notice that it will not renew the Agreement, or unless otherwise terminated as provided.

a. This Agreement shall terminate upon the earliest of the following dates:

i. The end of the term in which delivery of written notice of non-renewal.

ii. The effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement;

iii. (a) At the option of CHLIC, two (2) business days from the time Employer fails to respond to a request (from either CHLIC or Citibank) to deposit funds necessary to maintain the Bank Account in a sufficient amount pursuant to Section 3.a. CHLIC reserves the right to suspend the payment of claims during any period of insufficient funds in Bank Account;

(b) At the option of CHLIC, fifteen (15) days from the date upon which the Employer fails to pay the administration charge as provided in Section 4.

(c) CHLIC shall immediately communicate to the Employer, in writing, its election of this option (to terminate)

iv. At the option of either party, on the date specified in a written notice to the other of its intention to terminate, said notice to be given by Employer at least sixty (60) days prior to the specified date; or

v. Any other date mutually agreeable to the Employer and CHLIC.

vi. Notwithstanding the foregoing, all provisions in this Agreement reasonably related to CHLIC's administration of the Plan's Pharmacy Benefit (as such term is defined in the Schedule of Financial Charges) (the "Pharmacy Benefit Provisions"), shall continue in effect for no less than thirty-six (36) months commencing on the Effective Date, except that, if any of the following dates occurs, the Pharmacy Benefit Provisions will cease being in effect as of such date:

(a) The effective date of any Applicable Law or governmental action which prohibits performance of the activities in connection with the Pharmacy Benefit required by this Agreement;

(b) The date upon which Employer fails to fund the Bank Account as required by this Agreement for claims under the Pharmacy Benefit or fails to pay CHLIC any charges in connection with the Pharmacy Benefit identified in this Agreement when due, provided CHLIC notifies Employer of its election to terminate the Pharmacy Benefit Provisions; or

(c) The date that is sixty (60) days after notice by one Party ("non-defaulting party") of the material breach by the other Party (the "defaulting party") of a material obligation of the defaulting party related to the Pharmacy Benefit (other than failure to fund the Bank

Account or failure to pay any charges when due pursuant to Section 1.vi.b above) that is not cured to the reasonable satisfaction of the non-defaulting party within a reasonable time following the initial notice of breach.

(d) Should Employer terminate the administration of the Plan's Pharmacy Benefit prior to the end of thirty-six months from the Effective Date, CHLIC may, at its option, adjust the medical administration charges

During such thirty-six (36) month period (or shorter period, as applicable under (a), (b) or (c)above), CHLIC will continue to be the exclusive provider of Pharmacy Benefit administration services for the Plan's Pharmacy Benefit.

Section 2. Claim Administration and Additional Services

a. While this Agreement is in effect, CHLIC shall, consistent with, the claim administration policies and procedures then applicable to its own health care insurance business; (i) receive and review claims for Plan Benefits; (ii) determine the Plan Benefits, if any, payable for such claims; (iii) disburse payments of Plan Benefits to claimants; and (iv) provide in the manner and within the time limits required by Applicable Law, notification to claimants of (a) the coverage determination or (b) any anticipated delay in making a coverage determination beyond the time required by Applicable Law.

b. Following (i) termination of this Agreement, except pursuant to Section 1.a (iii); (ii) termination of Plan benefit option or (iii) termination of eligible Members, if the required fees have been paid in full, CHLIC shall process Run-Out Claims for the applicable Run-Out Period (See Schedule of Financial Charges for applicable fees and Run-Out Period). At the termination of any applicable Run-Out Period, CHLIC shall cease processing Run-Out Claims and, subject to the requirements of Section 6.b, make all relevant records in its possession relating to such claims reasonably available to Employer or Employer's designee. CHLIC is not required to provide proprietary information to Employer or any other party.

c. Recognizing that Employer is not subject to ERISA, Employer hereby delegates to CHLIC the authority, responsibility and discretion to (i) determine eligibility and enrollment for coverage under the Plan according to the information provided by the Employer's designee, the County of Palm Beach.-(ii) make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits, (iii) conduct a full and fair review of each claim which has been denied as required by ERISA, (iv) decide level one mandatory appeals of "Urgent Care Claims" (as that term is defined in ERISA), and (v) conduct both mandatory levels of appeal determinations for all "Concurrent", "Pre-service" and "Post-service" claims (as those terms are defined under ERISA) and notify the Member or the Member's authorized representative of its decision. Employer will ensure that all summary plan description materials provided to Members reflect this delegation.

d. In addition to the basic claim administrative duties described above, CHLIC shall also perform the Plan-related administrative duties agreed upon by the Parties and specified in Exhibit B.

Section 3. Funding and Payment of Claims

a. Employer shall establish a Bank Account, in accordance with Florida Statutes Section 136.091 and maintain in the Bank Account an amount sufficient at all times to fund checks written on it for (i) Plan Benefits; (ii) those charges and fees identified in the Schedule of Financial Charges as payable through the Bank Account (collectively "**Bank Account Payments**"); and (iii) any sales or use taxes, or any similar benefit- or Plan-related charge or assessment however denominated, which may be imposed by any governmental authority. Bank Account Payments may include without limitation: (i) all payments to participating providers including

capitated (i.e. fixed per Member) payments to Participating Providers; (ii) cost containment charges, subrogation and other claim settlement charges. (iii) amounts owed to CHLIC; and (iv) amounts paid to CHLIC's affiliates and/or subcontractors for, among other things, in- and out-of network health care services/products provided to Members. CHLIC may credit the Bank Account with payments due Employer under its or an affiliate's stop loss policy.

b. CHLIC, as agent for the Employer, shall make Bank Account Payments from the Bank Account in the amount CHLIC reasonably determines to be proper under the Plan and/or under this Agreement.

c. In the event that sufficient funds are not available in the Bank Account to pay all Bank Account Payments when due, CHLIC shall cease to process claims for Plan Benefits including Run-Out Claims.

d. CHLIC will promptly adjust any underpayment of Plan Benefits by drawing additional funds due the claimant from the Bank Account. In the event CHLIC overpays a claim for Plan Benefits or pays Plan Benefits to the wrong party, it shall take all reasonable steps to recover the overpayment; however, CHLIC shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover any overpayment. CHLIC shall not be liable to the Employer for unrecovered claim overpayments that are the result of mistakes of judgment or other actions taken in good faith. However, CHLIC shall reimburse the Plan for unrecovered overpayments resulting from its failure, in the aggregate, to perform its duties with the degree of skill and judgment possessed by other third party administrators experienced in furnishing claim administration services to plans of similar size and characteristics as the Plan.

e. Following termination of this Agreement, Employer shall remain liable for payment of all due Bank Account Payments and for all reimbursements due Members under the Plan. Employer shall promptly reimburse CHLIC for any Bank Account Payments paid by CHLIC with its own funds and no such payment by CHLIC shall be construed as an assumption of any of Employer's liability.

This provision shall survive termination of this Agreement.

Section 4. Charges

a. Charges. CHLIC shall provide to Employer a monthly statement of all charges Employer is obligated to pay under this Agreement including sales or use taxes, or any similar benefit- or plan-related charge, surcharge or assessment, however denominated, which may be imposed by any governmental authority that are not paid as Bank Account Payments. Payment of all billed charges shall be due on the first day of the month, as indicated on the monthly statement. Employer shall remit payment of charges billed by the forty-fifth (45th) day following receipt of a proper invoice. Payments remitted after the forty-fifth (45th) day of receipt of a proper invoice may be subject to late charges as provided for by Florida Statutes Section 218 "FLORIDA PROMPT PAYMENT ACT."

b. Member Changes – Additions and Terminations. If a Member's effective date is on or before the fifteenth (15th) day of the month, full charges applicable to that Member shall be due for that Member for that month. If coverage does not start or ceases on or before the fifteenth (15th) day of the month for a Member, no charges shall be due for that Member for that month.

c. Retroactive Member Changes and Terminations. Employer shall remain responsible for all charges and Bank Account Payments incurred or charged through the date CHLIC processed Employer's notice of a retroactive change or termination of Membership. However, if the change or termination would result in a reduction in charges, CHLIC shall credit to Employer the reduction in charges charged for the shorter of (a) the sixty (60) day period preceding the date CHLIC processes the notice, or (b) the period from the date of the change or termination to the date CHLIC processes the notice.

This provision shall survive termination of this Agreement.

Section 5. Enrollment and Determination of Eligibility

a. Eligibility Determinations and Information. Employer is responsible for administering Plan enrollment. In determining any person's right to benefits under the Plan, CHLIC shall rely upon enrollment and eligibility information provided by the Employer. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to CHLIC in a form and with such other information as reasonably may be required by CHLIC for the proper administration of the Plan.

b. Release of Liability. Notwithstanding any inconsistent provision of this Agreement to the contrary, if Employer, fails to provide CHLIC with accurate enrollment and eligibility information, benefit design requirements, or other agreed-upon information in CHLIC's standard timeframe and format, CHLIC shall have no liability under this Agreement for any act or omission by CHLIC, or its employees, affiliates, subcontractors, agents or representatives, directly or indirectly caused by such failure.

c. Reconciliation of Eligibility and Information and Default Terminations. CHLIC will periodically share potential discrepancies in eligibility information with Employer. Employer will review and reconcile any discrepancies within thirty (30) days of receipt. If Employer fails to timely do so, CHLIC may terminate coverage for any Member not listed as eligible in Employer's submitted eligibility information.

Section 6. Claim Audits and Confidentiality

a. Claim Audit. Employer may, in accordance with the following requirements and at no additional charge while this Agreement is in effect, audit CHLIC's payment of Plan Benefits:

i. Employer shall provide CHLIC forty-five (45) days advance written request for audit from the latter of (i) receipt by CHLIC of the audit scope letter or (ii) the fully executed Claim Audit Agreement attached hereto as Exhibit C. Employer will designate with CHLIC's consent, such consent not to be unreasonably withheld, an independent, third party auditor to conduct the audit (the "**Auditor**). In addition, Employer and CHLIC will agree upon the date for the audit during regular business hours at CHLIC's office(s). Employer shall be responsible for its Auditor's costs. Except as otherwise agreed to by the parties in writing prior to the commencement of the audit, the audit shall be conducted in accordance with the terms of CHLIC's Claim Audit Agreement attached hereto as Exhibit C, which is hereby agreed to by Employer and which shall be signed by the Auditor prior to the start of the audit.

ii. Employer may conduct one such audit every Plan Year (but not within six (6) months of a prior audit

iii. Auditor will review payment documents relating to a random, statistically valid sample of two-hundred twenty-five (225) claims paid during the two prior Plan years and not previously audited (the "**Audit**") subject to any contrary terms in Participating Provider agreements. With respect to the Audit, the scope may include types of claims prone to overpayments provided the types of claims prone to underpayments are equally included and will exclude electronic analysis. Any claim adjustments will be based upon the actual claims reviewed and not upon statistical projections or extrapolations. If significant erroneous claim payments are identified by an audit, the Employer and CHLIC will further evaluate such errors and mutually determine reasonable and appropriate steps to address such errors, subject to the provisions of Section 3.d. and 7.d. of this Agreement. CHLIC will provide written confirmation upon completion of any such steps mutually agreed upon. Such steps may include, but are not limited to generating claim impact reports specific to the error trends, providing written validation of underpayments being corrected, and providing recovery reports to validate successful recovery.

b. Confidentiality

i. Subject to the requirements of Applicable Law, the terms of this Agreement and the Privacy Addendum in Exhibit D, a signed Business Associate agreement between Employer and designee, and a signed

Confidentiality Agreement by applicable designee, CHLIC shall release copies of confidential claims and Plan Benefit payment information in CHLIC's claims system ("**Confidential Information**") and may release copies of proprietary information relating to the Plan in CHLIC's claims system ("**Proprietary Information**") to the Employer and/or its designees. Employer agrees that Employer and its designees will keep Confidential Information and Proprietary Information confidential and will use Confidential Information and Proprietary Information solely for the purpose of administering the Plan or as otherwise required by law. Employer is solely responsible for the consequences of any use, misuse, or disclosure of Confidential Information provided by CHLIC pursuant to this paragraph b.

ii CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum in Exhibit D and any applicable state privacy laws.

c. Upon termination of this Agreement and subject to the provisions of Section 6.b above, CHLIC shall make information available to the extent administratively feasible if the Parties agree upon the charge to be paid by Employer.

d. CHLIC acknowledges that, as of the Effective Date of this Agreement, Palm Beach County has established the Office of the Inspector General in Palm Beach County Code, Section 2-421 - 2-440, as may be amended. CHLIC further acknowledges that, to the extent required by then current law, the Inspector General's authority may include but is not limited to the power to review past, present and proposed County contracts, transactions, accounts and records, to require the production of records, and to audit, investigate, monitor, and inspect the activities of the CHLIC, its officers, agents, employees, and lobbyists in order to ensure compliance with contract requirements and detect corruption and fraud. Finally, CHLIC also acknowledges that as of the Effective Date of this Agreement, and to the extent required by law, failure to cooperate with the Inspector General or interfering with or impeding any investigation shall be in violation of Palm Beach County Code, Section 2-421 - 2-440, and punished pursuant to Section 125.69, Florida Statutes, in the same manner as a second degree misdemeanor.

The obligations set forth in this section, shall survive termination of the Agreement.

Section 7. Plan Benefit Liability

a. Employer Liability for Plan Benefits. Employer is responsible for all Plan Benefits including any Plan Benefits paid as a result of any legal action. Employer is responsible for reimbursing CHLIC, its directors, officers and employees for any reasonable expense incurred (excluding reasonable attorneys' fees) by them in the defense of any action or proceeding involving a claim for Plan Benefits. CHLIC shall reasonably cooperate with Employer in its defense of such actions.

If CHLIC pays a claim for Extra-Contractual Benefits, Employer is responsible for funding the payment and such payments shall not be considered in determining reimbursements or payments under stop loss insurance or in determining any risk-sharing or performance guarantee reimbursements. Employer shall reimburse

CHLIC for any liability or expenses (excluding reasonable attorneys' fees) it may incur in connection with making such payments.

b. Employer Liability for Plan Related Expenses. Employer shall reimburse CHLIC for any amounts CHLIC may be required to pay (i) as state premium tax or any similar Plan-related tax, charge, surcharge or assessment, or (ii) under any unclaimed or abandoned property, or escheat law, with respect to Plan Benefits and any penalties and/or interest thereon.

c. Alternative Litigation Management Option. Prior to the beginning of each Plan Year, and contingent upon timely payment by Employer of the associated additional "Claim Litigation Charge" set forth in the Schedule of Financial Charges, Employer may elect to have CHLIC assume responsibility for the management of any

claim-related legal action and bear the legal expenses associated with defending such action so long as CHLIC processed the claim(s) in dispute. This option does not extend to actions against Employer and/or CHLIC related to the payment of Extra-Contractual Benefits. Each Party will provide notice to the other of any action and will fully cooperate in the defense of the action unless a potential conflict of interest exists. Nothing in this Section shall be read to contravene the explicit terms of 7(a) and 7(b). Employer shall remain responsible for payment of any benefits determined due under the Plan and any damages or penalties assessed in connection with the action.

d. Standard of Care/Indemnity: In performing its obligations under this Agreement, CHLIC shall use reasonable diligence and that degree of skill and judgment possessed by one experienced in furnishing claim administration services to plans of similar size and characteristics as the Plan. CHLIC shall not be liable to the Employer for mistakes of judgment or other actions taken in good faith (including benefits erroneously overpaid) but shall be liable to and indemnify the Employer for any non-benefit loss, cost or expense (including reasonable attorneys' fees and court costs) for which Employer may become liable in consequence of any acts or omissions of CHLIC which, in the aggregate, constitute a failure on the part of CHLIC to perform its claim administration obligations under this Agreement in accordance with the standard set forth above

These reimbursement obligations shall survive termination of this Agreement.

