

MEMORANDUM

Special Item No. 1

TO: Honorable Chairman Anthony Rodriguez
and Members, Board of County Commissioners

DATE: August 13, 2025

FROM: Geri Bonzon-Keenan
County Attorney

SUBJECT: Resolution authorizing rejection of all proposals received in response to the competitive solicitation and waiver of competitive bidding procedures pursuant to section 5.03(D) of the Home Rule Charter and section 2-8.1(B) of the County Code, by a two-thirds vote of the Board Members Present, and award a non-competitive contract, Contract No. EVN0004282, Self-Funded Employee Group Healthcare Program, to Aetna Life Insurance Company in an amount estimated to be \$77,676,808.00 for a five-year term with one, two-year option to renew for the People and Internal Operations Department; and authorizing the County Mayor to execute the agreement and exercise all provisions of the contract, including any cancellation, renewal, or extensions, pursuant to section 2-8.1 of the County Code and Implementing Order 3-38

The accompanying resolution was prepared by the Strategic Procurement Department and placed on the agenda at the request of Prime Sponsor Commissioner Oliver G. Gilbert, III.



Geri Bonzon-Keenan
County Attorney

GBK/jp

MDC001

Memorandum



Date: August 13, 2025

To: Honorable Chairman Anthony Rodriguez
and Members, Board of County Commissioners

From: Daniella Levine Cava
Mayor

A handwritten signature in blue ink that reads "Daniella Levine Cava".

Subject: Recommendation to Award a Non-Competitive Bid Waiver Contract for Self-Funded Employee Group Healthcare Program

Summary

This item is for the award of a bid waiver contract that originated with a competitive process to Aetna Life Insurance Company (Aetna) for the provision of full administrative services for the County's Self-Funded Employee Group Healthcare Program (Program) including pharmacy benefits management, disease management, and wellness program services for the Department of People and Internal Operations (PIOD). A competitive solicitation was advertised for these services; however, a competitive bid waiver and rejection of proposals are being recommended in the best interest of the County in order to award the best offer received.

Covered groups in the Program, which vary by plan, include Miami-Dade County employees, Commissioners, retirees under and over the age of 65, Industrial Development Authority current employees, as well as current and retired judges. Additionally, the County anticipates the covered groups will include employees and members of the newly established Constitutional Offices (Clerk of the Court and Comptroller, Miami-Dade Sheriff's Office, Office of the Property Appraiser, Office of the Supervisor of Elections, and Office of the Tax Collector) that have agreed to have Miami-Dade County manage certain employee benefits on their behalf. These services are crucial for ensuring that County employees have access to healthcare insurance.

Recommendation

It is recommended that the Board of County Commissioners (Board) reject all proposals received in response to the competitive solicitation and waive competitive bidding procedures pursuant to Section 5.03(D) of the Home Rule Charter and Section 2-8.1(b)(1) of the Miami-Dade County Code (Code), by a two-thirds vote of the Board members present, and award a non-competitive bid waiver contract, *Contract No. EVN0004282, Self-Funded Employee Group Healthcare Program*, to Aetna in the amount of \$77,676,808 for a five-year term, with one, two-year option to renew for PIOD. This contract will replace *RFP-00196* approved by the Board via Resolution No. R-622-16 on July 16, 2016.

Background

A Request for Proposals was issued under full and open competition on January 31, 2025. On the closing date of March 24, 2025, the County received four proposals, including one from a local firm. Upon review of the proposals, staff identified potential responsiveness issues for two of the proposers, Quality Physical Therapy, LLC (Quality) and Specific Rehab Services, Inc. (Specific), and on March 27, 2025, requested a legal review of the proposals. On May 8, 2025, the County Attorney's Office opined that both proposals were non-responsive, stating that Quality's and Specific Rehab's proposals both suffered from the same material variance. In this solicitation, price is evaluated by examining the vendors' proposed costs for administering the County's self-funded employee group healthcare program. Per the solicitation's requirements, vendors needed to submit their costs for the County to evaluate, including their Administrative Services Only fees. Both proposers failed to submit their costs. The proposals from the two responsive bidders, Aetna and AvMed were sent to the Competitive Selection Committee (Committee) for review. The evaluation meeting was conducted on June 4, 2025, followed by oral presentations on June 9, 2025.

During the evaluation process, the Committee ranked Aetna as the highest-rated proposer and AvMed, Inc. (AvMed) as the second highest-rated proposer. However, the Committee recommended moving forward with AvMed based on the application of local preference. The Committee noted that Aetna and AvMed were closely matched in terms of the technical aspects of the solicitation; however, Aetna was ranked higher due to their broad national network, competitive pricing, strong customer service, and focus on innovation. Based on the proposals, it was estimated that selecting the Aetna proposal could save the County \$40M per year.

In consideration of the statements by the Committee regarding the benefits of the proposal from Aetna, the highest-rated proposer, and based on the overall scoring and potential for better pricing, both proposers were invited to submit a Best and Final Offer (BAFO) to determine which firm would advance to contract negotiations. A copy of the Committee Coordinator's Report is attached.

On June 27, 2025, a BAFO request was sent to Aetna and Avmed. On July 1, 2025, a BAFO was received from both proposers and, upon evaluation, Aetna had the better offer and advanced to negotiations. Based on the BAFO results, it was estimated that the Aetna offer could save the County at least \$42M per year over the Avmed offer. Negotiations were held with Aetna on July 7 and July 8, 2025, resulting in enhancements over their BAFO. These services will begin immediately upon award in order to timely prepare for the open enrollment period which happens in October of 2025, in order for benefits administration to begin on January 1, 2026.

A BAFO was requested simultaneously from both firms, as opposed to proceeding with negotiations with Avmed in consideration of local preference. This simultaneous BAFO process and negotiating with the firm submitting the better BAFO (Aetna) deviates from the process established in the solicitation. Hence, it is in the County's best interest to reject all of the RFP proposals and waive competitive bidding requirements pursuant to Section 2-8.1(b)(1) of the County Code and Section 5.03(D) of the Home Rule Charter to ensure continuity of services.

To foster vendor engagement ahead of the solicitation's release, the County conducted extensive market research. This process involved identifying potential vendors through GovWin IQ, Google, BidSync and Demandstar, in addition to various procurement websites, as well as posting the project's scope of work on the County's Future Solicitations website, which allowed vendors to preview the scope of work and offer feedback or suggestions. Subsequently, 22 vendors were invited to submit proposals; 15 accepted the invitation, and four ultimately responded.

Scope

The scope of this item is countywide in nature.