Section 8. Modification of Plan and Administrative Duties and Charges

a. CHLIC shall have the right to revise the charges identified in this Agreement giving a minimum of one hundred eighty (180) days written notice stating specifically what, if any rate change is proposed, (i) on each anniversary of this Agreement, (ii) upon any modification or amendment of the benefits under the Plan, (iii) upon any variation of fifteen percent (15%) or more in the number of Members used by CHLIC to calculate its charges under the Agreement, and/or (iv) upon any change in law or regulation that materially impacts CHLIC's liabilities and/or responsibilities under this Agreement.

b. Employer shall provide CHLIC written notice of any modification or amendment to the Plan sufficiently in advance of any such change as to allow CHLIC to implement the modification or amendment. Employer and CHLIC shall agree upon the manner and timing of the implementation subject to CHLIC's system and operational capabilities.

Section 9. Modification of Agreement

This Agreement constitutes the entire contract between the Parties regarding the subject matter herein. Except, as otherwise provided herein, the provisions of this Agreement shall control in the event of a conflict with the terms of any other agreements. No modification or amendment hereto shall be valid unless in writing and signed by an authorized person of each of the Parties, except that modification of charges pursuant to Section 8 above may be made by written notice to Employer by CHLIC.

Section 10. Laws Governing Contract

a. This Agreement shall be construed in accordance with the laws of the State of Florida without regard to conflict of law rules, and both Parties consent to the venue and jurisdiction of its courts. Venue shall be in Palm Beach County, Florida.

b. The Parties shall perform their obligations under this Agreement in conformance with all Applicable Laws and regulatory requirements.

Section 11. Information in CHLIC's Processing Systems

CHLIC may retain and use all Plan-related claim and Plan Benefit payment information recorded for or otherwise integrated into CHLIC's business records including claim processing systems during the ordinary course of business (provided, however, that claim or payment information will be available to Employer pursuant to Section 6). CHLIC will retain claim and payment information as required by Applicable Law.

Section 12. Resolution of Disputes

Any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("**Controversy**") shall be resolved exclusively pursuant to the following mandatory dispute resolution procedures:

a. Any Controversy shall first be referred to an executive level employee of each Party who shall meet and confer with his/her counterpart to attempt to resolve the dispute ("**Executive Review**") as follows: The disputing Party shall give the other Party written notice of the Controversy and request Executive Review. Within twenty (20) days of such written request, the receiving Party shall respond to the other in writing. The notice and the response shall each include a summary of and support for the Party's position. Within thirty (30) days of the request for Executive Review, an employee of each Party, with full authority to resolve the dispute, shall meet and attempt to resolve the dispute.

b. If the Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 12.a, above, the Parties agree to mediate the Controversy in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation ("**Mediation**"). The mediation shall be conducted in Palm Beach County, Florida. Each Party shall assume its own costs and attorneys' fees. The mediator's compensation and expenses and any administrative fees or costs associated with the mediation proceeding shall be borne equally by the Parties.

c. If the Controversy has not been resolved by Executive Review or Mediation, the Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 12.b. above, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The arbitration shall be binding on the Parties to the Agreement and on any respective affiliates which joined in the arbitration. The arbitrator's decision shall be final, conclusive and binding, and no action at law or in equity may be instituted by either Party other than to enforce the arbitrator's award. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys' fees. The arbitrator's compensation and expenses and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties.

This provision shall survive termination of this Agreement.

Section 13. Third Party Beneficiaries

This Agreement is for the benefit of Employer (the Employer's Plan, under Interlocal Agreement No. R2002 2287, includes Palm Beach County Board of County Commissioners, Palm Tran, Inc. and may be amended from time to time and CHLIC and not for any other person. It shall not create any legal relationship between CHLIC and any employee, beneficiary or any other party claiming any right, whether legal or equitable, under the terms of this Agreement or of the Plan.

Section 14. Waivers

No course of dealing or failure of either Party to strictly enforce any term, right or condition of this Agreement shall be construed as a waiver of such term, right or condition. Waiver by either Party of any default shall not be deemed a waiver of any other default.

Section 15. Headings

Article, section, or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 16. Severability

If any provision or any part of a provision of this Agreement is held invalid or unenforceable, such invalidity or unenforceability shall not invalidate or render unenforceable any other portion of this Agreement.

Section 17. Force Majeure

Neither party shall be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of such party , its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by such party, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations. Notwithstanding the foregoing, this section shall not in any way alter or release the Employer from its obligations under Section 3 and 4 of this Agreement.

Section 18. Assignment and Subcontracting

With the exception of the specific language in Section 23, neither Party may assign any right, interest, or obligation hereunder without the express written consent of the other Party; provided, however that CHLIC may assign any right, interest, or responsibility under this Agreement to its affiliates and/or subcontract specific obligations under the Agreement provided that CHLIC shall not be relieved of its obligations under the Agreement when doing so.

Section 19. Notices

Except as otherwise provided, all notices or other communications hereunder shall be in writing and shall be deemed to have been duly made when (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, (c) delivered electronically, or (d) deposited in the United States mail, postage prepaid, and addressed as follows:

To CHLIC:
CIGNA Health and Life Insurance Company
401 Chestnut Street
Suite 110
Chattanooga, TN 37402
Attention: Jenny Wilson, Underwriting Director

To Employer:
Palm Beach County Board of County Commissioners
100 Australian Ave.
Suite 200
West Palm Beach, FL 33406
Attention: Nancy Bolton, Director, Risk Management

CHLIC will send courtesy copies of notices to the following:

Palm Tran, Inc.
3201 Electronics Way
West Palm Beach, FL 33407
Attention: LaVern Blackwood

Supervisor of Elections
240 S. Military Trail
West Palm Beach, FL 33415
Attention: Amparo Korey

Palm Beach County Attorney's Office
301 North Olive Avenue, Suite 601
West Palm Beach, FL 33401
Attention: Tammy K. Fields

The address to which notices or communications may be given by either Party may be changed by written notice given by one Party to the other pursuant to this Section.

Section 20. Identifying Information and Internet Usage

Except, as necessary in the performance of their duties under this Agreement, neither Party may use the other's name, logo, service marks, trademarks or other identifying information or to establish a link to the other's World Wide Web site without its prior written approval.

Section 21. Nondiscrimination

CHLIC-represents that all of its employees are treated equally during employment without regard to race, color, religion, disability, sex, age, national origin, ancestry, marital status, familial status, sexual orientation, gender identity and expression.

Section 22. Certification

As provided in F.S. 287.132-133, by entering into this contract or performing any work in furtherance hereof, CHLIC certifies, to the best of its knowledge, that it, its affiliates, suppliers, subcontractors and consultants The CHLIC warrants and represents that all of its employees are treated equally during employment without regard to race, color, religion, disability, sex, age, national origin, ancestry, marital status, familial status, sexual orientation, gender identity and expression.

Section 23 Small Business Enterprise

CHLIC will to subcontract the services, as specified on the Schedule of Financial Charges, to Small Business Enterprises (SBE), and as it relates to the SBE subcontractors the following apply:

- If a subcontractor fails to perform or make progress, as required by this Agreement, and it is necessary to replace the subcontractor to complete the work in a timely fashion, the CHLIC shall promptly do so, subject to acceptance of the new subcontractor by the Employer.
- CHLIC agrees to abide by all provisions of the Palm Beach County Code establishing the SBE Program, as amended, and understands that failure to comply with any of the requirements will be considered a breach of contract.
- CHLIC shall provide the Employer with a copy of the CHLIC's contract with any SBE subcontractor or any other related documentation upon request.
- CHLIC understands the requirements to comply with the tasks and proportionate dollar amounts throughout the term of this Agreement as it relates to the use of SBE firms.
- CHLIC agrees that it will only be permitted to replace a certified SBE subcontractor who is unwilling or unable to perform. Such substitutions must be done with another certified SBE in order to maintain the SBE percentages established in this Agreement. Requests for substitutions of SBE's must be submitted to the County's representative and to the Office of Small Business Assistance.
- The CHLIC agrees to maintain all relevant records and information necessary to document compliance pursuant to Palm Beach County Code, Chapter 2, Article III, Sections 2-71 through 2-80.13 and any revisions thereto, and will allow the COUNTY to inspect such records.

Section 24 Request for Proposal

The provisions of RFP 11-057/LJ and all Amendments thereto, attached as Exhibit G, are hereby incorporated into the Agreement. To the extent the provisions of RFP 11-057/LJ and all Amendments thereto conflict with any other terms of the Agreement, Schedules, Exhibits, Addendums, Amendments, or like documents, the terms of the Agreement, Schedules, Exhibits, Addendums, Amendments, or like documents control.

SIGNATURES

IN WITNESS WHEREOF, the parties have made and executed this Third Amendment to the Agreement on behalf of the Supervisor of Elections, SWA and The County on behalf of its Department of Risk Management and Palm Tran, Inc. and has hereunto set its hand the day and year above written.

Dated at Hartford, Connecticut

This 5th day of October, 2012

CIGNA HEALTH AND LIFE INSURANCE COMPANY

By: Andrea M. Balestriere
Name: Andrea M. Balestriere
andrea.balestriere@CIGNA.com
Its Contractual Agreement Lead
Duly Authorized

WITNESSES:

(Signature)

(Print Name)

(Signature)

(Print Name)

THE SUPERVISOR OF ELECTIONS OF PALM BEACH COUNTY
By:_____

_____

Its _____

ATTEST:
SHARON BOCK, CLERK & COMPTROLLER

By:_____
Deputy Clerk & Comptroller

PALM BEACH COUNTY, FLORIDA BY ITS BOARD OF COUNTY COMMISSIONERS AND ON BEHALF OF PALM TRAN, INC.

By:_____
Karen T. Marcus, Chair

APPROVED AS TO FORM AND LEGAL SUFFICIENCYCONDITIONS

By:_____
County Attorney

APPROVED AS TO TERMS AND

By: Nancy L. Bolton
Department Director

Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to Employer monthly in accordance with CHLIC's then current standard billing practices. However, and only to the extent permitted by F.S. Section 136.091, as amended, CHLIC is authorized to pay all fees and charges from the Bank Account unless otherwise specified in this Agreement

	MEDICAL ADMINISTRATION CHARGES (Includes Commission payments agreed to by Employer)	
Product	**Description**	**Charge**
Medical	• Preferred Provider Organization (PPO) with PHS Plus Medical Management	**$16.27/employee/month**
Medical	• Network with PHS Plus Medical Management	**$16.27/employee/month**
Medical	• Network Point of Service (POS) with PHS Plus Medical Management	**$16.27/employee/month**
	MEDICAL NETWORK ACCESS FEE	
Product	**Description**	**Charge**
Medical	• PPO Access Fee	**$15.90/employee/month**
Medical	• Network Access Fee	**$17.49/employee/month**
Medical	• Network POS Access Fee	**$17.49/employee/month**
Mental Health/Substance Abuse	Administrative Charge for Mental Health/Substance Abuse Services including lifestyle management programs and a cognitive behavioral modification program.	**$2.51/member/month Network Products only; North Carolina Members. Charges are processed through the Bank Account includes all services and claims**

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS
Definitions • "Average Wholesale Price" or "AWP" is the Average Wholesale Price for a given pharmaceutical product in effect on the dispense date for the actual package size dispensed as published by First DataBank, Medi-Span or other alternative publication or benchmark reasonably designated by CHLIC. • "Brand Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a brand drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Brand Drug Claim" includes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies. • "Generic Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a generic drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Generic Drug Claim" does not include a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies. • "Mail Service Pharmacy" or "CIGNA Tel-Drug" or "CIGNA Home Delivery Pharmacy" is a pharmacy that is owned or operated by CHLIC or an affiliated company(ies) (currently, Tel-Drug, Inc. and Tel-Drug of Pennsylvania, LLC), which dispenses drugs covered under the Plan's Pharmacy Benefit by mail, and is not a Retail Pharmacy. • "Pharmacy Benefit" means the terms of the Plan that govern coverage and care/utilization management of drugs and related supplies dispensed to Members and charged to the Plan by the Mail Service Pharmacy or Retail Pharmacies through CHLIC's pharmacy claim processing system. • "Rebates" or "Manufacturer Formulary Payments" means amounts that CHLIC collects under contracts it enters into with drug manufacturers that are based on utilization of certain of the manufacturers' brand drugs under the Plan's Pharmacy Benefit and the drug's status on the CIGNA drug formulary. • "Retail Pharmacy" is a pharmacy that is entitled to payment under the Plan for drugs it dispenses that are covered under the Plan's Pharmacy Benefit, and is not a Mail Service Pharmacy. • "Specialty Drug Claim" is a claim for a pharmaceutical product that is reasonably determined by CHLIC to be a specialty drug in accordance with industry practice. Specialty drugs generally are (i) injected or infused and derived from living cells, or are oral non-protein compounds (e.g., oral chemotherapy drugs); (ii) target the underlying condition, which is usually one of a relatively rare, chronic and costly nature; and/or (iii) require restricted access and/or close monitoring.
PHARMACY ADMINISTRATION FEE
• CIGNA Pharmacy Product administration fee: Included in Medical Administration Charge

CHARGES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT
Drug Dispensed by Mail Service Pharmacy: CHLIC will charge Employer the following for claims covered under the Plan's Pharmacy Benefit and dispensed by the Mail Service Pharmacy:
Brand Drug Claims: AWP minus an average discount of 25% plus an average dispensing fee of $0.00. **Generic Drug Claims:** The drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at CIGNA Home Delivery Pharmacy to CHLIC's group-client book of business of AWP minus 75.5% plus an average dispensing fee across such Generic Drug Claims of not more than $0.00. **Specialty Drug Claims**: The drug's charge under a national specialty drug discount schedule that generates a 13% annual average aggregate discount off AWP across Specialty Drug Claims dispensed at CIGNA Home Delivery Pharmacy to CHLIC's group-client book of business.
Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer the following for drugs covered under the Plan's Pharmacy Benefit and dispensed by a Retail Pharmacy to the Plan Members, subject to the "Drug Charges – Additional Provisions" section:
Retail Brand Drug Claims: The lesser of (i) AWP minus the contracted discount of 16.5% plus the contracted dispensing fee charged by the Retail Pharmacy for the Brand Drug Claim of $1.20; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Generic Drug Claims** (other than those to which the above brand discount applies): The lesser of: (i) the drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Retail Pharmacies to CHLIC's group-client book of business of AWP minus 73.5% (Plan-specific results may vary based on drug mix), plus an average dispensing fee across such Generic Drug Claims of no more than $1.90; or (ii) the Retail Pharmacy's usual and customary charge. **Retail Specialty Drug Claims:** The lesser of (i) AWP minus an annual average aggregate discount of 10.5%, plus an average dispensing fee of no more than $1.80; or (ii) the Retail Pharmacy's usual and customary charge.

	DRUG CHARGES – ADDITIONAL PROVISIONS	

- CIGNA Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size).
- CIGNA Home Delivery Pharmacy will be reimbursed through the Bank Account for the price (discounted as per this Schedule) for replacement prescriptions shipped by CIGNA Home Delivery Pharmacy which are reported as lost or damaged despite CIGNA Home Delivery Pharmacy's shipment to the Participant's correct name and address.
- The amount paid to the Retail Pharmacy for Brand, Generic, or Specialty Drug Claims may or may not be equal to the amount charged to Employer, and CHLIC will absorb or retain any difference.
- An excess achieved in any Plan-specific discount floor or dispensing fee cap offered under this Agreement will be used to offset a shortfall in any other Plan-specific discount floor or dispensing fee cap offered under this Agreement.
- Industry Changes to or Replacement of Average Wholesale Price (AWP). Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Plan's Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace First DataBank, Medi-Span, or other such publication as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.
- Audits of Pharmacy Claims under the Plan's Pharmacy Benefit. Employer may, in accordance with the following requirements and at no additional charge while this Agreement is in effect, audit, once every Plan Year (but not within 6 months of a prior audit), such information that is directly related to CHLIC's payment of claims under the Plan's Pharmacy Benefit as necessary to determine whether CHLIC has met its contractual obligations related to claim payment (the "Audit"). Employer shall provide CHLIC with 45 days' advance written request for the Audit. Employer and CHLIC will agree on an independent, third party auditor to conduct the Audit (the "Auditor") and the date for the Audit during regular business hours at CHLIC's office where the information to be audited is located. Employer shall be responsible for its Auditor's costs. The Audit shall be conducted in accordance with CHLIC's Pharmacy-Claim Audit Agreement, which shall be signed by CHLIC, Employer, and the Auditor prior to the start of the Audit. The Audit will be based upon the actual claims reviewed by CHLIC and auditor and not upon statistical projections or extrapolations. The audit may include receipt and review of some of the claims information by the auditor prior to the on-site portion of the audit. This Section supersedes any other provision in this Agreement governing claim audits with respect to audits of claims under the Plan's Pharmacy Benefit.

DRUG MANUFACTURER-PAYMENT SHARING
Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization under the Plan's Pharmacy Benefit: The greater of 100% of Rebates, or the sum of $20.00 multiplied by the number of Retail Pharmacy Brand Drug Claims plus $50.00 multiplied by the number of Mail Service Pharmacy Brand Drug Claims. Caveats: (1) Upon termination of this Agreement, CHLIC may apply Rebates otherwise payable to offset Bank Account or other deficits of charges identified in this Agreement. (2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no additional Rebates shall be due with respect to that Plan Year. (3) All applicable caveats communicated in writing by CHLIC in connection with its proposal made in connection with this Agreement. (4) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC. (5) Rebates are not paid out on single source generic drug claims or Run-Out Claims. (6) CHLIC contracts with drug manufacturers on its own behalf, and not as agent of the Employer or the Plan. Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar quarter for the portion of such calendar quarter that coincides with the Plan Year.

	AUDIT RIGHTS RELATED TO MANUFACTURER PAYMENTS	
Employer's third party auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding sharing of manufacturer formulary payments (a/k/a "rebates") once in each twelve-month period upon the following conditions: Employer shall provide at least forty-five (45) days written notice to CHLIC; the auditor (including its individual auditors conducting the audit) shall be agreeable to Employer and CHLIC; a mutually agreed upon non-disclosure/non-use contract shall be executed by Employer, the auditor and CHLIC; the records to be audited shall be no more than two years old as of the date of the audit; the scope of records to be audited shall be as mutually agreed upon by Employer's third party auditor and CHLIC as those which are necessary to determine compliance with the rebate-sharing obligations under this Agreement; the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; records shall not be removed or photocopied without CHLIC's express written consent; the auditor shall provide its audit report to CHLIC and Employer at the same time; and the auditor may disclose the aggregate amount of manufacturer formulary payments due Employer but no other details of CHLIC's manufacturer contracts of which the auditor is apprised, if any.		
	FEES FOR PROCESSING RUN-OUT CLAIMS	
Network & Network POS	Run-Out Period of twelve (12) months CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**No Additional Cost**
PPO	Run-Out Period of twelve (12) months CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last four (4) months of medical administration charges applicable to the terminated Agreement.**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**No Additional Cost**

SUBROGATION		
	Subrogation/Conditional Claim Payment (Medical Only)	**5% of recovery plus litigation costs if Counsel is retained and an appearance is filed on behalf of CHLIC or Employer if any litigation, or a lawsuit is filed on their behalf; 29% of recovery if no Counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as part defendants or involuntary plaintiffs. Notwithstanding any other amount reflected in the Conditional Claim/Subrogation Recovery Services Exhibit.**

CHLIC COST CONTAINMENT FEES		
CHLIC, a CIGNA company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e. the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable. For covered services received from non-Participating Providers, CHLIC may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). This is consistent with the claim administration practices applicable to CHLIC's' own health care insurance business when these programs are implemented. CHLIC charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.		
MEDICAL AND PHARMACY COST CONTAINMENT		
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	

	• Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	DRG Validation and Appeals	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries [Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits	**29% of recovery**
9.	Pharmacy Vendor Recoveries	**30% of recovery**
10.	Class Action Recoveries	**35% of recovery**
CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by CHLIC, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
ELIGIBILITY OVERPAYMENT RECOVERY FEES		
	Eligibility Overpayment Recovery Vendor Services	**29% of recovery**

	EXTERNAL REVIEW FEES	
	External expert reviews may be required on a consultative basis as part of the internal appeal process, or pursuant to a formal external review following exhaustion of the internal review process. The range of external review charges is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. External review charges will be commensurate with the number of reviewers, as well as their level of expertise and time required to complete the review.	**$500-$4,000 Review**
	STRATEGIC ALLIANCES	
	CHLIC contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in CHLIC's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings are paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
	Capitation and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits and will appear in Employer's standard Bank Account activity data reports. Such payments will be at CHLIC's applicable capitation or fee-for-service charges then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
	Unless indicated otherwise in the Schedule of Financial Charges, CHLIC retains all payments it may receive from manufacturers of pharmaceutical products covered under the Plan. Information on the amount of such payments with respect to the Plan will be provided upon request.	**All Pharmacy Products**
	From time to time, CHLIC, either directly or through its affiliates, contracts with vendors, provider network managers and providers in connection with various cost containment programs. CHLIC and its affiliates may receive payments from such parties that are intended to help defray expenses associated with implementing such programs.	**All Products**

ADDITIONAL SERVICES		
Service	**Description**	**Charge**
HIPAA Certificates	Individual HIPAA certificates for Members who leave active coverage.	**$0.15/employee/month Included in Medical Administration Charge**
Behavioral Health Care Advocacy	Behavioral Health Care Advocacy provides focused utilization review and case management of in-network, outpatient behavioral health services. (For PPO CA/NC Members Only)	**Included in Medical Access Fee**
Pharmacy Clinical Programs	CIGNA TheraCare® Program – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**
Prior Authorization Reviews	Review requests for coverage of drugs subject to prior authorization. Notwithstanding any other provision in this Agreement, CHLIC's charges for the reviews will be deducted from Employer's contracted share of manufacturer payments.	**Included at No Additional Cost**
Your Health First-200	A proactive health education and improvement program for those with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. Members are identified as having a chronic condition through a variety of sources including but not limited to: claim data, referrals, and self-identification. A variety of resources are provided to those with a chronic condition and based on severity and readiness to change. The program targets 60% of the chronic population for telephonic support. Identified Members work with a dedicated health advocate on improving their health. The program includes the following components: • Chronic Condition Specific Coaching • Pre and post discharge calls when CHLIC is the medical carrier • Life style management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously assess the effectiveness of our programs, some Members may be placed in a comparison group which receives alternative services, or even no services for a specified period. This will not affect the total number of Members targeted for outreach or any of the financial or clinical goals of the program.	**Included in Medical Access Fee**

Claim Litigation	Claim Litigation Services	**Included in Medical Administration Charge**
	Small Business Enterprise Subcontractors	
Wellness services, including an on-site coordinator, biometric screenings Printing CHLIC materials including benefit summaries as further specified on attachment 1 to the Schedule of Financial Charges.	Please see Section 23 of ASO Agreement core language	**Biometric charges are processed through the Bank Account.** **On-site Coordinator, and Print costs are included in the Medical Administration Charges.**

Exhibit 1

Schedule of Financial Charges

Small Business Enterprise Subcontractors

SCHEDULE 1

LIST OF PROPOSED SBE-M/WBE PRIME AND/OR SUBCONTRACTOR PARTICIPATION

PROJECT NAME OR BID NAME: Palm Beach County Board of Commissioners — PROJECT NO. OR BID NO.: RFP # 11-057/LS

NAME OF PRIME BIDDER: CIGNA Health and Life Insurance Company — ADDRESS: 900 Cottage Grove Road, Bloomfield CT 06152

CONTACT PERSON: Scott Evelyn — PHONE NO.: 860-226-6000 — FAX NO.: 954-514-6906

BID OPENING DATE: 7/28/2011 — USER DEPARTMENT:

THIS DOCUMENT IS TO BE COMPLETED BY THE PRIME CONTRACTOR AND SUBMITTED WITH THE BID PACKET. PLEASE LIST THE NAME, CONTACT INFORMATION AND DOLLAR AMOUNT OR PERCENTAGE OF WORK TO BE COMPLETED BY ALL SBE-M/WBE SUBCONTRACTORS ON THIS PROJECT. IF THE PRIME IS AN SBE-M/WBE, PLEASE ALSO LIST THE NAME, CONTACT INFORMATION AND DOLLAR AMOUNT OR PERCENTAGE OF WORK TO BE COMPLETED BY THE PRIME ON THIS PROJECT.

Name, Address and Phone Number	(Check one or both Categories) M/WBE: Minority Business	(Check one or both Categories) SBE: Small Business	DOLLAR AMOUNT OR PERCENTAGE OF WORK: Black	Hispanic	Women	Caucasian	Other (Please Specify)
1. A & A Associates, Inc.	☒	☒	357,000				
2. Marketing Innovations Enterprises Inc.	☒	☒			6000		
3.	☐	☐					
4.	☐	☐					
5.	☐	☐					
(Please use additional sheets if necessary)			Total: 357,000		6,000		

Total Bid Price: $ ASC/NAF/STOPLOSS $2,039,063 — Total SBE-M/WBE Participation Dollar Amount or Percentage of Work: _____

Note:
1. The amount listed on this form for each subcontractor must be supported by price or percentage listed on the signed Schedule 2 on signed proposal in order to be counted toward goal attainment.
2. Firms may be certified by Palm Beach County as an SBE and/or and M/WBE. If firms are certified as both an SBE and M/WBE, please indicate the dollar amount or percentage under the appropriate category.
3. M/WBE information is being collected for tracking purposes only.

Revised 3/25/11

SCHEDULE 2

LETTER OF INTENT TO PERFORM AS AN SBE-M/WBE SUBCONTRACTOR

This document must be completed by the SBE-M/WBE Subcontractor and submitted with bid packet. Specify in detail, the particular work items to be performed and the dollar amount and/or percentage for each work item. SBE credit will only be given for items which the SBE-M/WBE Subcontractor are SBE certified to perform. Failure to properly complete Schedule 2 may result in your SBE participation not being counted.

PROJECT NUMBER: RFP NO 11-057/LJ PROJECT NAME: Employee Self-Funded Medical Benefits Plan

TO: A & Associates, Inc.
(Name of Prime Bidder)

The undersigned is certified by Palm Beach County as a – (check one or more, as applicable):

Small Business Enterprise ✓ Minority Business Enterprise ✓

Black X Hispanic _____ Women _____ Caucasian _____ Other (Please Specify) _____

Date of Palm Beach County Certification: 7/12/2011 to 7/11/2014 (Vendor # VC0000134473)

The undersigned is prepared to perform the following described work in connection with the above project. Additional Sheets May Be Used As Necessary

Line Item/ Lot No.	Item Description	Qty/Units	Unit Price	Total Price/ Percentage
	Flu Shots			Estimated $153,000
	Biometric Screening			Estimated $132,000
	One Full-time on-site Wellness Coordinator	1		Estimated $72,000

at the following price or percentage estimated $357,000
(Subcontractor's quote)

and will enter into a formal agreement for work with you conditioned upon your execution of a contract with Palm Beach County.

If undersigned intends to sub-contract any portion of this subcontract to a non-certified SBE subcontractor, the amount of any such subcontract must be stated.

Price or Percentage _____

The undersigned subcontractor understands that the provision of this form to Prime Bidder does not prevent Subcontractor from providing quotations to other bidders.

A & Associates, Inc
(Print name of SBE-M/WBE Subcontractor)

By: _____
(Signature)

Andrew Luchey, CEO
(Print name/title of person executing on behalf of SBE-M/WBE Subcontractor)

Date: 07/14/2011

SCHEDULE 2

LETTER OF INTENT TO PERFORM AS AN SBE-M/WBE SUBCONTRACTOR

This document must be completed by the SBE-M/WBE Subcontractor and submitted with bid packet. Specify in detail, the particular work items to be performed and the dollar amount and/or percentage for each work item. SBE credit will only be given for items which the SBE-M/WBE Subcontractor are SBE certified to perform. Failure to properly complete Schedule 2 may result in your SBE participation not being counted.

PROJECT NUMBER: RFP NO 11-057/LJ PROJECT NAME: Employee Self-Funded Medical Benefits Plan

TO: Marketing Innovations Enterprises, Inc.
(Name of Prime Bidder)

The undersigned is certified by Palm Beach County as a – (check one or more, as applicable):

Small Business Enterprise ✓ Minority Business Enterprise ✓

Black ____ Hispanic ____ Women ✓ Caucasian ____ Other (Please Specify) ____

Date of Palm Beach County Certification: 8/5/2009 to 8/4/2012 (Vendor # VC0000134616)

The undersigned is prepared to perform the following described work in connection with the above project. Additional Sheets May Be Used As Necessary

Line Item/ Lot No.	Item Description	Qty/Units	Unit Price	Total Price/ Percentage
	Printing of CIGNA Benefit Summary Booklets, Rider Booklets, Flyers and Postcards plus postage.			Estimated $6,000

at the following price or percentage estimated $6,000
(Subcontractor's quote)

and will enter into a formal agreement for work with you conditioned upon your execution of a contract with Palm Beach County.

If undersigned intends to sub-contract any portion of this subcontract to a non-certified SBE subcontractor, the amount of any such subcontract must be stated.

Price or Percentage ____

The undersigned subcontractor understands that the provision of this form to Prime Bidder does not prevent Subcontractor from providing quotations to other bidders.

Marketing Innovations Enterprises, Inc.
(Print name of SBE-M/WBE Subcontractor)

By: [signature]
(Signature)

[illegible]
(Print name/title of person executing on behalf of SBE-M/WBE Subcontractor)

Date: 2/13/11

SCHEDULE 3
SBE M/WBE ACTIVITY FORM

SBE-M/WBE ACTIVITY FOR MONTH ENDING_____ PROJECT#:_____

PROJECT NAME_____

PRIME CONTRACTOR NAME_____

PROJECT SUPERVISOR_____

Schedule 3 is used to show the monthly payment activity for each SBE-M/WBE Subcontractor on the project. It also shows approved change orders as they impact the SBE-M/WBE Subcontractors. It is to be submitted by the Prime with each monthly payment request to Palm Beach County. In the SBE-M/WBE Subcontracting Information section, list the name(s) of each SBE-M/WBE Subcontractor on the project and the total contracted amount for each SBE-M/WBE Subcontractor on the project. As the project proceeds, please complete each column under the SBE M/WBE Subcontracting Information section accordingly. In the SBE M/WBE Category, please check the appropriate category that represents each SBE-M/WBE Subcontractor.

SBE-M/WBE SUBCONTRACTING INFORMATION								SBE-M/WBE Category (check all applicable)						
Name of SBE-M/WBE Subcontractor	SBE-M/WBE Total Contract Amount	Approved Change Orders	Revised SBE-M/WBE Contract Amount	Amount drawn for SBE-M/WBE Sub This Period	Amount drawn for SBE-M/WBE Sub to Date	Amount Paid to Date for SBE-M/WBE Subcontractor	Actual Starting Date	Minority Business (M)	Small Business (S)	Black	Hispanic	Women	Caucasian	Other (Please Specify)

I hereby certify that the above information is true to the best of my knowledge._____
(Signature and Title)

Return to: Palm Beach County

Additional Sheets May Be Used As Necessary

NOTE: Firms may be certified as an SBE and/or an M/WBE. If firms are certified as both an SBE and M/WBE, the dollar amount will not be counted twice.