Fiscal Impact/Funding Source

The fiscal impact for the five-year term is estimated to be \$55,483,434. Should the County choose to exercise, at its sole discretion, the one, two-year option to renew, the estimated cumulative value will be \$77,676,808. However, the actual amount will be based on the Program usage. The current contract is estimated to be valued at about \$70,615,280 for a seven-year and six months term and expires on December 31, 2025. The annualized allocation under the proposed contract is higher than the current contract as healthcare costs trend upwards. The estimated amounts are for the full administrative services for the Program, as the County has a complete self-funded healthcare program that costs about \$550-600M per year for expenses and claims. The County will also be responsible for remitting claims payments to the awarded vendor in arrears.

Department	Allocation	Funding Source	Contract Manager
PIOD	\$77,676,808	Health Trust Fund	Michael Naftaniel
Total	\$77,676,808		

Track Record/Monitor

Pearl Bethel of the Strategic Procurement Department (SPD) is the Procurement Contracting Manager.

Delegated Authority

If this item is approved, the County Mayor or County Mayor's designee will have the authority to exercise all provisions of the contract, including any cancellation, renewal, or extensions, pursuant to Section 2-8.1 of the Code and Implementing Order 3-38.

Vendor Recommended for Award

Vendor	Principal Address	Local Address	Number of Employee Residents	Principal
			1) Miami-Dade 2) Percentage*	
Aetna Life Insurance Company	151 Farmington Avenue Hartford, CT	None	3,300	Thomas Moffatt
			12%	

*Provided pursuant to Resolution No. R-1011-15. Percentage of employee residents is the percentage of vendor's employees who reside in Miami-Dade County as compared to the vendor's total workforce.

Vendors Not Recommended for Award

Vendor	Local Address	Reason for Not Recommending
Avmed, Inc.	Yes	Evaluation scores/ranking and BAFO process
Quality Physical Therapy, LLC	No	Deemed non-responsive by the CAO (opinion attached)
Specific Rehab Services, Inc.	No	

Due Diligence

Pursuant to Resolution No. R-187-12, due diligence was conducted in accordance with SPD's Procurement Guidelines to determine contractor responsibility, including verifying corporate status and that there are no performance or compliance issues through various vendor responsibility lists and a keyword internet search. The lists that were referenced included convicted vendors, debarred vendors, delinquent contractors, suspended vendors, and federal excluded parties. There were no adverse findings relating to contractor responsibility.

Applicability of Ordinances and Contract Measures

- The User Access Program does not apply.
- The Small Business Enterprise Selection Factor did not apply.
- Local Preference was applicable.
- The Living Wage Ordinance does not apply.

Attachment



Carladenise Edwards
Chief Administrative Officer

Memorandum



Date: June 25, 2025

To: Namita Uppal, C.P.M.
Director and Chief Procurement Officer
Strategic Procurement Department

From: Princess Brown *Princess Brown*
Selection Committee Coordinator

Subject: Report of Competitive Selection Committee for RFP No. EVN0004282, Self-Funded Employee Group Healthcare Program

The Strategic Procurement Department (SPD) issued a competitive Request for Proposals (RFP) on January 31, 2025, on behalf of the People and Internal Operations Department (PIOD), to obtain proposals from qualified firms to provide full administrative services for the County's Self-Funded Employee Group Healthcare Program (Program) including pharmacy benefits management, disease management and wellness program services. The Program will be effective for the Plan Year starting on January 1, 2026. The County anticipates awarding a contract for five years with one, two-year option to renew period.

On March 24, 2025, four proposals were received in response to the solicitation. The Competitive Selection Committee (Committee) has completed the evaluation of the responsive proposals following the guidelines published in the solicitation.

Competitive Selection Committee meeting dates:

May 13, 2025 (Kick-off)

June 4, 2025 (Evaluation, Scoring and Recommendation for Orals)

June 9, 2025 (Oral Presentations, Scoring and Recommendation)

Verification of compliance with contract measures:

A Small Business Enterprise selection factor was assigned to this solicitation. None of the proposers qualified for the selection factor.

Verification of compliance with minimum qualification requirements and responsiveness:

The solicitation had minimum qualification requirements which were reviewed by the Selection Committee Coordinator and the County's benefits consultant, Gallagher Benefits Services, Inc. (Gallagher). There were two responsive proposals that met the requirements.

Proposals from Quality Physical Therapy, LLC (Quality) and Specific Rehab Services, Inc. (Specific Rehab) were forwarded to the County Attorney's Office (CAO) for review of the same material variance. In this solicitation, the County evaluates price by examining the proposer's proposed costs for administering the County's self-funded employee group healthcare program. Per the solicitation's requirements, proposers submitted their costs, including their Administrative Services Only (ASO) fees, by filling out Appendix G, Medical Financial Response form of the solicitation. Both proposers failed to submit Appendix G. A vendor's failure to provide the County with a price proposal as required by solicitation deprives the County of the assurance that the contract the County is soliciting would be entered into and performed according to the County's specific requirements. The CAO deemed both the Quality and Specific Rehab proposals non-responsive. A copy of the CAO's opinion is attached.

Local Certified Veteran's Business Enterprise Preference:

Veteran's Preference was considered. None of the proposers qualified for the preference.

Office of the Inspector General (OIG) and/or Commission on Ethics and Public Trust (COE) Reports, Findings and/or Enforcement Documentation for Proposer and Subcontractor(s):

Staff submitted a request to the OIG and COE on March 25, 2025. A response was received from the OIG on March 26, 2025, advising that no reports were found. A response was received from the COE on April 2, 2025, advising that no reports were found.

Office of the Commission Auditor (OCA) Background Check:

Staff provided Committee members with the Neutrality Affidavits, along with the list of proposers and subcontractors, to complete. Staff submitted Committee member's completed Neutrality Affidavits and resumes to OCA. A response from OCA was received advising that no conflicts of interest were identified. OCA submitted the results of the background checks to the COE for further review of findings. A response was received from COE, advising that there were no conflicts of interest.

Summary of scores:

The Committee conducted scoring in accordance with the criteria outlined in the solicitation. The preliminary scores are as follows:

Pre-Oral Presentations

Proposer	Technical Score <i>(max. 4000)</i>	Price Score <i>(max. 1000)</i>	Total Combined Score <i>(max. 5000)</i>
1. Aetna Life Insurance Company	3743	761	4504
2. Avmed, Inc.	3607	725	4332

The Committee decided to hold oral presentations which consisted of a question-and-answer period. The final scores are as follows:

Post-Oral Presentations

Proposer	Technical Score <i>(max. 4000)</i>	Price Score <i>(max. 1000)</i>	Total Combined Score <i>(max. 5000)</i>
1. Aetna Life Insurance Company	3839	859	4698
2. Avmed, Inc.	3670	806	4476

Upon review of the scores, one Committee member had a variance for one criterion that was below 33% of the average score award by all Committee members by criteria. After discussion of the variance with the Committee member, there were no changes to the scores or the ranking, the scores and variance remained the same. The Committee member stated that her scores were based on the fact that the proposer did not present any innovation beyond what the County has previously seen, and the proposal does not produce any anticipated savings.