Revised 3/15/11

Schedule 3(A)
PROFESSIONAL SERVICES ACTIVITY REPORT

APPLICATION #: _____

REPORTING PERIOD: _____

Prime Consultant Address: _____
City/State: _____ Zip _____
Contact Person: _____ Phone # _____
Contract Name: _____
Contract Term: _____ Contract $ Amount
Total Percentage performed by the Prime's Firm: _____ SBE-M/WBE Firm: _____
Total # of Sub-Consultants: _____ SBE-M/WBE Subs _____
Service Type: Architectural _____ Engineering _____ Planning _____
Other (Specify) _____
Have Sub-Consultants completed work for this application? _____ Yes
No
Note: If yes, complete below:

SUB-CONSULTANTS

1. Firms Name: _____
   Address/Tel: _____
   Estimated Start Time: _____ Contract Amount: _____
   SCOPE OF WORK: _____
   Percentage/Hrs Completed: _____ Amount Paid To Date _____

2. Firm's Name: _____
   Address//Tel: _____
   Estimated Start Time: _____ Contract Amount: _____
   SCOPE OF WORK: _____
   Percentage/Hrs Completed: _____ Amount Paid To Date _____

3. Firm's Name: _____
   Address/Tel: _____
   Estimated Start Time: _____ Contract Amount _____
   SCOPE OF WORK: _____
   Percentage/Hrs Completed: _____ Amount Paid To Date _____

I certify that the above is true to the best of my knowledge

_____
Signature/Title

SCHEDULE 4 - SBE-M/WBE PAYMENT CERTIFICATION

The Prime Contractor is to submit Schedule 4 with its Monthly Payment Request to Palm Beach County to reflect actual payments made to the SBE-M/WBE Subcontractor. The Prime Contractor is not to request signature from an SBE-M/WBE Subcontractor unless it has made a payment to the SBE-M/WBE Subcontractor. The SBE-M/WBE Subcontractor is not to complete and sign this form unless it has received a payment from the Prime Contractor. A separate Schedule 4 is required for each SBE-M/WBE Subcontractor payment.

This is to certify that _____ received
(SBE or M/WBE Subcontractor Name)

(Monthly) or (Final) payment of $

On ___ ___ ____ from _____
MM DD YYYY (Prime Contractor Name)

For labor and/or materials used on _____ / _____
(Project Name) (Work Order)

DEPT.: PROJECT NO.:

PRIME CONTRACTOR VENDOR CODE:

SBE OR M/WBE SUBCONTRACTOR VENDOR CODE:

If the SBE Subcontractor intends to disburse any funds associated with this payment to any non-SBE Subcontractor for labor provided on this project, please provide the following information:

Non-SBE Subcontractor Name: _____ Amount to be paid: _____

By: _____ _____
(Signature of Subcontractor) (Print Name & Title of Person executing on behalf of Subcontractor)

STATE OF FLORIDA
COUNTY OF _____

Sworn to and subscribed before me this _____ day of _____, 20____

By: _____

_____
Notary Public, State of Florida

_____
Print, Type or Stamp Commissioned Name of Notary

Personally Known ____ OR Produced Identification ____ Type of Identification _____

Rev. 1

Last updated: 12/6/2010

Exhibit A - Plan Document

A "Summary Plan Document" or "Plan Booklet" that includes Plan Benefits and Members' rights and responsibilities under the Plan will be provided by Employer to CHLIC. CHLIC agrees to draft the SPD or Plan Booklet based upon Employers direction and will provide the draft to Employer for its review and approval. Upon review and approval by Employer, the Employer represent that the "SPD" or Plan Booklet shall become the official Plan Booklet. CHLIC will use the finalized Plan Booklet to administer the plan. The Plan Booklet will be reviewed and updated no less than annually.

If Employer has not provided CHLIC with a copy of its finalized Plan Booklet by the time this Agreement is effective, CHLIC will administer the Plan in accordance with the medical management and claims administration policies and procedures and/or practices then applicable to its own health insurance business and the definitions and other language contained in the draft version of the Plan Booklet provided by CHLIC to Employer. CHLIC will continue to administer the Plan in this manner until CHLIC receives the finalized Plan Booklet and follows its preparation and review process. After that time CHLIC will use the finalized Plan Booklet to administer the plan.

Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Report to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. CHLIC shall file applicable forms and pay assessments/surcharge based on covered lives on behalf of Employer in accordance with and as required by other applicable state law and regulations including: New Hampshire Health Plan (High Risk Pool) New Hampshire Small Employer Health Reinsurance Pool New Hampshire Vaccine Association Vermont Vaccine Purchasing Program(*) (**) CHLIC shall file applicable forms and pay assessments/surcharge based on claims on behalf of Employer in accordance with and as required by other applicable state law and regulations including: Louisiana High Risk Health Insurance Association Fund Maine Dirigo Health Reform Act(*) Massachusetts Uncompensated Care Trust Fund(*) Vermont Health Care IT Fund	**All Products (excluding *Vision and **Dental)**

CLAIM ADMINISTRATION		
Products excluding Health Savings Account		
1.	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
2.	Prepare and make available CHLIC's standard claim forms.	**All Products**
3.	Investigate claims, as necessary, by CHLIC's Special Investigations Unit.	**All Products**
4.	Discuss claims, when appropriate, with providers of health services.	**All Products**
5.	Perform internal audits of Plan Benefit payments on a random sample basis.	**All Products**
6.	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 16 Report (SAS70 successor report).	**All Products (excluding Vision)**
7.	Respond to Insurance Department complaints.	**All Products**
8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
1.	CHLIC's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**
Pharmacy Only		
1.	CHLIC's standard ID cards with toll-free telephone number are prepared and mailed directly to Members.	**All Pharmacy Products**
2.	Pharmacy claims are adjudicated typically on-line at time of service without access to information on other coverage, and therefore coordination of benefits (COB) for pharmacy claims does not occur. Claims for Plan Benefits will be paid regardless of coverage under another plan.	**All Pharmacy Products**
3.	CHLIC's standard drug utilization review services.	**All Pharmacy Products**
4.	CHLIC may receive and retain payments under contracts with drug manufacturers with respect to utilization covered under the Employer's medical benefit for the manufacturer's specialty drugs, which are drugs that typically are injected or infused and derived from living cells; target an underlying rare, chronic or costly condition; and/or require restricted access and/or close monitoring. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan.	**All Pharmacy Products**
DOCUMENT PRODUCTION		

	Products excluding Health Savings Account	
	Prepare and deliver Member benefit booklets to Employer.	**All Products**
	UNDERWRITING SERVICES	
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
	HIPAA INDIVIDUAL RIGHTS	
	Products excluding Health Savings Account	
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**
	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicaid.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
6.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
7.	Pharmacy Vendor Recoveries (when implemented).	**All Pharmacy Products**
	CUSTOMER REPORTING	
1.	Summary reports of medical, dental and pharmacy cost and utilization experience available through CIGNA web site.	**All Medical and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide its standard reports and information based upon paid claim data only. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**
4.	CIGNA Behavioral Health Reporting will be provided.	**All Products**

	MEMBER EXTERNAL REVIEW PROGRAM	
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may voluntarily appeal to a selected external independent review organization. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
	MEDICAL MANAGEMENT SERVICES	
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assisting providers with resources and tools to enable them to develop Long Term Treatment Plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The CIGNA HealthCare Healthy Babies® Program, a no-cost to Member prenatal program that provides education and support for a healthy pregnancy and healthy baby.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCIGNA.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
7.	The CIGNA HealthCare 24-Hour Health Information Line℠, a service that provides 24 hour toll free access to registered nurses and an extensive audio health information library.	**All Medical Products**
8.	CIGNA *LifeSOURCE* Transplant Network® contracts with over five-hundred (500) transplant programs at more than one-hundred thirty (130) independent transplant facilities. We provide access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A Health Education Program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by CIGNA Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**PPO and All Network Products Only**

11.	Implementing clinical quality measurements, managing data, tracking and validating performance and initiating continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**
	NETWORK MANAGEMENT SERVICES	
	CHLIC, and/or its affiliates shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, capitation, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others;	**All Medical Products**
2.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical Products**
3.	Review Participating Provider compliance with protocols and procedures for quality, Participant satisfaction, and grievance resolution;	**All Medical Products**
4.	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**
5.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical Products**

BEHAVIORAL HEALTH

	CHLIC has contracted with an affiliate, CIGNA Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents as capitation. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs and a cognitive behavioral modification program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs and a cognitive behavioral modification program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting. CHLIC will commit to a thirty (30) day notice for CBA rates.	**PPO (Non-CA/NC Members) & All Network Products**

CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The CIGNA HealthCare of Arizona, Inc. staff model ("Cigna Medical Group") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Participants may at some time receive treatment from a Cigna Medical Group ("CMG") facility or provider even if they do not reside in Arizona (as when traveling). Participants utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Participants in PPO or EPO plans. Except as provided below, for services provided to Participants, CMG is paid on a fee schedule basis at the rates in effect at the time of service (as may be amended from time to time). A representative CMG fee schedule of routinely performed services is attached. A copy of the full fee schedule is available on request and mutually agreed Non Disclosure Agreement ("NDA"). If the Plan requires Participants to select a primary care physician (PCP), Phoenix area Participants who do not select a PCP during open enrollment are assigned to a CMG PCP. CMG is paid a monthly primary care capitation amount for those Phoenix area Participants who select or are assigned to a CMG PCP. Charges will appear in Employer's standard Bank Account activity data reports at the rates in effect at the time of payment. Primary care capitation charges are age/sex adjusted and may be amended from time to time. A primary care capitation rate grid and a list of the services included in the capitation are available upon request and mutually agreed Non Disclosure Agreement ("NDA"). Primary care services rendered to Participants in Open Access Plans that do not provide for PCP assignment are charged on a fee schedule basis, as described above.	**All Medical Products**

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG)
REPRESENTATIVE FEE SCHEDULE OF ROUTINELY PERFORMED MEDICAL SERVICES
EFFECTIVE OCTOBER 1, 2011

(Applicable to all PPO and EPO Products)

CPT Service Code	Service Description	Charge
45330	Sigmoidoscopy, flexible; Diagnostic (combined rate, includes facility fee $485.00)	$557.97
45378	Diagnostic Colonoscopy (combined rate, includes facility fee $650)	$907.75
71020	Chest X-Ray, Pa & Lat	$30.38
74000	Abdomen X-Ray (Kub)	$24.57
77057	Mammogram, Screening (Bilateral)	$78.64
92014	Eye Exam & Treatment	$109.35
92567	Tympanometry	$15.62
93000	Electrocardiogram, Complete	$21.86
94760	Oximetry Single Determination	$2.47
95115	Allergy Injection, Single	$9.69
95117	Allergy Injection, Multiple	$11.85
99211	Office Visit, Est Min (Md Or Non-Md)	$19.21
99212	Office Visit, Est Prob Focused	$39.18
99213	Office Visit, Est Exp Prob Foc	$65.80
99214	Office Visit, Est Detailed	$98.58
99231	Subsequent Hospital Care	$38.26
99242	Office Consult, Exp Prob Focused, 30 Minutes	$92.15
99395	Well Exam, Est, 18-39 Years	$94.20
99396	Well Exam, Est, 40-64 Years	$102.94

The Urgent Care case rate excluding radiology and laboratory services is $115.

The CMG CareToday (CMG low acuity clinics) visit rate is $59. Lab tests performed at the CMG CareToday facilities are $10 per service. A complete CMG CareToday fee schedule is available on request.

ASC (Ambulatory surgical center) grouper rates based on 2006 Medicare for facility component of outpatient surgery services:

Group 1 - $485
Group 2 - $650
Group 3 - $740
Group 4 - $900
Group 5 - $950
Group 6 - $1100
Group 7 - $1420
Group 8 - $1400
Group 9 - $1200
Unlisted - $740

CMG pharmacy fee schedule:

Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: AWP – 35% + $2.75 dispensing fee

Plan charges are reduced by any applicable copayment, coinsurance and/or deductible for service. Services not identified by CPT code or codes without established RVUs are billed at the 50th Percentile of the Arizona Regional Medicode Schedule.

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG) REPRESENTATIVE FEESCHEDULE OF ROUTINELY PERFORMED MEDICAL SERVICES EFFECTIVE OCTOBER 1, 2011

(Applicable to all Network and Network POS Products)

CPT Service Code	Service Description	Charge
45330	Sigmoidoscopy, flexible; Diagnostic (combined rate, includes facility fee $485)	$545.81
45378	Diagnostic Colonoscopy (combined rate, includes facility fee $650)	$864.79
71020	Chest X-Ray, Pa & Lat	$44.05
74000	Abdomen X-Ray (Kub)	$35.63
77057	Mammogram, Screening (Bilateral)	$114.03
80053	Comprehensive Metabolic Panel	$21.95
80061	Cardiac Risk	$27.83
82565	Creatinine; Blood	$10.64
82947	Glucose, Serum	$8.15
84075	Phosphatase, Alkaline,Blood	$10.74
84443	Tsh, Assay	$34.89
84450	Sgot (Ast) Transaminase	$10.74
84520	Bun (Urea Nitrogen)Assay	$8.19
85025	CBC and Differential	$13.33
87086	Culture, Urine, Colony Ct	$16.78
88164	Cytopathology, Slides	$21.94
88305	Surg Path, Gross and Micro	$147.76
92014	Eye Exam & Treatment	$158.56
92567	Tympanometry	$24.32
93000	Electrocardiogram, Complete	$28.81
94760	Oximetry Single Determination	$3.58
95115	Allergy Injection, Single	$14.05
95117	Allergy Injection, Multiple	$17.19
99211	Office Visit, Est Min (Md Or Non-Md)	$27.86
99212	Office Visit, Est Prob Focused	$58.82
99213	Office Visit, Est Exp Prob Foc	$95.41
99214	Office Visit, Est Detailed	$142.95
99231	Subsequent Hospital Care	$55.48
99242	Office Consult, Exp Prob Focused, 30 Minutes	$133.62
99395	Well Exam, Est, 18-39 Years	$136.59
99396	Well Exam, Est, 40-64 Years	$149.26

The Urgent Care case rate excluding radiology and laboratory services is $115.

The CMG CareToday (CMG low acuity clinics) visit rate is $59. Lab tests performed at the CMG CareToday facilities are $10 per service. A complete CMG CareToday fee schedule is available on request.

ASC (Ambulatory surgical center) grouper rates based on 2006 Medicare for facility component of outpatient surgery services:

Group 1 - $485
Group 2 - $650
Group 3 - $743
Group 4 - $918
Group 5 - $1044
Group 6 - $1202
Group 7 - $1449
Group 8 - $1416
Group 9 - $1950
Unlisted - $743

CMG pharmacy fee schedule:

Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: AWP – 35% + $2.75 dispensing fee

Plan charges are reduced by any applicable copayment, coinsurance and/or deductible for service. Services not identified by CPT code or codes without established RVUs are billed at the 50th Percentile of the Arizona Regional Medicode Schedule.

Exhibit C – Claim Audit Agreement (Sample)

A. WHEREAS, CHLIC ("CHLIC") desires to cooperate with requests by _____(" Employer") to permit an audit for the purposes set forth below; and

B. WHEREAS, _____("Auditor") has been retained by Employer for the purpose of performing an audit ("Audit") of claims administered by CHLIC.

C. WHEREAS, the Auditor and the Employer recognize CHLIC's legitimate interests in maintaining the confidentiality of its claim information, protecting its business reputation, avoiding unnecessary disruption of its claim administration, and protecting itself from legal liability;

NOW THEREFORE, IN CONSIDERATION of the premises and the mutual promises contained herein, CHLIC, the Employer and the Auditor hereby agree as follows:

1. Audit Specifications

The Auditor will specify to CHLIC in writing at least forty-five (45) days prior to the commencement of the Audit the following "Audit Specifications":

a. the name, title and professional qualifications of individual Auditors;
b. the Claim Office locations, if any, to be audited;
c. the Audit objectives;
d. the scope of the Audit (time period, lines of coverage and number of claims);
e. the process by which claims will be selected for audit;
f. the records/information required by the Auditor for purposes of the Audit; and
g. the length of time contemplated as necessary to complete the Audit.

2. Review of Specifications

CHLIC will have the right to review the Audit Specifications and to require any changes in, or conditions on, the Audit Specifications which may be necessary to protect CHLIC's legal and business interests identified in paragraph C above.

3. Access to Information

CHLIC will make the records/information called for in the Audit Specifications available to the Auditor at a mutually acceptable time and place.

4. Audit Report

The Auditor will provide CHLIC with a true copy of the Audit's findings, as well as of the Audit Report, if any, that is submitted to the Employer. Such copies will be provided to CHLIC at the same time that the Audit findings and the Audit Report are submitted to the Employer.

5. Comment on Audit Report

CHLIC reserves the right to provide the Auditor and the Employer with its comments on the findings and, if applicable, the Audit Report.

6. Confidentiality

The Auditor understands that CHLIC is permitting the Auditor to review the claim records/information solely for purposes of the Audit. Accordingly, the Auditor will ensure that all information pertaining to individual claimants will be kept confidential in accordance with all Applicable Laws and/or regulations. Without limiting the generality of the foregoing, the Auditor specifically agrees to adhere to the following conditions:

a. The Auditor shall not make photocopies or remove any of the claim records/information without the express written consent of CHLIC;

b. The Auditor agrees that its Audit Report or any other summary prepared in connection with the Audit shall contain no individually identifiable information.

7. Restricted Use of the Audit Information

With respect to persons other than the Employer, the Auditor will hold and treat information obtained from CHLIC during the Audit with the same degree and standard of confidentiality owed by the Auditor to its clients in accordance with all applicable legal and professional standards. The Auditor shall not, without the express written consent of CHLIC executed by an officer of CHLIC, disclose in any manner whatsoever, the results, conclusions, reports or information of whatever nature which it acquires or prepares in connection with the Audit to any party other than the Employer except as required by Applicable Law. The Employer and Auditor agree to indemnify and to hold harmless CHLIC for any and all claims, costs, expenses and damages which may result from any breaches of the Auditor's obligations under paragraphs 6 and 7 of this Agreement or from CHLIC's provision of information to the Auditor. The Employer authorizes CHLIC to provide to the designated Auditor the necessary information to perform the audit in a manner consistent with all Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Privacy Standards and in compliance with the signed Business Associate Agreement ("BAA").

8. Termination

CHLIC may terminate this agreement with prior written notice. The obligations set forth in Sections 4 through 7 shall survive termination of the Agreement.

CIGNA Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date: _____

Exhibit D – Privacy Addendum

("Business Associate Agreement")

I. GENERAL PROVISIONS

Section 1. Effect. As of the Effective Date, the terms and provisions of this Addendum are incorporated in and shall supersede any conflicting or inconsistent terms and provisions of (as applicable) the Administrative Services Only Agreement and/or Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement to which this Addendum is attached, including all exhibits or other attachments to, and all documents incorporated by reference in, any such applicable agreements (individually and collectively any such applicable agreements are referred to as the "**Agreement**"). This Addendum sets out terms and provisions relating to the use and disclosure of Protected Health Information ("**PHI**") without written authorization from the Individual.

Section 2. Amendment to Comply with Law. CHLIC, Employer (also referred to as "**Plan Sponsor**") and the group health plan that is the subject of the Agreement (also referred to as the **"Plan"**) agree to amend this Addendum to the extent necessary to allow either the Plan or CHLIC to comply with Applicable Laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 and its implementing Administrative Simplification regulations (45 C.F.R. Parts 142, 160, 162 and 164) ("**HIPAA**"), also known as the HIPAA Standards for Electronic Transactions, the HIPAA Security Standards, and the HIPAA Privacy Rule; the Health Information Technology for Economic and Clinical Health Act, which was included in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5 ("**ARRA**")) and its implementing regulations and guidance ("**HITECH**").

Section 3. Definitions. Certain capitalized terms used in this Addendum are defined in Article V. Terms used in this Addendum shall have the meanings ascribed to them by HIPAA and HITECH including their respective implementing regulations and guidance. If the meaning of any term defined herein is changed by regulatory or legislative amendment, then this Addendum will be modified automatically to correspond to the amended definition. All capitalized terms used herein that are not otherwise defined have the meanings described in HIPAA and HITECH. A reference in this Addendum to a section in the HIPAA Privacy Rule, HIPAA Security Rule, or HITECH means the section then in effect, as amended.

II. OBLIGATIONS OF CHLIC

Section 1. Use and Disclosure of PHI. CHLIC may use and disclose PHI only if such use or disclosure is permitted or required by the HIPAA Privacy Rule, including the applicable provisions of 45 C.F.R. §164.504(e), is required to satisfy its obligations or is permitted under the Agreement, and/or is permitted or required by law, but shall not otherwise use or disclose any PHI. CHLIC shall not use or disclose, and shall ensure that its directors, officers and employees do not use or disclose, PHI in any manner that would constitute a violation of the HIPAA Privacy Rule or HITECH if done by the Plan, except that CHLIC may use and disclose PHI as permitted under the HIPAA Privacy Rule (i) for the proper management and administration of CHLIC, (ii) to carry out the legal responsibilities of CHLIC or (iii) to provide Data Aggregation services relating to the health care operations of the Plan if such services are required under the Agreement.

Section 2. Receiving Remuneration in Exchange for PHI Prohibited. Effective for exchanges occurring on or after the date that is six (6) months after the date of the promulgation of final regulations by the Secretary implementing Section 13405(d) of HITECH, CHLIC shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual, unless the Plan obtained from the Individual, in accordance with 45 C.F.R. §164.508, a valid authorization that, in accordance with such section, specifies whether the PHI can be further exchanged for remuneration by the entity receiving PHI of that Individual, unless the purpose of the exchange is:

(A) For public health activities (as described in 45 C.F.R. §164.512(b));

(B) For research (as described in 45 C.F.R. §§164.501 and 164.512(i)) and the price charged reflects the costs of preparation and transmittal of the data for such purpose;

(C) For the treatment of the Individual, subject to any applicable regulation preventing PHI from inappropriate access, use, or disclosure;

(D) The health care operation specifically described in the definition of health care operations in 45 C.F.R. §164.501(6)(iv);

(E) For remuneration provided by the Plan to CHLIC for activities involving the exchange of PHI that CHLIC undertakes on behalf of and at the request of the Plan pursuant to the Agreement and this Addendum;

(F) To provide an Individual with a copy of his or her PHI pursuant to 45 C.F.R. §164.524; or

(G) Otherwise determined by regulations of the Secretary to be similarly necessary and appropriate as the exceptions described in subsections (A) through (F), above.

Section 3. Limited Data Set or Minimum Necessary Standard and Determination. CHLIC shall, to the extent practicable, limit its use, disclosure, or request of Individuals' PHI to the Limited Data Set (as defined in 45 C.F.R. §164.514(e)(2)) or, if needed by CHLIC, to the minimum necessary amount of Individuals' PHI to accomplish the intended purpose of such use, disclosure, or request and to perform its obligations under the underlying Agreement and this Addendum. CHLIC shall determine what constitutes the minimum necessary to accomplish the intended purpose of such disclosure. CHLIC's obligations under this Section 3 shall be subject to modification to comply with future guidance to be issued by the Secretary.

Section 4. Security Standards. As required by HITECH Section 13401(a), CHLIC shall comply with the administrative, physical, and technical safeguards and standards set out in 45 C.F.R. §164.308, §164.310, and §164.312, and with the policies and procedures and documentation requirements set out in 45 C.F.R. §164.316. On and after the effective date of final regulations issued by the Secretary requiring CHLIC's compliance with 45 C.F.R. §164.314, CHLIC shall comply with the organizational requirements set forth at 45 C.F.R. §164.314, to the extent applicable.

Section 5. Protection of Electronic PHI. With respect to Electronic PHI, CHLIC shall:

(A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that CHLIC creates, receives, maintains, or transmits on behalf of the Plan as required by the Security Standards;

(B) Ensure that any agent, including a subcontractor, to whom CHLIC provides such information agrees to implement reasonable and appropriate safeguards to protect it; and,

(C) Report to the Plan any Security Incident of which it becomes aware.

Section 6. Reporting of Violations. CHLIC shall report to the Plan any use or disclosure of PHI not provided for by this Addendum of which it becomes aware. CHLIC agrees to mitigate, to the extent practicable, any harmful effect from a use or disclosure of PHI in violation of this Addendum of which it is aware.

Section 7. Security Breach Notification. CHLIC will notify the Plan of a Breach without unreasonable delay. This notification will include, to the extent known:

i. the names of the individuals whose PHI was involved in the Breach;

ii. the circumstances surrounding the Breach;

iii. the date of the Breach and the date of its discovery;

iv. the information Breached;

v. any steps the impacted individuals should take to protect themselves;

vi. the steps CHLIC is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and,

vii. a contact person who can provide additional information about the Breach.

For purposes of discovery and reporting of Breaches, CHLIC is not the agent of the Plan or the Employer (as "agent" is defined under common law). CHLIC will investigate Breaches, assess their impact under applicable state and federal law, including HITECH, and make a recommendation to the Plan has to whether notification is required pursuant to 45 C.F.R. §§164.404-408 and/or applicable state breach notification laws. With the Plan's prior approval, CHLIC will issue notices to such individuals, state and federal agencies - including the Department of Health and Human Services, and/or the media as the Plan is required to notify pursuant to, and in accordance with the requirements of Applicable Law (including 45 C.F.R. §§164.404-408). CHLIC will pay the costs of issuing notices required by law and other remediation and mitigation which, in CHLIC's discretion, are appropriate and necessary to address the Breach. CHLIC will not be required to issue notifications that are not mandated by Applicable Law. CHLIC shall provide the Plan with information necessary for the Plan to fulfill its obligation to report Breaches affecting fewer than 500 Individuals to the Secretary as required by C.F.R. §164.408(c).

Section 8. Disclosures to and Agreements by Third Parties. CHLIC shall ensure that each agent and subcontractor to whom it provides PHI agrees to the same restrictions and conditions with respect to such PHI that apply to CHLIC pursuant to this Addendum.

Section 9. Access to PHI. CHLIC shall provide an Individual with access to such Individual's PHI contained in a Designated Record Set in response to such Individual's request in the manner and time required in 45 C.F.R. §164.524.

Section 10. Availability of PHI for Amendment. CHLIC shall respond to a request by an Individual for amendment to such Individual's PHI contained in a Designated Record Set in the manner and time required in 45 C.F.R. §164.526, except that the Plan shall handle any requests for amendment of PHI originated by the Plan, Plan Sponsor or the Plan's other business associates, such as enrollment information.

Section 11. Modifications to Individual Rights and Accounting of Disclosures. CHLIC shall comply with, and shall assist the Plan in complying with, responding to Individuals' requests to restrict the uses and disclosures of their PHI under 45 C.F.R. §164.522. This shall include complying with valid requests to restrict the disclosure of certain PHI in accordance with Section 13405(A) of the HITECH Act. As required by HITECH, CHLIC shall provide Individuals with access to certain PHI in electronic form. CHLIC shall provide an accounting of disclosures of PHI to an Individual who requests such accounting in the manner and time required in 45 C.F.R. §164.528.

Section 12. Requests for Privacy Protection. CHLIC shall handle requests by an Individual for privacy protection for such Individual's PHI pursuant to the requirements of 45 C.F.R. §164.522.

Section 13. Processes and Procedures. In carrying out its duties set forth in Article II, Sections 9 – 12, above, CHLIC will implement the Standard Business Associate Processes and Procedures (the "Processes and Procedures") attached hereto for requests from Individuals, including the requirement that requests be made in writing, the creation of forms for use by Individuals in making such requests, and the setting of time periods for the Plan to forward to CHLIC any such requests made directly to the Plan or Plan Sponsor. In addition, CHLIC will implement the Processes and Procedures relating to disclosure of PHI to Plan Sponsor or designated third parties.

Section 14. Availability of Books and Records. CHLIC hereby agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by CHLIC on behalf of the Plan, available to the Secretary for purposes of determining the Plan's compliance with the Privacy Rule.

III. TERMINATION OF AGREEMENT WITH CHLIC

Section 1. Termination Upon Breach of Provisions Applicable to PHI. Any other provision of the Agreement notwithstanding, the Agreement may be terminated by the Plan upon prior written notice to CHLIC in the event that CHLIC materially breaches any obligation of this Addendum and fails to cure the breach within such reasonable time as the Plan may provide for in such notice; provided that in the event that termination of the Agreement is not feasible, in the Plan's sole discretion, the Plan shall have the right to report the breach to the Secretary.

If CHLIC knows of a pattern of activity or practice of the Plan, that constitutes a material breach or violation of the Plan's duties and obligations under this Addendum, CHLIC shall provide a reasonable period of time, as agreed upon by the parties, for the Plan to cure the material breach or violation. Provided, however, that, if the Plan does not cure the material breach or violation within such agreed upon time period, CHLIC shall terminate the Agreement, if feasible, at the end of such period.

Section 2. Use of PHI upon Termination. The parties hereto agree that it is not feasible for CHLIC to return or destroy PHI at termination of the Agreement; therefore, the protections of this Addendum for PHI shall survive termination of the Agreement, and CHLIC shall limit any further uses and disclosures of such PHI to the purpose or purposes which make the return or destruction of such PHI infeasible.

IV. OBLIGATION OF THE PLAN

The Plan will not request CHLIC to use or disclose PHI in any manner that would not be permissible under HIPAA or HITECH if done by the Plan.

V. DEFINITIONS FOR USE IN THIS ADDENDUM

"**Breach**" means the unauthorized acquisition, access, use, or disclosure of Unsecured PHI which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information. A Breach does not include any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of CHLIC if such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual with CHLIC; any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by CHLIC to another similarly situated individual at the same facility; and such information is not further acquired, accessed, used, or disclosed without authorization by any person.

"**Designated Record Set**" shall have the same meaning as the term "designated record set" as set forth in the Privacy Rule, limited to the enrollment, payment, claims adjudication, and case or medical management record systems maintained by CHLIC for the Plan, or used, in whole or in part, by CHLIC or the Plan to make decisions about Individuals.

"**Effective Date**" shall mean the earliest date by which the Plan is required to have executed a Business Associate Agreement with CHLIC pursuant to the requirements of Applicable Law.

"**Electronic Protected Health Information**" shall mean PHI that is transmitted by or maintained in electronic media as that term is defined in 45 C.F.R. §160.103.

"**Limited Data Set**" shall have the same meaning as the term "limited data set" as set forth in as defined in 45 C.F.R. §164.514(e)(2).

"**Protected Health Information**" or "**PHI**" shall have the same meaning as set forth at 45 C.F.R. §160.103.

"**Secretary**" shall mean the Secretary of the United States Department of Health and Human Services.

"**Security Incident**" shall have the same meaning as the term "security incident" as set forth in 45 C.F.R. §164.304.

"**Unsecured Protected Health Information**" shall mean PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under Section 13402(h)(2) of ARRA.

CIGNA Health and Life Insurance Company
Standard Business Associate Processes and Procedures

These Standard Business Associate Processes and Procedures apply to each self-funded group health plan ("Plan") of an entity ("Plan Sponsor") that has entered or will enter into an Administrative Services Only Agreement, Flexible Spending Account or Reimbursement Accounts Administrative Services Agreement and/or Continuation Coverage Services Agreement (collectively, as applicable, the "Administrative Services Agreement") with CIGNA Health and Life Insurance Company ("CHLIC"). The Plan and CHLIC are parties to a Business Associate Agreement/Privacy Addendum. Unless otherwise defined, capitalized terms have the meaning provided therein, or if not defined in such agreement, as defined in 45 C.F.R. parts 142, 160, 162 and 164 ("HIPAA"), also known as the HIPAA Standards for Electronic Transactions, the HIPAA Security Standards, and the HIPAA Privacy Rule and/or the Health Information Technology for Economic and Clinical Health Act, which was included in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5 ("ARRA")).

Section 1. Access to PHI. When an Individual requests access to PHI contained in a Designated Record Set and such request is made directly to the Plan or Plan Sponsor, the Plan shall forward the request to CHLIC within five (5) business days of such receipt. Upon receipt of such request from the Plan, or upon receipt of such a request directly from an Individual, CHLIC shall make such PHI available directly to the Individual within the time and manner required in 45 C.F.R. §164.524. The Plan delegates to CHLIC the duty to determine, on behalf of the Plan, whether to deny access to PHI requested by an Individual and the duty to provide any required notices and review in accordance with the HIPAA Privacy Rule.