Local Preference:

Local Preference was considered and affected the outcome whereby the second-highest ranked proposer is local, and their scoring was within 5% of the highest ranked non-local proposer. Therefore, the second highest ranked proposer was recommended for negotiations in compliance with Local Preference.

Administrative Leave Eligibility:

The following County employees served as scoring members of the Committee and timely completed all committee-related duties, including submittal of the Neutrality Affidavit within three business days from Selection Committee's notification; initial scoring within 30 calendar days of Selection Committee Coordinator's completion of required reviews; and final scoring at any additional meetings required within 15 calendar days of initial scoring meeting, and are hereby entitled to one (1) day of paid administrative leave pursuant to Implementing Order No. 3-34.

Employee's Name	Employee's Department
John Sundry	OMB
Baunie McConnell	PIOD

Two Committee members did not qualify for administrative leave, as the Neutrality Affidavit was submitted after the timeframe. One Committee member was not eligible as they are not a County employee.

Deadlines for Completion of Tasks During Evaluation:

Implementing Order No. 3-34, Formation and Performance of Competitive Selection Committees and Implementing Order No. 2-13, Guidelines and Procedures Regarding Legal Opinions, establishes certain timeframes for the completion of reviews and receipt of information during the evaluation phase. Timeframes for completion of tasks are included in the table below:

<u>Task</u>	Date	Number of Days* per I.O.	Actual Number of Days*
Proposals received	03/24/25	NA	NA
Upon Proposal Submission: SPD Review within 10 Calendar Days			
SPD sent proposals to CAO for responsiveness	03/27/25	10	3
SPD sent list of proposers/subcontractors to Committee/Review Team members for Neutrality Affidavit/Resume Note: The CSC appointment memo was received 4/21/25 with a subsequent memo for a substitution 5/1/25.	04/23/25	10	30
After SPD Review Above: Below Tasks Completed Concurrently within 30 Calendar Days Total			
Committee members returned completed Neutrality Affidavit/Resume to SPD within three business days of request	04/23/25	3*	0*
	04/28/25		3*
	04/30/25		5*
	05/06/25		9*
SPD sent received Neutrality Affidavit/Resume to OCA for background check	05/05/25 thru 05/07/07	NA	NA
OCA returned background checks to SPD	05/13/25	5*	4*
COE responded to OCA findings (if OCA refers findings)	05/30/25	14	17
CAO provided opinion to SPD	05/08/25	30	42
After Above Tasks Completed, Conduct Scoring Meeting(s)**			
Scoring meeting	06/04/25	30	5
Additional scoring meeting (post orals)	06/09/25	15	5

* All numbers listed are calendar days except when marked with an asterisk are business days.

**Scoring to be scheduled within 30 days from all required background checks, responsiveness and compliance reviews.

The CAO responsiveness opinion took longer than expected as these are large proposals for a complex contract.

Negotiations:

The Committee recommends that the County enter into negotiations with the local proposer, Avmed, Inc. pursuant to Local Preference. The following individuals will participate in the negotiations:

Princess Brown, Procurement Contracting Officer, SPD

Michael Naftaniel, Division Director, Benefits Administration and ESS, PIOD

Victor Martinez, Section Manager, Benefits Administration, PIOD

Technical and operational assistance and feedback will be requested from appropriate staff as needed during the negotiation process.

Consensus Statement:

The Committee recommended moving forward with AvMed, Inc. based on the application of Local Preference. However, Committee members ranked Aetna as the highest-rated proposer. Committee members mentioned that Aetna and Avmed were closely matched in terms of the technical aspects of the solicitation; however, Aetna stood out by offering more competitive pricing.

The Committee expressed that Aetna best aligned with the County's healthcare objectives and overall needs. Members voiced concerns that the use of Local Preference required the selection of a provider (Avmed) that, despite a 27-year history with the County, has repeatedly demonstrated they may not be the best fit for the County's future direction in healthcare.

Committee members concluded that Aetna was ranked higher due to their broad national network, competitive pricing, strong customer service, and focus on innovation—all essential elements in delivering quality healthcare to employees.

Copies of the score sheets are attached for each Committee member, as well as a composite score sheet. Your approval of the Committee's recommendation is requested.

Alternative Recommendation by SPD:

☒ Recommendation to conduct Best and Final Offer (BAFO)

The CSC's recommendation to proceed with negotiations with the second-highest ranked proposer was based on the application of Local Preference. In consideration of the statements by the CSC regarding the benefits of the proposal from the highest-rated proposer, and based on the scoring, it is recommended that both proposers, Aetna and Avmed, be invited to submit a Best and Final Offer (BAFO) in order to determine which firm will advance to contract negotiations for these services.

Approved

Namita Uppal

Digitally signed by Namita Uppal
DN: cn=Namita Uppal,
o=Miami Dade County,
ou=Chief Procurement Officer,
email=uppaln@miamidade.gov,
c=US
Date: 2025.06.26 16:21:24
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Namita Uppal, C.P.M.
Director and Chief Procurement Officer

Date

Memorandum



Date: May 8, 2025

To: Princess Brown
Strategic Procurement Department (SPD)
Procurement Contracting Officer

From: Eduardo W. Gonzalez
Assistant County Attorney

Subject: Request for Responsiveness Determination
RFP No. EVN0004282 – Self-Funded Employee Group Healthcare Program

This memorandum is prepared in response to your request for responsiveness opinion that the undersigned received on April 24, 2025. The solicitation at issue is a Request for Proposals (RFP) that solicited proposals from qualified organizations interested in providing full administrative services, for the County's Self-Funded Employee Group Healthcare Program for the Plan Year starting on January 1, 2026. You identified issues with two proposers: (1) Quality Physical Therapy, LLC (Quality); and (2) Specific Rehab Services, Inc. (Specific Rehab). For the reasons set forth below, both proposals are non-responsive.

Discussion

In general, a proposal may be rejected or disregarded if there is a material variance between the proposal and the solicitation. While a minor variance will not invalidate the proposal, a material variance will. *See Robinson Elec. Co. v. Dade County*, 417 So. 2d 1032, 1034 (Fla. 3d DCA 1982). The determination of whether a variance is material or minor is fact specific and may differ from bid to bid. Florida courts have used a two-part test to determine if the variance in a proposal constitutes a material and, therefore, nonwaivable issue: (1) whether the effect of the waiver would be to deprive the County of the assurance that the contract would be entered into, performed, and guaranteed according to its specific requirements; and (2) whether it would adversely affect competitive bidding by placing a proposer in a position of advantage over other proposers. *See Glatstein v. City of Miami*, 399 So. 2d 1005, 1007-08 (Fla. 3d DCA 1981).

Quality's and Specific Rehab's proposals both suffer from the same material variance. In this solicitation, the County evaluates price by examining the vendors' proposed costs for administering the County's self-funded employee group healthcare program. Per the solicitation's requirements, vendors submitted their costs, including their Administrative Services Only (ASO) fees, by filling out Appendix G of the solicitation, the Medical Financial Response form. Both proposers failed to submit Appendix G. Consistent with prior opinions from this office, a vendor's failure to provide the County with a price or costs proposal as required by an RFP deprives the County of the assurance that the contract the County is soliciting would be entered into and performed according to the County's specific requirements.

Accordingly, for the foregoing reasons, Specific Rehab's and Quality's proposals are non-responsive.

/s/ Eduardo W. Gonzalez

Eduardo W. Gonzalez

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Post Oral Presentations)

COMPOSITE

EVALUATION CRITERIA	PROPOSERS	Maximum Points Per Member	Maximum Total Points (5 members)	Aetna Life Insurance Company	Avmed, Inc.
A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' and Subcontractors' Key Personnel		150	750	721	702
B – Proposer's ability to perform the services in the Scope of Services		200	1000	960	945
C - Proposed Plan Design		200	1000	971	931
D - Member Services		150	750	727	681
E - Innovative Approaches		100	500	460	411
Total Technical Points		800	4000	3839	3670
Total (Technical & Selection Factor)		800	4000	3839	3670
Price Points		200	1000	859	806
TOTAL POINTS		1000	5000	4698	4476
Ranking				1	2

Signature:

Princess Brown

Chairperson

Coleen Christie

Reviewer

Print Name:

Princess Brown

Print Name:

Coleen Christie

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Post Oral Presentations)

COMMITTEE MEMBER NAME: Barbara Galvez

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors and Subcontractors' Key		150	140	147
B – Proposer's ability to perform the services in the Scope of Services		200	190	185
C - Proposed Plan Design		200	190	190
D - Member Services		150	140	130
E - Innovative Approaches		100	75	50
Total Technical Points		800	735	702
Price Points		200	170	160
TOTAL POINTS		1000	905	862

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Post Oral Presentations)

COMMITTEE MEMBER NAME: Baunie McConnell

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
	A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' Key	150	145	130
	B – Proposer's ability to perform the services in the Scope of Services	200	185	180
	C - Proposed Plan Design	200	190	170
	D - Member Services	150	150	125
	E - Innovative Approaches	100	90	75
Total Technical Points		800	760	680
Price Points		200	170	160
TOTAL POINTS		1000	930	840

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Post Oral Presentations)

COMMITTEE MEMBER NAME: Mario Morlote

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
	A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors and Subcontractors' Key	150	145	145
	B – Proposer's ability to perform the services in the Scope of Services	200	190	190
	C - Proposed Plan Design	200	195	190
	D - Member Services	150	145	140
	E - Innovative Approaches	100	100	100
	Total Technical Points	800	775	765
	Price Points	200	150	125
	TOTAL POINTS	1000	925	890

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Post Oral Presentations)

COMMITTEE MEMBER NAME: John Sarduy

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
A - Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' and Subcontractors' Key		150	144	144
B – Proposer's ability to perform the services in the Scope of Services		200	200	200
C - Proposed Plan Design		200	196	196
D - Member Services		150	146	146
E - Innovative Approaches		100	100	99
Total Technical Points		800	786	785
Price Points		200	196	190
TOTAL POINTS		1000	982	975

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Post Oral Presentations)

COMMITTEE MEMBER NAME: Se'Adoreia Brown

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
	A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' Key	150	147	136
	B – Proposer's ability to perform the services in the Scope of Services	200	195	190
	C - Proposed Plan Design	200	200	185
	D - Member Services	150	146	140
	E - Innovative Approaches	100	95	87
	Total Technical Points	800	783	738
	Price Points	200	173	171
	TOTAL POINTS	1000	956	909

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Pre Oral Presentations)

COMPOSITE

EVALUATION CRITERIA	PROPOSERS	Maximum Points Per Member	Maximum Total Points (5 members)	Aetna Life Insurance Company	Avmed, Inc.
A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' and Subcontractors' Key Personnel		150	750	709	696
B – Proposer's ability to perform the services in the Scope of Services		200	1000	920	920
C - Proposed Plan Design		200	1000	958	926
D - Member Services		150	750	721	671
E - Innovative Approaches		100	500	435	394
Total Technical Points		800	4000	3743	3607
Total (Technical & Selection Factor)		800	4000	3743	3607
Price Points		200	1000	761	725
TOTAL POINTS		1000	5000	4504	4332
Ranking				1	2

Signature:  Chairperson  Reviewer	Print Name: Princess Brown Print Name: Coleen Christie
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RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Pre Oral Presentations)

COMMITTEE MEMBER NAME: Barbara Galvez

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors and Subcontractors' Key		150	140	147
B – Proposer's ability to perform the services in the Scope of Services		200	185	185
C - Proposed Plan Design		200	190	190
D - Member Services		150	145	140
E - Innovative Approaches		100	75	50
Total Technical Points		800	735	712
Price Points		200	175	160
TOTAL POINTS		1000	910	872

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Pre Oral Presentations)

COMMITTEE MEMBER NAME: Baunie McConnell

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
	A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' Key	150	145	130
	B – Proposer's ability to perform the services in the Scope of Services	200	170	170
	C - Proposed Plan Design	200	190	170
	D - Member Services	150	150	125
	E - Innovative Approaches	100	90	75
Total Technical Points		800	745	670
Price Points		200	170	160
TOTAL POINTS		1000	915	830

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Pre Oral Presentations)

COMMITTEE MEMBER NAME: Mario Morlote

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
	A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors and Subcontractors' Key	150	140	145
	B – Proposer's ability to perform the services in the Scope of Services	200	175	175
	C - Proposed Plan Design	200	190	190
	D - Member Services	150	140	140
	E - Innovative Approaches	100	100	100
	Total Technical Points	800	745	750
	Price Points	200	100	75
	TOTAL POINTS	1000	845	825

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Pre Oral Presentations)

COMMITTEE MEMBER NAME: John Sarduy

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
A - Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' and Subcontractors' Key		150	144	144
B – Proposer's ability to perform the services in the Scope of Services		200	200	200
C - Proposed Plan Design		200	188	196
D - Member Services		150	146	146
E - Innovative Approaches		100	100	99
Total Technical Points		800	778	785
Price Points		200	196	190
TOTAL POINTS		1000	974	975

RFP NO. EVN0004282
Self-Funded Employee Group Healthcare Program
EVALUATION OF PROPOSALS (Pre Oral Presentations)