Section 2. Availability of PHI for Amendment.

(a) When an Individual requests amendment to PHI contained in a Designated Record Set, and such request is made directly to the Plan or Plan Sponsor, within five (5) business days of such receipt, the Plan shall forward such request to CHLIC for handling, except that the Plan shall retain and handle all such requests to the extent that they pertain to Individually Identifiable Health Information (such as enrollment information) originated by the Plan, Plan Sponsor, or the Plan's other business associates. CHLIC shall respond to such forwarded requests as well as to any such requests that it receives directly from Individuals as required by 45 C.F.R. §164.526, except that CHLIC shall forward to the Plan for handling any requests for amendment of PHI originated by the Plan, Plan Sponsor, or the Plan's other business associates.

(b) With respect to those requests handled by CHLIC under subparagraph (a) above, the Plan delegates to CHLIC the duty to determine, on behalf of the Plan, whether to deny a request for amendment of PHI and the duty to provide any required notices and review as well as, in the case of its determination to grant such a request, the duty to make any amendments in accordance with the terms of the Privacy Rule. In all other instances, the Plan retains all responsibility for handling such requests, including any denials, in accordance with the HIPAA Privacy Rule.

(c) Whenever CHLIC is notified by the Plan that the Plan has agreed to make an amendment pursuant to a request that it handles under subparagraph (a) above, CHLIC shall incorporate any such amendments in accordance with 45 C.F.R. §164.526.

Section 3. **Accounting of Disclosures.** When an Individual requests an accounting of disclosures of PHI held by CHLIC directly to the Plan or Plan Sponsor, the Plan shall within five (5) business days of such receipt forward the request to CHLIC to handle. CHLIC shall handle such requests, and any such requests for an accounting of disclosures received directly from Individuals, in the time and manner as required in 45 C.F.R. §164.528.

Section 4. **Requests for Privacy Protection.** CHLIC shall handle Individuals' requests made to it for privacy protection for PHI in CHLIC's possession pursuant to the requirements of 45 C.F.R. §164.522. The Plan shall forward to CHLIC to handle any such requests the Plan receives from Individuals that affect PHI held by CHLIC.

Section 5. **General Provisions Regarding Requests.** CHLIC may require that requests pursuant to Sections 1 through 4 above be made in writing and may create forms for use by Individuals in making such requests. When responding to an Individual's request as provided above, CHLIC may inform the Individual that there may be other "protected health information" created or maintained by the Plan and/or the Plan's other business associates and not included in the CHLIC's response. CHLIC shall not be responsible for performing any duties described in the Business Associate Agreement with respect to any such other "protected health information." In carrying out its duties set forth herein, CHLIC may establish such additional procedures and processes for requests from Individuals as permitted by the Privacy Rule.

Section 6. **Disclosure of PHI to the Plan Sponsor.** To the extent that the fulfillment of CHLIC's obligations under the Administrative Services Agreement requires CHLIC to disclose or provide access to PHI to Plan Sponsor or any person under the control of Plan Sponsor (including third parties), CHLIC shall make such disclosure of or provide such access to PHI only as follows:

(i) CHLIC shall disclose Summary Health Information to any employee or other person under the control of Plan Sponsor (including third parties) upon the Plan Sponsor's written request for the purpose of obtaining premium bids for the provision of health insurance or HMO coverage for the Plan or modifying, amending or terminating the Plan; and

(ii) If the Plan elects to provide PHI to the Plan Sponsor, CHLIC shall disclose or make available PHI, other than Summary Health Information, at the written direction of the Plan to only those employees or other persons identified in the Plan documents and under the control of Plan Sponsor solely for the purpose of carrying out the Plan administration functions that Plan Sponsor performs for the Plan. Such employees or other persons (including third parties) will be identified by the Plan in writing (by name, title, or other appropriate designation) to CHLIC as a condition of disclosure of PHI pursuant to this Section 6(ii). The Plan may modify such list from time to time by written notice to CHLIC.

Section 7. **Disclosures of PHI to Third Parties.** Upon the Plan's written request, CHLIC will provide PHI to certain designated third parties who assist in administering the Plan and who are authorized by the Plan to receive such information solely for the purpose of assisting in carrying out Plan administration functions ("Designated Third Parties"). Such parties may include, but are not limited to, third-party administrators, consultants, brokers, auditors, successor administrators or insurers, and stop-loss carriers. As a condition to providing PHI to a Designated Third Party, CHLIC may require that the Plan have a business associate agreement (within the meaning of the Privacy Rule) with such Designated Third Party.

Exhibit E – Conditional Claim/Subrogation Recovery Services

I. Plans Without CHLIC Stop Loss Coverage

If Employer has not purchased individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan:

A. All conditional claim payment and/or subrogation recoveries under the Plan will be handled by the entity checked below;

___ Employer
___ An independent recovery vendor whose name and address follow:
___ CHLIC and its subcontractor(s)

B. If Employer has designated CHLIC and its subcontractors to act as its recovery agent in paragraph I.A. above, then:

i. Employer hereby confers upon CHLIC and its subcontractors' discretionary authority to reduce recovery amounts by as much as fifty percent (50%) of the total amount of benefits paid on Employer's behalf, and to enter into binding settlement agreements for such amounts.

ii. In the event a settlement offer represents a reduction greater than the percentage identified above, CHLIC and its subcontractors should seek settlement advice from:

Name:
Title:
Address:
Telephone:

iii. All amounts reimbursed to Employer's Bank Account shall be refunded at the gross amount. CHLIC's and it subcontractors' subrogation administration fee on cases where CHLIC and its subcontractors' have retained counsel and in cases where no counsel has been retained by CHLIC and its subcontractors are both reflected in the Schedule of Financial Charges.

C. Except where agreed to by CHLIC and Employer, CHLIC and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of this Agreement, but shall make available to Employer and/or Employer's counsel such information relevant to such action or proceeding as CHLIC and its subcontractors may have as a result of its handling of any matter under this Agreement.

D. In the event Employer purchases individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan at any time during the life of this Agreement, the provisions of paragraph II., below, shall control.

II. Plans with CHLIC Stop Loss Coverage

If Employer has purchased individual or aggregate stop loss coverage from CHLIC or an affiliate with respect to its self-funded employee welfare benefit plan:

A. CHLIC and its subcontractors shall have the right and responsibility to manage all conditional claim payment and/or subrogation recoveries under the Plan. CHLIC and its subcontractors shall reimburse to the Plan the recovery minus relevant individual and aggregate stop loss payments made by CHLIC.

B. All amounts reimbursed to Employer's Bank Account shall be refunded at the gross amount. CHLIC's and its subcontractors' subrogation administration fee on cases where CHLIC and its subcontractors' have retained counsel and in cases where no counsel has been retained by CHLIC and its subcontractors, are both reflected in the Schedule of Financial Charges.

C. CHLIC and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of this Agreement but shall make available to Employer and/or Employer's counsel such information relevant to such action or proceeding as CHLIC and its subcontractors may have as a result of its handling of any matter under this Agreement. Notwithstanding the foregoing, CHLIC and its subcontractors reserve to itself the right to retain counsel to represent CHLIC's own interests in any subrogation and/or conditional claim recovery action under the Plan.

Exhibit F – California Transfer Addendum to ASO Agreement

The following provisions are applicable to that portion of the Plan that covers California Members under a managed care coverage option utilizing a provider network established by CIGNA HealthCare of California, Inc. or its affiliates ("CHC"), and the Agreement is hereby modified accordingly. These provisions are added for the purpose of ensuring compliance with California regulatory requirements which are applicable when the provider network includes capitated providers.

1. California Banking Arrangements

   a. In addition to the Bank Account(s) required to be established under Section 3, a separate Citibank, N.A., program account (the "CHC Program Account") will be established by CHC for the purpose of funding all in-network benefits.

   b. Employer shall, through a bank of its choice, periodically fund the CHC Program Account as described in the CHC Group Service Agreement ("GSA").

2. California Contracting Requirements

   a. CHC shall issue to Employer a GSA. In-network services under the Plan for California Members shall be provided by CHC pursuant to this GSA.

3. Funding

   a. In addition to any other charges payable by Employer to CHLIC for the performance of services under this Agreement, Employer shall pay to CHLIC any amounts funded by Employer through the CHC Program Account which CHC is required to return to Employer pursuant to the Return of Payments provision of the GSA. In recognition of its obligation to fund benefits under this Administrative Services Agreement, Employer authorizes and directs CHC to pay over any such amounts directly to CHLIC. Such amounts shall be held by CHLIC to be paid to CHC in the event CHC seeks to recover from Employer any prior years' Losses under the Loss Recovery provision of the GSA. In the event that the GSA terminates at a time when CHLIC is still holding amounts paid by CHC under the Return of Payments provision, such amounts shall be considered additional compensation owed to CHLIC for services provided pursuant to this Administrative Services Agreement.

   b. From the amounts paid to CHLIC pursuant to the preceding subsection, CHLIC shall pay to CHC any amounts which Employer may be required to pay to CHC under the "Loss Recovery" provision of the GSA.

4. Stop Loss Coverage

   a. All amounts funded by Employer through the CHC Program Account shall be considered as benefit payments under the Plan for purposes of any stop loss policy issued to the Employer by a CIGNA company with respect to the Plan, including amounts in excess of the Maximum Premium amount reflected in the GSA.

Exhibit G
Request for Proposal

Place marker request to be added.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/27/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
MARSH USA Inc.
TWO LOGAN SQUARE
PHILADELPHIA, PA 19103
Attn: Healthcare.AccountsCSS@marsh.com/FAX: 212 948-1307

100607-CIGNA-CAS-11-12

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : ACE American Insurance Company	22667
INSURER B : N/A	N/A
INSURER C : Indemnity Ins Co Of North America	43575
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
CIGNA CORPORATION AND ITS SUBSIDIARIES
TWO LIBERTY PLACE, TL15B
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2438

COVERAGES **CERTIFICATE NUMBER:** CLE-003504204-09 **REVISION NUMBER:** 6

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			HDO G2553006-8	07/01/2011	07/01/2012	EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 3,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 1,000,000
	X POLICY PRO-JECT LOC							$
A	AUTOMOBILE LIABILITY			ISA H08635729	07/01/2011	07/01/2012	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	X ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			WLR C4648115-A (AOS)	07/01/2011	07/01/2012	X WC STATU-TORY LIMITS / OTH-ER	
A	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N: N	N/A		SCF C4648116-1 (WI)	07/01/2011	07/01/2012	E.L. EACH ACCIDENT	$ 1,000,000
A				WLR C4648114-8 (CA & MA)	07/01/2011	07/01/2012	E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
A	If yes, describe under DESCRIPTION OF OPERATIONS below			WLR C4648113-8 (NW)	07/01/2011	07/01/2012	E.L. DISEASE - POLICY LIMIT	$ 1,000,000
	EXCESS						LIMIT	$1,000,000
A	WORKERS COMPENSATION			WCU C4648117-3 (OH only)	07/01/2011	07/01/2012	SIR	$1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS IS INCLUDED AS ADDITIONAL INSURED AS RESPECTS GENERAL LIABILITY. THIS INSURANCE IS PRIMARY AND NON-CONTRIBUTORY OVER ANY EXISTING INSURANCE AND LIMITED TO LIABILITY ARISING OUT OF THE OPERATIONS OF THE NAMED INSURED AND WHERE REQUIRED BY WRITTEN CONTRACT. WAIVER OF SUBROGATION IS APPLICABLE WHERE REQUIRED BY WRITTEN CONTRACT AND ALLOWED BY LAW.

CERTIFICATE HOLDER

PALM BEACH COUNTY BOARD OF COUNTY COMMISSIONERS
C/O PURCHASING DEPARTMENT
ATTN: CONNIE BAKER
50 S MILITARY TRAIL, SUITE 110
W. PALM BEACH, FL 33415

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Donna Clampitt

ACORD 25 (2010/05)

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE(MM/DD/YYYY) 03/29/2011

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:
Aon Risk Services Central, Inc. Philadelphia PA Office One Liberty Place 1650 Market Street Suite 1000 Philadelphia PA 19103 USA	PHONE (A/C, No, Ext): (866) 283-7122 FAX (A/C, No): (847) 953-5390 E-MAIL ADDRESS:

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Cigna Corporation [c a] 1601 Chestnut Street TWO Liberty Place Philadelphia PA 19192 USA	INSURER A: Lexington Insurance Company	19437
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** 570041948215 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. Limits shown are as requested

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE ☐ OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY ☐ PRO-JECT ☐ LOC						EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS HIRED AUTOS SCHEDULED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)
	UMBRELLA LIAB ☐ OCCUR EXCESS LIAB ☐ CLAIMS-MADE DED ☐ RETENTION						EACH OCCURRENCE AGGREGATE
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N N/A (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						WC STATU-TORY LIMITS ☐ OTH-ER E.L. EACH ACCIDENT E.L. DISEASE-EA EMPLOYEE E.L. DISEASE-POLICY LIMIT
A	E&O-ProfLiabPri			10570461 I&O/Managed Care SIR applies per policy terms & conditions	03/30/2011	03/30/2012	occ/agg $1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

Palm Beach County Board
of County Commissioners
c/o Purchasing Department
Attn: Connie Baker
50 S Military Trail, Ste 110
West Palm Beach FL 33415 USA

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Aon Risk Services Central Inc.

Holder Identifier :

Certificate No : 570041948215

ACORD 25 (2010/05) The ACORD name and logo are registered marks of ACORD

4/11/11

CIGNA HealthCare

Performance Guarantee Agreement

By and Between

Palm Beach County Board of County Commissioners

"Employer"

And

Connecticut General Life Insurance Company

And Applicable Affiliates

Collectively "Connecticut General"

Effective Date: January 1, 2012

Table of Contents

EXHIBIT A –Performance Guarantees and Penalties

SERVICE

Claim Time-to-Process	**Amount At Risk**
Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 90% of Claims processed w/in 14 Calendar Days. Results measured at Account Level.	$24,000.00
Financial Accuracy	**Amount At Risk**
Medical Financial Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99% of total audited Claim dollars are correctly paid. Results measured at Account Level.	$48,000.00
Processing Accuracy	**Amount At Risk**
Medical Processing Accuracy (Overall Accuracy). Measured for the Term of the Agreement, results will meet or exceed: 95% of total audited Claims are correctly processed. Results measured at Account Level.	$24,000.00
Average Speed of Answer	**Amount At Risk**
Medical ASA. Measured for the Term of the Agreement, results will not exceed: 30 seconds to answer a phone call. Results measured at Special Account Queue.	$24,000.00
Call Abandonment Rate	**Amount At Risk**
Medical Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 3% of calls received by Call Center(s) terminated. Results measured at Account Level.	$24,000.00
First Call Resolution	**Amount At Risk**
Medical First Call Resolution. Measured for the Term of the Agreement, results will meet or exceed: 85% of calls resolved on first call, 45 day look back/forward. Results measured at Account Level.	$24,000.00

DISCOUNT

Medical

One Way Medical Discount Guarantee. See Exhibit B2 for details.

This Performance Guarantee Agreement ("Agreement") is between Connecticut General Life Insurance Company and applicable affiliates (collectively "Connecticut General") and Palm Beach County Board of County Commissioners ("Employer") and is effective on January 1, 2012 ("Effective Date").

WHEREAS, in connection with certain services and programs that Connecticut General is providing to Employer for certain employee welfare benefit plans sponsored by Employer (the "Plans") under the applicable agreements between the parties (individually or collectively, the "Service Agreements and/or Policies"), Connecticut General and Employer desire to implement certain performance guarantees set forth in Exhibit A attached hereto, according to the terms set forth below.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, Connecticut General and Employer hereby agree as follows:

Section 1. – Term and Termination

1.1. This Agreement is effective on the Effective Date and shall remain in effect for one (1) year or, if applicable, for specific Performance Guarantees, the period of time expressly noted for applicable Performance Guarantees in applicable Exhibit B (the "Term") unless terminated sooner upon the earliest of the following dates:

1.1.1. As to specific Performance Guarantees, the date when Connecticut General ceases to administer the Plan(s) (run-out services notwithstanding) or when the applicable Service Agreements and/or Policies are terminated (run-out services notwithstanding) or suspended;

1.1.2. The date when any state or other applicable jurisdiction prohibits the activities of the parties under this Agreement;

1.1.3. The Effective Date, in the event that any condition precedent listed in Section 3 or in applicable Exhibit B as to specific Performance Guarantees, is not satisfied.