COMMITTEE MEMBER NAME: Se'Adoreia Brown

EVALUATION CRITERIA	PROPOSERS	Maximum Points	Aetna Life Insurance Company	Avmed, Inc.
	A. Proposer's Relevant Experience, Qualifications Past Performance and Relevant Experience, Qualifications Past Performance of its Key Personnel and Subcontractors' Key	150	140	130
	B – Proposer's ability to perform the services in the Scope of Services	200	190	190
	C - Proposed Plan Design	200	200	180
	D - Member Services	150	140	120
	E - Innovative Approaches	100	70	70
	Total Technical Points	800	740	690
	Price Points	200	120	140
	TOTAL POINTS	1000	860	830

Memorandum



Date: July 9, 2025

To: Honorable Chairman Anthony Rodriguez
Board of County Commissioners

From: Namita Uppal, C.P.M.
Director and Chief Procurement Officer
Strategic Procurement Department

Subject: Request to Process Late Departmental Agenda Item

 Digitally signed by Namita Uppal
DN: cn=Namita Uppal,
o=Miami Dade County,
ou=Chief Procurement
Officer,
email=uppaln@miamidade.g
ov, c=US
Date: 2025.07.09 15:33:57
-04'00'

I am requesting that the below item be processed for placement on the July 16, 2025 Board of County Commissioners agenda:

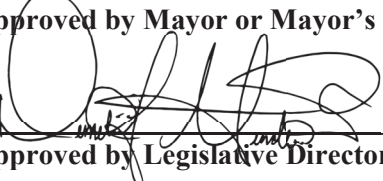
RESOLUTION AUTHORIZING REJECTION OF ALL PROPOSALS INITIALLY RECEIVED IN RESPONSE TO THE COMPETITIVE SOLICITATION AND WAIVER OF COMPETITIVE BIDDING PROCEDURES PURSUANT TO SECTION 5.03(D) OF THE HOME RULE CHARTER AND SECTION 2-8.1(B) OF THE COUNTY CODE, BY A TWO-THIRDS VOTE OF THE BOARD MEMBERS PRESENT, AND AWARD A NON-COMPETITIVE CONTRACT, CONTRACT NO. EVN0004282, SELF-FUNDED EMPLOYEE GROUP HEALTHCARE PROGRAM, TO AETNA LIFE INSURANCE COMPANY IN AN AMOUNT ESTIMATED TO BE \$77,676,808.00 FOR A FIVE-YEAR TERM WITH ONE, TWO-YEAR OPTION TO RENEW FOR THE PEOPLE AND INTERNAL OPERATIONS DEPARTMENT; AND AUTHORIZING THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE TO EXECUTE THE AGREEMENT AND EXERCISE ALL PROVISIONS OF THE CONTRACT, INCLUDING ANY CANCELLATION, RENEWAL, OR EXTENSIONS, PURSUANT TO SECTION 2-8.1 OF THE COUNTY CODE AND IMPLEMENTING ORDER 3-38

Although this item has not met the noticed deadline and has been provided to the Agenda Coordination Office late, this item is important for the People and Internal Operations Department (PIOD) to provide a Self-Funded Employee Group Healthcare Program in time for Open Enrollment starting in October 2025. This contract provides full administrative services, including pharmacy benefits management, disease management, and wellness program services have access to healthcare insurance. These services are crucial for ensuring that County employees have access to healthcare insurance.

Therefore, please process the item notwithstanding that the 4-day rule may be applicable to it. I am aware that this item is subject to approval for placement on the agenda by the appropriate committee chairperson as well as the BCC Chairman, and review by the Office of the County Attorney.



Approved by Mayor or Mayor's Designee



Approved by Legislative Director or Designee

Carladenise Edwards

Print Name

Demetria Henderson

Print Name

c: Geri Bonzon-Keenan, County Attorney
CAOagenda@miamidade.gov
Eugene Love, Agenda Coordinator



MEMORANDUM

(Revised)

TO: Honorable Chairman Anthony Rodriguez
and Members, Board of County Commissioners

DATE: August 13, 2025

FROM: 
Gen Bonzon-Keenan
County Attorney

SUBJECT: Special Item No. 1

Please note any items checked.

- ☐ "3-Day Rule" for committees applicable if raised
- ☐ 6 weeks required between first reading and public hearing
- ☐ 4 weeks notification to municipal officials required prior to public hearing
- ☐ Decreases revenues or increases expenditures without balancing budget
- ☐ Budget required
- ☐ Statement of fiscal impact required
- ☐ Statement of social equity required
- ☐ Ordinance creating a new board requires detailed County Mayor's report for public hearing
- ☐ No committee review
- ☒ Applicable legislation requires more than a majority vote (i.e., 2/3's present ☒, 2/3 membership ____, 3/5's ____, unanimous ____, majority plus one ____, CDMP 7 vote requirement per 2-116.1(3)(h) or (4)(c) ____, CDMP 2/3 vote requirement per 2-116.1(3) (h) or (4)(c) ____, CDMP 9 vote requirement per 2-116.1(4)(c) (2) ____) to approve
- ☐ Current information regarding funding source, index code and available balance, and available capacity (if debt is contemplated) required

Approved _____ Mayor
Veto _____
Override _____

Special Item No. 1
8-13-25

RESOLUTION NO. _____

RESOLUTION AUTHORIZING REJECTION OF ALL PROPOSALS RECEIVED IN RESPONSE TO THE COMPETITIVE SOLICITATION AND WAIVER OF COMPETITIVE BIDDING PROCEDURES PURSUANT TO SECTION 5.03(D) OF THE HOME RULE CHARTER AND SECTION 2-8.1(B) OF THE COUNTY CODE, BY A TWO-THIRDS VOTE OF THE BOARD MEMBERS PRESENT, AND AWARD A NON-COMPETITIVE CONTRACT, CONTRACT NO. EVN0004282, SELF-FUNDED EMPLOYEE GROUP HEALTHCARE PROGRAM, TO AETNA LIFE INSURANCE COMPANY IN AN AMOUNT ESTIMATED TO BE \$77,676,808.00 FOR A FIVE-YEAR TERM WITH ONE, TWO-YEAR OPTION TO RENEW FOR THE PEOPLE AND INTERNAL OPERATIONS DEPARTMENT; AND AUTHORIZING THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE TO EXECUTE THE AGREEMENT AND EXERCISE ALL PROVISIONS OF THE CONTRACT, INCLUDING ANY CANCELLATION, RENEWAL, OR EXTENSIONS, PURSUANT TO SECTION 2-8.1 OF THE COUNTY CODE AND IMPLEMENTING ORDER 3-38

WHEREAS, this Board desires to accomplish the purposes outlined in the accompanying memorandum, a copy of which is incorporated herein by reference,

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA, that:

Section 1. This Board finds it is in the best interest of Miami-Dade County to reject all proposals received in response to the competitive solicitation and waive competitive bidding procedures pursuant to section 5.03(D) of the Home Rule Charter and section 2-8.1(b)(1) of the County Code, by a two-thirds vote of the Board members present, and award a non-competitive contract, Contract No. EVN0004282, in substantially the form attached and made a part hereto, to Aetna Life Insurance Company for Self-Funded Employee Group Healthcare Program in an

amount estimated to be \$77,676,808.00 for a five-year term with one, two-year option to renew for the People and Internal Operations Department. Copies of attachments for the Pharmacy Workbook, Pharmacy Workbook-NACo, and the Plan Design are available upon request from the Strategic Procurement Department.

Section 2. This Board authorizes the County Mayor or County Mayor's designee to execute the agreement and exercise all provisions of the contract, including any cancellation, renewal, or extensions, pursuant to section 2-8.1 of the County Code and Implementing Order 3-38.

The foregoing resolution was offered by Commissioner ,
who moved its adoption. The motion was seconded by Commissioner
and upon being put to a vote, the vote was as follows:

Anthony Rodriguez, Chairman	
Kionne L. McGhee, Vice Chairman	
Marleine Bastien	Juan Carlos Bermudez
Sen. René García	Oliver G. Gilbert, III
Roberto J. Gonzalez	Keon Hardemon
Danielle Cohen Higgins	Eileen Higgins
Natalie Milian Orbis	Raquel A. Regalado
Micky Steinberg	

The Chairperson thereupon declared this resolution duly passed and adopted this 13th day of August, 2025. This resolution shall become effective upon the earlier of (1) 10 days after the date of its adoption unless vetoed by the County Mayor, and if vetoed, shall become effective only upon an override by this Board, or (2) approval by the County Mayor of this resolution and the filing of this approval with the Clerk of the Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF
COUNTY COMMISSIONERS

JUAN FERNANDEZ-BARQUIN, CLERK

By: _____
Deputy Clerk

Approved by County Attorney as
to form and legal sufficiency.

A handwritten signature in black ink, appearing to read 'E. Gonzalez', written over a horizontal line.

Eduardo W. Gonzalez

Contract No. EVN0004282
Self-Funded Employee Group Health Care Program

THIS AGREEMENT for the provision of full administrative services for Miami-Dade County's Self-funded Employee Group Healthcare Program, made and entered into as of this _____ day of _____ 2025 by and between Aetna Life Insurance Company, a corporation organized and existing under the laws of the State of Connecticut, having its principal office at 151 Farmington Avenue, Hartford, CT (the "Contractor"), and Miami-Dade County, a political subdivision of the State of Florida, having its principal office at 111 NW 1st Street, Miami, Florida 33128 (the "County") (collectively, the "Parties").

WITNESSETH:

WHEREAS, the Contractor has offered to provide full administrative services for the Self-funded Employee Group Healthcare Program, on a non-exclusive basis, that shall conform to the Scope of Services, Miami-Dade County's Request for Proposal ("RFP") No. EVN0004282 and all associated addenda and attachments, and the requirements of this Agreement; and

WHEREAS, the Contractor submitted a written proposal dated March 24, 2025 (the "Contractor's Proposal") which is incorporated herein by reference, and which was amended through the Contractor's Best and Final Offer and subsequent negotiations between the Parties; and

WHEREAS, the Contractor is licensed by the State of Florida, Office of Insurance Regulation to provide the plan services pursuant to this Agreement; and

WHEREAS, the Contractor's Proposal was the highest ranked proposal as a result of the evaluation process conducted pursuant to the RFP; and

WHEREAS, on June 26, 2025, Miami-Dade County invited proposers to submit Best and Final Offers, and the Contractor submitted revisions to its proposal that resulted in a better offer; and

WHEREAS, as a result of the Contractor's better offer, the Contractor was selected to negotiate an agreement, and the Parties successfully completed the negotiations that resulted in this Agreement; and

WHEREAS, the County desires to procure from the Contractor the full administrative services for the Self-funded Employee Group Healthcare Program for the County, in accordance with the terms and conditions of this Agreement;

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, the Parties hereto agree as follows:

ARTICLE 1. DEFINITIONS

The following words and expressions used in this Agreement shall be construed as follows, except when it is clear from the context that another meaning is intended:

- a) The words "Article" or "Articles" means the terms and conditions delineated in this Agreement.
- b) The words "Cafeteria Plan" means a plan that offers flexible benefits under the Internal Revenue Services (IRS) Code Section 125. Employees choose their benefits from a menu of cash and benefits, some of which can be paid with pretax deductions from wages.
- c) The word "Contract" or "Agreement" means collectively the (i) Articles, (ii) Scope of Services, (iii) Price Schedule, (iv) all other appendices and attachments hereto, and (v) all amendments issued hereto, and Contractor's Proposal.
- d) The words "Contract Manager" means the Chief Procurement Officer, Strategic Procurement Department, or the duly authorized representative designated to manage the Contract.

- e) The word "Contractor" means the corporation identified in the preamble and its permitted successors.
- f) The "Custom Formulary" means a list of covered pharmaceuticals.
- g) The word "Days" means calendar days.
- h) The word "Deliverables" means all documentation and any items of any nature submitted by the Contractor to the Project Manager for review and approval pursuant to the terms of this Agreement.
- i) "Developed Works" means those work products created by Contractor that are, newly created and customized for Miami-Dade County.
- j) The words "Eligible Member" means active Employee, their spouse or domestic partner.
- k) The word "Employee" means employees and officials of Miami-Dade County and any of its constitutional offices (Clerk of Court, Sheriff, Property Appraiser, Supervisor of Elections, and Tax Collector) that has agreed to have Miami-Dade County manage certain employee benefits (including health insurance) on its behalf.
- l) The words "Medical Necessity" means accepted healthcare services and supplies provided by healthcare entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
- m) The word "Members" means all employees, retirees, and their dependents enrolled in the Program.
- n) The word "On-site" means location where County provides office space for Contractor's staff.
- o) The word "Participant" means all employees and eligible dependents who choose to participate in the Disease Management Program; and employees and their spouse or domestic partner who choose to participate in the Wellness Program.
- p) The words "Plan Design" or "Plan" means designed benefit option to establish a course of healthcare.
- q) The words "Plan Year" means calendar year, January 1 through December 31.
- r) The words "Project Manager" means the County Mayor or the duly authorized representative designated to manage the Project.
- s) The word "Provider" means medical/pharmaceutical professional rendering services under the Program.
- t) The words "Self-funded Program" means a program offered by employers who directly assume the risk.
- u) The words "Scope of Services" means the document appended hereto as Appendix A, which details the Work to be performed by the Contractor.
- v) The word "Subcontractor" or "Subconsultant" means any person, entity, firm, or corporation, other than the employees of the Contractor, who furnishes labor and/or materials, in connection with the Work, whether directly or indirectly, on behalf and/or under the direction of the Contractor and whether or not in privity of Contract with the Contractor.
- w) The word "Subscriber" means person whose employment makes them eligible for group health insurance benefits.
- x) The words "Wellness Program" means both wellness and disease management program services.
- y) The words "Work", "Services" "Program", or "Project" means all matters and things required to be done by the Contractor in accordance with the provisions of this Contract.