1.2. This Agreement is not renewable.

Section 2. – Definitions

2.1. Additional definitions applicable to specific Performance Guarantees are listed in applicable Exhibit B. Terms not defined in this Section, in applicable Exhibit B or otherwise in this Agreement shall be deemed to reflect the common use industry meaning.

2.1.1. Benefit Profile - The benefits offered under the Plan(s), including plan design and structure.

2.1.2. Business Days – The days of the week that Connecticut General is open to the public for conducting business.

2.1.3. Employee - A person who is employed by Employer and covered under the Plan.

2.1.4. Guarantee Period – The time frame for which Performance Guarantees will be measured, which shall be one (1) year from the Effective Date, unless expressly noted otherwise in Exhibit A or applicable Exhibit B.

2.1.5. Payment Amount – The amount payable to Employer, as determined by Connecticut General under the criteria set forth in this Agreement, if Performance Guarantees are not met.

2.1.6. Performance Guarantees – The level of performance that Connecticut General commits to achieve under the applicable Service Agreements and/or Policies, as set forth in the Exhibit A.

2.1.7. Plan Participants – Eligible persons enrolled in the applicable Plan connected to the specific Performance Guarantee.

2.1.8. Projected Population – The number of Employees that Employer estimated would be enrolled on the Effective Date. The Projected Population for Employer is 5,000 medical enrolled Employees.

Section 3. – Conditions Precedent

3.1. Employer acknowledges and agrees that the following conditions precedent are required for the Performance Guarantees set forth in this Agreement to be in effect, otherwise the Performance Guarantees set forth in this Agreement are null and void:

3.1.1. This Agreement is signed by both parties within three (3) months of the Effective Date;

3.1.2. Employer does not make a material change in Benefit Profiles during the Term that, as reasonably determined by Connecticut General, affects the performance being measured in the Performance Guarantees;

3.1.3. Connecticut General continuously administers the services on which the applicable Performance Guarantees are based throughout the Term of this Agreement;

3.1.4. Employer must be an active client for the type of coverage to which this Agreement relates (e.g. Medical, Dental, Pharmacy, Vision, etc.) at the time the payment amount is otherwise due under this agreement;

3.1.5. There are at least 200 enrolled Employees as of the Effective Date;

3.1.6. This Agreement remains in effect throughout the Term of this Agreement;

3.1.7. The applicable Plan(s) remain in effect throughout the Term of this Agreement;

3.1.8. The applicable Service Agreements and/or Policies to which the Performance Guarantee relates remains in effect throughout the Term of this Agreement or the Employer materially performs under the applicable Service Agreements and/or Policies throughout the Term of this Agreement;

3.1.9. The conditions precedent for specific Performance Guarantees set forth in applicable Exhibit B occur.

Section 4. – Evaluation of Performance and Payment Amounts

4.1. Performance Guarantees and the applicable levels of measurement, Payment Amounts are listed in Exhibit A. Any additional terms, conditions precedent and definitions, if applicable, for specific Performance Guarantee, are listed in applicable Exhibit B. In the event of a conflict between terms in the Agreement, the applicable Exhibit B shall control.

4.2. Connecticut General will report to Employer on each Performance Guarantee (the "Performance Reports") within the specific time frame listed in applicable Exhibit B for each specific Performance Guarantee.

4.3. Employer shall notify Connecticut General in writing within sixty (60) days of receiving the Performance Report of any dispute concerning the Performance Report.

4.4. Connecticut General shall pay to Employer any Payment Amount due under the Performance Report after the Guarantee Period. Upon prior written notice to Employer, Connecticut General may offset the Payment Amount against any payments owed by Employer to Connecticut General.

4.5. In the event that Employer fails to perform under the applicable Service Agreements and/or Policies in a way that affects Connecticut General's ability to perform one of the functions being measured in a Performance Guarantee, Connecticut General reserves the right to adjust the Payment Amount, if any, to account for Employer's act or omission.

4.6. Performance Reports measure results for the entire Guarantee Period. Any quarterly or other periodic results shared with Employer are for informational purposes only.

4.7. No third party audit results will be used to measure Performance Guarantees.

4.8. Payment Amounts are based on the Projected Population and/or total amount of fees

expected to be paid by Employer to Connecticut General under the applicable Service Agreements and/or Policies. Payment Amounts are subject to change by Connecticut General in the event that the Projected Population and/or total amount of fees paid by Employer under the applicable Service Agreements and/or Policies during the Guarantee Period changes.

Section 5. – Measurement Methodology/Changes

5.1. Connecticut General shall apply its standard methodology, consistent with industry standards, to measure Performance Guarantees. Additional information about methodology for specific Performance Guarantees, if applicable, is detailed in applicable Exhibit B. Industry standard codes, including but not limited to CPT, ICD-9, NDC and CDT codes, that are set by the industry or a government agency are subject to update/change. Any such updates/changes occurring after the Effective Date will be deemed incorporated into this Agreement without further action required by the parties.

5.2. Connecticut General may replace or modify Performance Guarantees if necessitated by a change in the way Connecticut General systematically tracks or measures the applicable Performance Guarantee. Any substitute Performance Guarantee will, to the extent reasonably possible, attempt to reflect the same underlying objective and performance level reflected in the original Performance Guarantee, consistent with its new measurement/tracking methodology. Connecticut General shall explain the reasons for the change of a Performance Guarantee and the specifics of the substitute Performance Guarantee in writing at least 30 days prior to such change.

Section 6. – Agreement Modification

This Agreement constitutes the entire contract between the parties relating to the subject matter herein and no modification or amendment hereto shall be valid unless it is in writing and signed by an officer of Employer and by Connecticut General's Regional Financial Officer.

Section 7. – Laws Governing Contract

This Agreement shall be construed in accordance with the laws of the State of Florida without regard to conflict of law rules, and both parties consent to the venue and jurisdiction of its courts.

Section 8. - Resolution of Disputes

8.1. Any dispute between the parties arising from or relating to the performance or interpretation of this Agreement ("Controversy") shall be resolved exclusively pursuant to the following mandatory dispute resolution procedures:

8.1.1. Any Controversy shall first be referred for "Executive Review". The disputing party shall give the other party written notice of the Controversy and request Executive Review. Within twenty (20) calendar days of such written request, the receiving party shall respond to the other in writing. The notice and the response shall each include a summary of and support for the party's position. Within thirty (30) calendar days of the request for Executive Review, an employee of each party, with full authority to resolve the dispute, shall meet and attempt to resolve the dispute.

8.1.2. If the Controversy has not been resolved within thirty-five (35) calendar days of the request of Executive Review under Section 8.1.1 above, the parties agree to mediate the Controversy in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation ("Mediation"). The Mediation shall be conducted in Hartford, Connecticut. Each party shall assume its own costs and attorneys fees. The mediator's compensation and expenses of the mediator and any administrative fees or costs associated with the Mediation proceeding shall be borne equally by the parties.

8.1.3. If the Controversy has not been resolved by Executive Review or Mediation, the Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 8.1.2 above, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The arbitration shall be binding on the parties to the Agreement and on any respective affiliates which joined the arbitration. The arbitrators' decision shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the arbitrators' award. Judgment on the award rendered by the arbitrators may be entered in any court having jurisdiction thereof. Each party shall assume its own costs and attorneys fees. The arbitrators' compensation and expenses and any administrative fees or costs associated with the arbitration proceeding shall be borne equally by the Parties.

8.1.4. This provision shall survive the termination of this Agreement.

Section 9. – Third Party Beneficiaries

This Agreement is for the benefit of Employer and Connecticut General. It shall not be construed to create any legal relationship between Connecticut General and any other party.

Section 10. – Assignment and Subcontracting

No assignment of rights or interests hereunder shall be binding unless approved in writing by a duly authorized officer of each of the parties.

Section 11. – Nondisclosure

This Agreement, the information Connecticut General reports to Employer in connection with this Agreement, including the Performance Guarantee Reports and the Payment Amounts, are proprietary and confidential. Employer shall maintain the confidentiality of this Agreement and any information provided to Employer pursuant to this Agreement and shall not disclose either this Agreement nor said information to any other party without the express written consent of Connecticut General.

Section 12. – Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Agreement shall be construed as a waiver of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

Section 13. – Headings

Article, section, or paragraph headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

Section 14. – Survival

Provisions contained in this Agreement that by their sense and context are intended to survive completion of performance, termination or cancellation of this Agreement shall so survive.

Section 15. – Force Majeure

Neither party shall be liable for any failure to meet any of the obligations required under this Agreement where such failure to perform is due to any contingency beyond the reasonable control of such party, its employees, officers, or directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by such party, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations.

Section 16. – Notices

Except as otherwise provided, all notices or other communications hereunder shall be in writing and shall be deemed to have been duly made when (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, (c)

delivered electronically, or (d) deposited in the United States mail, postage prepaid, and addressed as follows:

To Connecticut General:
Connecticut General Life Insurance Company
401 Chestnut Street, Suite 110
Chattanooga, TN 37402
Attention: Jenny Wilson, Underwriting Director

To Employer:
Palm Beach County Board of County Commissioners
100 Australian Avenue
Suite 200
West Palm Beach, FL 33406
Attention: Nancy Bolton,
Director, Risk Management

The address to which notices or communications may be given by either party may be changed by written notice given by such party to the other pursuant to this Section.

Section 17. – Entire Agreement

This Agreement constitutes the entire Agreement between the parties on the subject matter herein. Any and all other Performance Guarantee Agreements between the parties, if not already terminated, are terminated as of the Effective Date of this Agreement.

Signatures

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in duplicate and signed by their respective officers duly authorized to do so as of the dates given below.

Connecticut General Life Insurance Company

By: Andrea M. Balestriere

Printed Name: Andrea M. Balestriere

Title: Contractual Agreement Lead,
CIGNA HealthCare

Date: October 5, 2011

Palm Beach County Board of County Commissioners

By: _____

Printed Name:

Title:

Date: _____

WITNESSES:

(Signature)
Keila Gonzalez
(Print Name)

(Signature)
Aimee Burnham
(Print Name)

THE SUPERVISOR OF ELECTIONS OF PALM BEACH COUNTY

By:_____

_____

Its_____

ATTEST:
SHARON BOCK, CLERK & COMPTROLLER

By:_____
Deputy Clerk & Comptroller

APPROVED AS TO FORM AND LEGAL SUFFICIENCY

By:_____
County Attorney

PALM BEACH COUNTY, FLORIDA BY ITS BOARD OF COUNTY COMMISSIONERS AND ON BEHALF OF PALM TRAN, INC.

By:_____
Karen T. Marcus, Chair

APPROVED AS TO TERMS AND CONDITIONS

By:_____
Department Director

EXHIBIT B1 - SERVICE

1. **Additional Definitions**

1.1. Account Level – The performance commitment is measured with respect to Employer's claims processed during the Guarantee Period.

1.2. Average Speed to Answer - The sum of the total elapsed time between the moment when a telephone call is queued and the time the call is responded to.

1.3. Call Center – Member service center of Connecticut General that receives and responds to Plan Participant telephone calls.

1.4. Claim – Refers to claims received by Connecticut General under the Plan(s). If the term "claim" is used without a capital c, it refers to claims received by Connecticut General, whether under the Employer's Plan(s) or under other plans.

1.5. Connecticut General's Standard Quality Assurance Audit Methodology - The objective of audit claim quality is to measure claim accuracy by identifying claim payment or processing errors that are based on data available to the claim processor at the time/day the claim was paid, that caused incorrect payment or correspondence that has a customer impact and that results in correctional work by Connecticut General.

1.6. Customer Service Associate ("CSA") – A person responding to callers for a Call Center.

1.7. Inquiry - An activity generated as a result of a call received for a Call Center about the services Connecticut General provides to the Plan(s). One call may result in one or more activities.

1.8. Maintenance Eligibility –Means additions, deletions and changes in eligibility that are processed during the Guarantee Period. Maintenance Eligibility does not include any eligibility loads that are done at or before the beginning of the plan year to prepare for Plan administration.

1.9. Maintenance ID Cards – Means ID Cards issued during the Guarantee Period for changes in member address, changes in enrollment, etc. Maintenance ID Cards does not include the initial issuance of ID cards at the beginning of the Plan year.

1.10. Office Level – The performance commitment is measured using a random sample of all the claims processed for the Service Center(s) on the same claim engine that processes Employer's Claims. And, for all Vision Plan performance guarantees, Office Level shall mean that the performance commitment is measured using a random sample of all vision claims processed across the entire book of vision business.

1.11. Processed – A Claim/claim shall be considered "processed" when Connecticut General has made a determination as to whether the billed services are covered and, if covered, determined the amount of reimbursement or determined that the Claim/claim is missing critical data which must be requested from an external source .

1.12. Service Center – A claim processing office of Connecticut General that processes Claims and/or answers calls.

1.13. Special Account Queue – A defined group of associates that handle a specific block of business with similar ASA and abandonment rate requirements. For measurement purposes, results are derived by compiling combined results for all accounts with this requirement.

2. **Performance Metrics**

2.1. **Claim Time-to-Process (TTP)**

2.1.1. Time-to-Process Measurement - Time-to-Process will be calculated by counting the number of Business Days or calendar days (as appropriate) from the day that a Claim is received by Connecticut General to and including the day the Claim is processed.

The day that the Claim is received will not be included in this calculation.

2.2. Claim Quality

2.2.1. **Financial Accuracy**

2.2.1.1. Financial Accuracy Measurement - Financial Accuracy Performance Commitment will be determined by applying Connecticut General's Standard Quality Assurance Audit Methodology to a statistically valid sample of Claims (Account Level) or claims (Office Level) processed during the Guarantee Period.

Financial Accuracy represents the sum of the absolute value of total dollars overpaid and the total dollars underpaid subtracted from the total dollars paid, divided by the total dollars paid, expressed as a percent. Overpayments and underpayments are determined from auditing a statistically valid sample of claims paid during the period.

2.2.1.2. Administration Charge - In the event that an Account Level Financial Accuracy Performance Commitment is applicable and Employer has fewer than 5,000 Employees enrolled in the Plan(s) on the Effective Date, Connecticut General may charge Employer a reasonable administrative fee determined by Connecticut General.

2.2.2. **Claim Processing Accuracy (Overall Accuracy)**

2.2.2.1. Claim Processing Accuracy (Overall Accuracy) Measurement - Claim Processing Accuracy (Overall Accuracy) Performance Commitment will be determined by applying Connecticut General's Standard Quality Assurance Audit Methodology to a statistically valid sample of Claims (Account Level) or claims (Office Level) processed during the Guarantee Period.

Claim Processing Accuracy (Overall Accuracy) represents the total number of claims processed without any errors (both financial and non-financial errors) divided by the total claims processed, expressed as a percent. The calculation of claims paid with error is determined from auditing a statistically valid sample of claims paid during the period.

2.2.2.2. Administration Charge – In the event that an Account Level Claim Processing Accuracy (Overall Accuracy) Performance Commitment is applicable and Employer has fewer than 5,000 Employees enrolled in the Plan(s) on the Effective Date, Connecticut General may charge Employer a reasonable administrative fee determined by Connecticut General.

2.3. Inquiry

2.3.1. **Average Speed of Answer (ASA)**

2.3.1.1. ASA Measurement - The ASA will be determined by measuring the sum of the total elapsed time between the moment when a telephone call is queued and the time the call is responded to for all answered calls, and then dividing that number by the total number of telephone calls answered during the Guarantee Period.

The calculation of ASA is either based on all Inquiries (Account Level) or on all calls received that are serviced in the Special Account Queue.