ARTICLE 2. ORDER OF PRECEDENCE

If there is a conflict between or among the provisions of this Agreement, the order of precedence is as follows:

- 1) these Articles 1 through 48,

- 2) Appendix A, Scope of Services,
- 3) Appendix B, Price Schedule, BAFO and as negotiated
 - o B.1 Self-Funded Medical Financial Package MDCG
 - o B.2 Pharmacy Fee Schedule
 - o B.2.a Pharmacy Fee Schedule - NACO
 - o B.3 Pharmacy Workbook
 - o B.3.a Pharmacy Workbook - NACO
 - o B.4 Gene Therapy Stop Loss Proposal-Approved & Pipeline
 - o B.5 Gene Therapy Stop Loss Proposal-Approved Only
 - o B.6 COBRA Admin Scope of Services (BOI)
 - o B.7 Quest Biometrics Screening - Sample Pricing
 - o B.8 LabCorp Sample Biometric Screening Pricing
- 4) Attachment 1 Plan Designs,
- 5) Attachment 2, HIPAA Business Associate Addendum,
- 6) Miami-Dade County's RFP No. EVN0004282 and any associated addenda and attachments thereof, and
- 7) Contractor's Proposal.

ARTICLE 3. RULES OF INTERPRETATION

- a) References to a specified Article, section or schedule shall be construed as reference to that specified Article, or section of, or schedule to this Agreement unless otherwise indicated.
- b) Reference to any agreement or other instrument shall be deemed to include such agreement or other instrument as such agreement or other instrument may, from time to time, be modified, amended, supplemented, or restated in accordance with its terms.
- c) The terms "hereof", "herein", "hereinafter", "hereby", "herewith", "hereto", and "hereunder" shall be deemed to refer to this Agreement.
- d) The terms "directed", "required", "permitted", "ordered", "designated", "selected", "prescribed" or words of like import to mean respectively, the direction, requirement, permission, order, designation, selection or prescription of the Project Manager.
- e) The terms "approved", "acceptable", "satisfactory", "equal", "necessary", or words of like import to mean respectively, approved by, or acceptable or satisfactory to, equal or necessary in the opinion of the Project Manager.
- f) The titles, headings, captions, and arrangements used in these Terms and Conditions are for convenience only and shall not be deemed to limit, amplify, or modify the terms of this Contract, nor affect the meaning thereof.

ARTICLE 4. NATURE OF THE AGREEMENT

- a) This Agreement incorporates and includes all prior negotiations, correspondence, conversations, agreements, and understandings applicable to the matters contained in this Agreement. The Parties agree that there are no commitments, agreements, or understandings concerning the subject matter of this Agreement that are not contained in this Agreement, and that this Agreement contains the entire agreement between the Parties as to all matters contained herein. Accordingly, it is agreed that no deviation from the terms hereof shall be predicated upon any prior representations or agreements, whether oral or written. It is further agreed that any oral representations or modifications concerning this Agreement shall be of no force or effect, and that this Agreement may be modified, altered, or amended only by a written amendment duly executed by the Parties hereto or their authorized representatives.
- b) The Contractor shall provide the services set forth in the Scope of Services and render full and prompt cooperation with the County in all aspects of the Work performed hereunder.
- c) The Contractor acknowledges that this Agreement requires the performance of all things necessary for or incidental to the effective and complete performance of all Work under this Contract. All things not expressly mentioned in this Agreement but necessary to carrying out its intent are required by this Agreement provided that they are customary or traditionally contemplated for the types or services under this agreement, the Contractor shall perform the same as though they were specifically mentioned, described, and delineated.

- d) The Contractor shall furnish all labor, materials, tools, supplies, and other items required to perform the Work necessary for the completion of this Contract. All Work shall be accomplished at the direction of and to the satisfaction of the Project Manager.
- e) The Contractor acknowledges that the County shall make all policy decisions regarding the Scope of Services. The Contractor agrees to provide input on policy issues in the form of recommendations. The Contractor shall implement all changes in providing services hereunder as a result of a policy change implemented by the County. The Contractor agrees to act in an expeditious and fiscally sound manner in providing the County with input regarding the time and cost to implement said changes and in executing the activities required to implement said changes.

ARTICLE 5. CONTRACT TERM

The Contract shall become effective on the date identified on the first page of this Agreement and shall continue through December 30, 2030. The County, at its sole discretion, may renew this Contract for one, two-year optional renewal period. The County may extend this Contract for up to an additional one hundred-eighty (180) calendar days beyond the current Contract period and will notify the Contractor in writing of the extension. This Contract may be extended beyond the initial one hundred-eighty (180) calendar day extension period by mutual agreement between the County and the Contractor, upon approval by the Board of County Commissioners (the "Board").

ARTICLE 6. NOTICE REQUIREMENTS

All notices required or permitted under this Agreement shall be in writing and shall be deemed sufficiently served if delivered by: (i) Registered or Certified Mail, with return receipt requested; (ii) personally by a by courier service; (iii) Federal Express Corporation or other nationally recognized carrier to be delivered overnight; or (iv) via e-mail (if provided below) with delivery of hard copy pursuant to (i), (ii), or (iii) in this paragraph. The addresses for such notice are as follows:

(1) To the County

- a) to the Project Manager:

Miami-Dade County
People and Internal Operations Department
Attention: Raymond Hall
111 NW 1st Street, Suite 2110
Miami, FL 33128
Phone: (305) 375-4737
E-mail: Raymond.Hall@miamidade.gov
With a copy to: Michael.Naftaniel@miamidade.gov

and

- b) to the Contract Manager:

Miami-Dade County
Strategic Procurement Department
Attention: Chief Procurement Officer
111 NW 1st Street, Suite 1300
Miami, FL 33128-1974
Phone: (305) 375-4900
Email: cpo@miamidade.gov

(2) To the Contractor

Aetna Life Insurance Company
Attention: Cathy Aguirre and/or Renthia Jackson
Address: 261 North University Dr.
Plantation, FL 33324
E-mail: craguirre@aetna.com and or rxjackson@aetna.com

Either party may at any time designate a different address and/or contact person by giving notice as provided above to the other party. Such notices shall be deemed given upon receipt by the addressee.