2.3.2. **Call Abandonment Rate**

2.3.2.1. Call Abandonment Rate Measurement - The Call Abandonment Rate will be calculated as the total number of calls received during the Guarantee Period that result in the caller terminating the call after it is queued to a CSA, divided by the total number of telephone calls received during the Guarantee Period, expressed as a percent.

The calculation of Call Abandonment Rate is based on all Inquiries (Account Level) or on all calls received during the Guarantee Period that are serviced in the Special Account Queue.

2.3.3. **First Call Resolution**

2.3.3.1. First Call Resolution Measurement - An Inquiry will be considered closed on first inquiry when Connecticut General gives it a closed status on the Inquiry Tracking System(s) and no Inquiries involving the same matter are received during the 45 day period prior to the Inquiry or during the 45 day period following the Inquiry.

The First Call Resolution rate will be calculated by dividing the number of Inquiries that were closed on first inquiry during the Guarantee Period by the total number of Inquiries received during the Guarantee Period, expressed as a percent.

3. **Evaluation of Performance and Payment Amounts**

3.1. Within four (4) months after the end of the Term, Connecticut General shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each performance commitment set forth in this Agreement and make this information available to Employer.

The Payment Amounts in Exhibit A have been established in relationship to the Projected Population. In the event that the actual number of Employees enrolled on the Effective Date is greater than one-hundred and fifteen percent (115%) of the Projected Population, the Employer reserves the right to increase the Payment Amounts in proportion to the variation between the actual and projected number of enrolled Employees. Correspondingly, Connecticut General reserves the right to decrease the Payment Amounts in proportion to the variation between the actual and projected number of enrolled Employees in the event that the actual number of Employees enrolled on the Effective Date is less than eighty-five percent (85%) of the projected number.

EXHIBIT B2 - DISCOUNT

Table 1 - Networks

Rating Area Name	Network ID	Standard Discount
AZ, TUCSON METRO/PRIME COUNTY	AZ801E	60.2%
FL, OCALA/GAINESVILLE	FL413	52.8%
FL, COCOA BEACH	FL419	58.6%
FL, FT MYERS	FL420	55.2%
FL, TAMPA IPA	FL802P	61.5%
FL, ORLANDO PROPER	FL815A	61.4%
FL, LAKE/VOLUSIA	FL815B	58.9%
FL, VOLUSIA	FL815V	59.3%
FL, BROWARD COUNTY	FL816A	65.5%
FL, DADE COUNTY	FL816B	64.1%
FL, PALM BEACH COUNTY	FL816C	66.6%
FL, MARTIN COUNTY	FL816D	61.6%
FL, SOUTH FLORIDA SELECT	FL826	58.5%
GA, ATLANTA	GA8021	58.0%
GA, AUGUSTA-AIKEN	GA8025	54.9%
IN, TERREHAUTE (HS)	IN401C	42.8%
MA, BOSTON	MA8024	46.0%
NC, TRIAD	NC043C	41.7%
NC, TRIANGLE NON CORE	NC043D	47.5%
NC, WEST NC	NC043H	45.8%
SC, GREENVILLE	SC401I	53.0%
TN, TRI-CITIES	TN404B	55.1%
TN, JACKSON WESTERN	TN405G	60.8%

1. **Additional Definitions**

1.1. Actual Discount – The weighted average of all Service Area Discounts.

1.2. Covered Charges – The fee-for-service charges submitted for reimbursement under the Plan by Participating Providers for Covered Services, calculated as if there were no Discounts.

1.3. Covered Services – Health care services and supplies that are covered under the in-network coverage of the Plan.

1.4. Discount Target – The weighted average of the Service Area Discount Targets.

1.5. Eligible Charges – Covered Charges minus discounts.

1.6. Fees at Risk – The portion of network access fees that will be used to calculate the amount that either party may be required to pay the other under this Agreement.

1.7. Plan – The program of medical welfare benefits which Employer has adopted for its Plan Participants and which is administered by Connecticut General. The term "Plan" shall include each change, as of its effective date, which has been adopted by Employer and accepted by Connecticut General as compatible with its guarantee obligations hereunder. Such adoption and acceptance shall be documented in writing and executed by an authorized officer of each of the parties.

1.8. Service Area – Means a location, listed in Table 1, where In-Network Services are available under the Plan.

1.9. Service Area Discount – The discount that is calculated by dividing the Eligible Charges by the Covered Charges and subtracting the result from one (1). [Example – if Covered Charges are $100 and Eligible Charges are $75, then 75 divided by 100 is .75; one minus .75 is .25, or a 25% discount].

1.10. Service Area Discount Target – Means the percentage discount from Covered Charges that Connecticut General expects to achieve through its Participating Provider Agreements during the Guarantee Period for all Covered Services in a given Service Area. The Service Area Discount Target for each Service Area is identified in Table 1.

1.11. Service Termination Date – The date on which the Connecticut General Service Agreements and/or Policies with respect to the Plan ends (not counting any run-out periods).

2. **Additional Conditions Precedent**

2.1. The guarantee applies only to Service Areas approved by Connecticut General and identified in Table 1.

2.2. This Discount Performance Guarantee agreement and the calculations herein do not apply to:

2.2.1. Charges that are not fee-for service charges (e.g. capitation payments);

2.2.2. Charges for services/supplies that are not Covered Services (such as COB, plan exclusions, UM denials, pended/duplicate claims, etc.);

2.2.3. Charges made by providers that are not Participating Providers in a Service Area;

2.2.4. Services provided under an agreement with a provider where all billed charges equal negotiated discounted charges (such as Gentiva, NIA, etc.);

2.2.5. Charges made by any CIGNA company (e.g., including but not limited to Tel-Drug, Inc., Tel-Drug of Pennsylvania, Inc., CIGNA Behavioral Health and CIGNA HealthCare of Arizona, Inc.'s staff model);

2.2.6. Claims exceeding $100,000, which will be removed in their entirety; and

2.2.7. Claims for persons over age 65.

2.3. In the event any federal, state or local legislation or regulation (a) impacts Connecticut General's ability to enter into Participating Provider Agreements in one or more Service Areas, or (b) affects the Eligible Charges in one or more Service Areas, Connecticut General reserves the right to revise the Service Area Discount Targets to account for such changes.

2.4. When projecting the Discount Target for future periods, Connecticut General based the Discount Target on a projected increase in Covered Charges using projections from a third party (Projected Trend) and computed the Discount Target based on that projection. In the event that the actual increase in Covered Charges during periods that projections were used, which includes the Guarantee Period, is lower than Projected Trend for Covered Charges by 1.0% or more, for all Service Areas combined, Connecticut General may revise the Discount Target to reflect the difference between the actual increase in Covered Charges and Projected Trend.

2.5. In the event there is a substantial change (i.e. including but not limited to the addition of a new participating hospital, termination of a participating hospital) in CIGNA's network in the Service Area that affects the financial discounts expected in place, Connecticut General may revise the Performance Guarantees to account for such changes.

3. **Methodology**

3.1. Discount Target – Prior to the Guarantee Period, Connecticut General will identify the Service Area Discount Target(s) to be achieved during the Guarantee Period in each Service Area. These Service Area Discount Targets are identified in Table 1. After the end of the Guarantee Period, Connecticut General shall calculate the weighted average of all Service Area Discount Targets for the Guarantee Period. In calculating the weighted average of all Service Area Discount Targets, the proportional relevance assigned to each Service Area Discount Target will be determined by dividing the total of all Covered Charges for that Service Area during the Guarantee Period by the total Covered Charges for all Service Areas within the same period.

3.2. Actual Discount – Within five months after the end of the Guarantee Period, Connecticut General shall determine the Service Area Discount(s) actually achieved during the Guarantee Period in each Service Area. Connecticut General shall then calculate the weighted average of all the Service Area Discounts during the Guarantee Period. In calculating the weighted average of the Service Area Discounts, the proportional relevance assigned to each Service Area Discount will be determined by dividing the total Covered Charges for that Service Area during the Guarantee Period by the total Covered Charges for all Service Areas during the same period.

4. **Risk-Sharing Guarantees**

4.1. If the Actual Discount is within 3% - that is, that number of percentage points plus or minus of the Discount Target (the "Risk Free Corridor"), no amounts will be owed by Connecticut General under this Agreement.

4.2. If the Actual Discount is less than the Discount Target and not within the Risk Free Corridor, Connecticut General will pay or credit to Employer:

4.2.1. $2.00 Per Employee Per Month if the Actual Discount is within 3.1 - 5 percentage points of the Discount Target; or

4.2.2. $4.00 Per Employee Per Month if the Actual Discount is greater than 5 percentage points of the Discount Target.

5. **Evaluation of Performance and Payment Amounts**

5.1. Connecticut General shall provide the Performance Report to Employer within five (5) months following the end of the Guarantee Period.

5.2. Connecticut General or Employer, as the case may be, shall pay or credit to the other any amounts due under this Agreement within sixty (60) days following delivery by Connecticut General of the Performance Report.

FOURTH AMENDMENT
TO INTERLOCAL AGREEMENT
BETWEEN
PALM BEACH COUNTY ON BEHALF OF ITS DEPARTMENT OF RISK MANAGEMENT AND PALM TRAN INC. AND PALM BEACH COUNTY SUPERVISOR OF ELECTIONS
(Agreement No. R2002 2287)

THIS FOURTH AMENDMENT, dated _____ day of _____, 2006, to Agreement No. R2002 2287, dated December 17, 2002, which was originally by and between Palm Beach County, a Political Subdivision of the State of Florida, (hereinafter "County") on behalf of its Department of Risk Management and Palm Tran, Inc. (hereinafter "Palm Tran), and the Palm Beach County Supervisor of Elections (hereinafter "SOE").

WITNESSETH:

WHEREAS, the parties have entered into the Interlocal Agreement of December 17, 2002, hereinafter referred to as the "Agreement", under which the parties have established a self-insured group health benefits program to provide group health benefits coverage for employees and their eligible dependents, retirees, and COBRA participants and set forth the obligations and responsibilities of each party with regard to the group health benefits program; and

WHEREAS, the initial term of the Agreement continued in full force and effect up to and through December 31, 2005 and was by and between the County and the Solid Waste Authority of Palm Beach County; and

WHEREAS, the First Amendment of this Agreement renewed the term for one (1) additional one year period up to and through December 31, 2006 (R2005 1753); and

WHEREAS, the Second Amendment of this Agreement renewed the term for five (5) additional years up to and through December 31, 2011 (R2006-2288); and

WHEREAS, the Third Amendment of this Agreement added the Supervisor of Elections as a party to this Agreement effective January 2, 2007 (R2007-0070); and

WHEREAS, The Solid Waste Authority exercised the termination rights under this Agreement effective December 31, 2008, leaving the County, Palm Tran, and Supervisor

of Elections as remaining parties to this Agreement ; and

WHEREAS, it is necessary to amend the Interlocal Agreement to renew the term for five (5) additional years up to and through December 31, 2016.

NOW THEREFORE, in consideration of the mutual covenants and agreements expressed herein, the parties agree as follows:

1. The Board of County Commissioners and on behalf of Palm Tran, Inc. and Supervisor of Elections are hereby restated as parties to this agreement, and shall continue to assume all the rights and responsibilities as a participant in the self-insured group health benefits program established through Interlocal Agreement R2002 2287.
2. The term of this Agreement is amended to include five (5) additional years up to and through December 31, 2016.
3. All other provisions of said Agreement, dated December 17, 2002, previous amendments thereto, are hereby confirmed and, except as provided herein, are not otherwise altered or amended and shall remain in full force and effect.

IN WITNESS WHEREOF, the parties have made and executed this Third Amendment to the Agreement on behalf of the Supervisor of Elections, SWA and The County on behalf of its Department of Risk Management and Palm Tran, Inc. and has hereunto set its hand the day and year above written.

WITNESSES:

Charmaine A. Kelly
(Signature)
CHARMAINE KELLY
(Print Name)

M Sallenbach
(Signature)
Marion Sallenbach
(Print Name)

THE SUPERVISOR OF ELECTIONS
OF PALM BEACH COUNTY

By: Susan Bucher

Its Supervisor of Elections

ATTEST:
SHARON BOCK, CLERK & COMPTROLLER

By:_____
Deputy Clerk & Comptroller

PALM BEACH COUNTY,
FLORIDA BY ITS BOARD OF
COUNTY COMMISSIONERS
AND ON BEHALF OF PALM
TRAN, INC.

By:_____
Karen T. Marcus, Chair

APPROVED AS TO FORM AND
LEGAL SUFFICIENCY

By:_____
County Attorney

APPROVED AS TO TERMS AND
CONDITIONS

By: Nancy L. Roth
Department Director

APPENDIX P
DISCLOSURE OF OWNERSHIP INTERESTS
RFP NO. 11-057/LJ

TO: PALM BEACH COUNTY CHIEF OFFICER, OR HIS OR HER OFFICIALLY DESIGNATED REPRESENTATIVE

STATE OF FLORIDA
COUNTY OF PALM BEACH

BEFORE ME, the undersigned authority, this day personally appeared _Scott Evelyn_____, hereinafter referred to as "Affiant," who being by me first duly sworn, under oath, deposes and states as follows:

1. **Affiant appears herein as: [ ] an individual or [ ] the __Vice President_____ of _CIGNA Health and Life Insurance Company_____. [position—e.g., sole proprietor, president, partner, etc.] [name & type of entity—e.g., ABC Corp., XYZ Ltd. Partnership, etc.]. The Affiant or the entity the Affiant represents herein seeks to do business with Palm Beach County through its Board of County Commissioners.**

2. **Affiant's address is: ___900 Cottage Grove Road, Bloomfield, CT 06152_____**

_____.

3. **Attached hereto as Exhibit "A" is a complete listing of the names and addresses of every person or entity having a five percent (5%) or greater interest in the Affiant's corporation, partnership, or other principal. Disclosure does not apply to nonprofit corporations, government agencies, or to an individual's or entity's interest in any entity registered with the Federal Securities Exchange Commission or registered pursuant to Chapter 517, Florida Statutes, whose interest is for sale to the general public.**

4. **Affiant acknowledges that this Affidavit is given to comply with Palm Beach County policy, and will be relied upon by Palm Beach County and the Board of County Commissioners. Affiant further acknowledges that he or she is authorized to execute this document on behalf of the entity identified in paragraph one, if any.**

5. **Affiant further states that Affiant is familiar with the nature of an oath and with the penalties provided by the laws of the State of Florida for falsely swearing to statements under oath.**

6. **Under penalty of perjury, Affiant declares that Affiant has examined this Affidavit and to the best of Affiant's knowledge and belief it is true, correct and complete.**

Attachment # 5

FURTHER AFFIANT SAYETH NAUGHT.

____Scott Evelyn_____, Affiant

(Print Affiant Name)

The foregoing instrument was acknowledged before me this 27 day of July, 20 11, by Scott Evelyn, [ ] who is personally known to me or [ ] who has produced _____ as identification and who did take an oath.

Notary Public Michelle Knight

(Print Notary Name) Michelle Knight

State of Florida at Large
My Commission Expires: 12/17/2014

MICHELLE KNIGHT
Notary Public - State of Florida
My Comm. Expires Dec 17, 20'4
Commission # EE 45258
Bonded Through National Notary Assn.

CHLIC is 100 percent privately held.

EXHIBIT "A"

DISCLOSURE OF OWNERSHIP INTERESTS IN AFFIANT

Affiant must identify all entities and individuals owning five percent (5%) or more ownership interest in Affiant's corporation, partnership or other principal, if any. Affiant must identify individual owners. For example, if Affiant's principal is wholly or partially owned by another entity, such as a corporation, Affiant must identify the other entity, its address, and the individual owners of the other entity. Disclosure does not apply to any nonprofit corporation, government agency, or to an individual's or entity's interest in any entity registered with the Federal Securities Exchange Commission or registered pursuant to Chapter 517, Florida Statutes, whose interest is for sale to the general public.

Name **Address**

CHLIC is 100 percent privately held.