ARTICLE 7. PAYMENT FOR SERVICES FUNDING AND PAYMENT OF CLAIMS

- a. The Contractor warrants that it has reviewed the County's requirements and has asked such questions and conducted such other inquiries as the Contractor deemed necessary in order to determine the price the Contractor will charge to provide the Work and Services to be performed under this Contract. The compensation for all Work and Services performed under this Contract, including all costs associated with such Work and Services, shall be in accordance with Appendix B, Price Schedule. The County shall have no obligation to pay the Contractor any additional sum in excess of this amount, except for a change and/or modification to the Contract, which is approved and executed in writing by the County and the Contractor.
- b. All Services undertaken by the Contractor before County's approval of this Contract shall be at the Contractor's risk and expense.
- c. The Contractor shall establish a benefit plan account ("Account") with a Qualified Public Depository bank agreed upon between County and the Contractor. The account shall be in the name of the County for the exclusive use of the County's plan. An initial imprest balance will be maintained in the Account. Should it become necessary to increase the imprest amount, the County will agree to do so based on satisfactory evidence, at the County's sole discretion, from the Contractor of insufficient funds. The Account shall be funded weekly by the County based on electronic reports provided by the Contractor of issued checks. The County will issue payments via wire transfer. Any interest earned in the Account shall be accrued to the County and any banking fees will be charged to the Account.
- d. The Contractor shall establish an account ("Disbursement Account") with a Qualified Public Depository bank for the purpose of disbursements. The Disbursement Account shall be in the name of the Contractor. The Contractor, on behalf of the County, shall issue payments from the Disbursement Account for healthcare Plan benefits and Plan-related expenses in the amount Contractor determines to be proper under the healthcare Program and/or under this Agreement. The Contractor shall provide to the County a monthly reconciliation of the Disbursement Account.
- e. In the event that sufficient funds are not available in the Account to pay all healthcare Plan benefits and Plan-related expenses when due, then Contractor shall notify the County accordingly.
- f. In the event Contractor pays any person less than the amount to which they are entitled under the Self-Funded Employee Group Healthcare Program, Contractor will promptly adjust the underpayment by drawing the additional funds from the County's Account. In the event Contractor overpays any person entitled to benefits under the Self-Funded Employee Group Healthcare Program or pays benefits to any person not entitled to them, Contractor shall take all reasonable steps to recover the overpayment and credit the Account; accordingly, however, Contractor shall not be required to initiate court proceedings to recover an overpayment. Contractor shall only be liable for overpayments that are the direct result of errors or actions by the Contractor.
- g. Contractor shall indemnify and save the County harmless from any loss proximately caused by criminal or intentionally wrongful acts by any employee of Contractor arising out of its use of the Account. This indemnity shall survive the termination of this Agreement. The County shall give Contractor prompt and timely notice of any fact or condition which comes to its attention which may give rise to a claim of indemnity under this paragraph.
- h. Following termination of this Agreement, the County shall remain liable for payment of all Plan benefits or fees due any provider or entity for services rendered prior to termination. County shall reimburse Contractor to the extent Contractor makes any such payment. In no event shall any payment of healthcare Plan benefits or fees by Contractor be construed to oblige Contractor to assume any liability of the County for the payment of such benefits or fees. This provision shall survive the termination of this Agreement.

ARTICLE 8. PRICING

Prices for the Administrative Services Only (ASO) Fee shall be in accordance with Appendix B - Price Schedule. However, the Contractor may offer incentive discounts to the County at any time during the Contract term, including any renewal or extension thereof.

ARTICLE 9. METHOD AND TIMES OF PAYMENT

The County will remit applicable Administrative Fees and/or Premiums on fully insured products to the Contractor on a bi-weekly basis for the prior County pay period, accompanied by an electronic file of employee salary deductions after the County either deducts the employee contributions through its payroll process or receives payment from employees on an unpaid leave of absence. The County retains the right, at all times, to self-bill. The County will remit Administrative Fees and/or Premium payments based on its records.

Invoices and associated back-up documentation shall be submitted electronically or in hard copy format by the Contractor to the County as follows:

- Electronic submission (preferred) to invsubp@miamidade.gov; or
- Hard copy format mailed to:
Miami-Dade County, Finance Shared Services
111 NW 1st Street, 26 Floor
Miami, Florida 33128

Invoice shall include a Bill to Address, which is the County department being invoiced for the services.

Bill to:
People and Internal Operations Department
111 NW 1st Street, Suite 2110
Miami, FL 33128
Attention: Melanie McLean

The County may at any time designate a different address and/or contact person by giving written notice to the other party.

ARTICLE 10. INDEMNIFICATION AND INSURANCE

The Contractor shall indemnify, defend and hold harmless the County and its officers, employees, agents and instrumentalities from any and all liability, losses or damages, including attorneys' fees and costs of defense, which the County or its officers, employees, agents or instrumentalities may incur as a result of claims, demands, suits, causes of actions or proceedings of any kind or nature arising out of, relating to or resulting from the performance of this Agreement by the Contractor or its employees, agents, servants, partners principals or Subcontractors. The Contractor shall pay all claims and losses in connection therewith and shall investigate and defend all claims, suits or actions of any kind or nature in the name of the County, where applicable, including appellate proceedings, and shall pay all costs, judgments, and attorney's fees which may be issued thereon. The Contractor expressly understands and agrees that any insurance protection required by this Agreement or otherwise provided by the Contractor shall in no way limit the responsibility to indemnify, keep and save harmless and defend the County or its officers, employees, agents, and instrumentalities as herein provided.

Upon County's notification, the Contractor shall furnish to the Strategic Procurement Department, certificate(s) of insurance that indicates that insurance coverage has been obtained, which meets the requirements as outlined below:

1. Worker's Compensation Insurance for all employees of the Contractor as required by Chapter 440, Florida Statutes.
2. Commercial General Liability Insurance in an amount not less than \$300,000 per occurrence, and \$600,000 in the aggregate.
Miami-Dade County must be shown as an additional insured with respect to this coverage.
3. Automobile Liability Insurance covering all owned, non-owned, and hired vehicles used in connection with the Services, in an amount not less than \$300,000 combined single limit per occurrence for bodily injury and property damage.

4. Professional Liability Insurance in an amount not less than \$3,000,000 per claim.
5. Cyber Liability Insurance to include data breach and third-party liability, in an amount not less than \$1,000,000 per occurrence.

All insurance policies required above shall be issued by companies authorized to do business under the laws of the State of Florida, with the following qualifications:

The company must be rated no less than "A-" as to management, and no less than "Class VII" as to financial strength, by Best's Insurance Guide, published by A.M. Best Company, Oldwick, New Jersey, or its equivalent, subject to the approval of the County Risk Management Division.

OR

The company must hold a valid Florida Certificate of Authority as shown in the latest "List of All Insurance Companies Authorized or Approved to Do Business in Florida", issued by the State of Florida Department of Financial Services and are a member of the Florida Guaranty Fund.

The mailing address of Miami-Dade County as the certificate holder must appear on the certificate of insurance as follows:

**Miami-Dade County
111 NW 1st Street
Suite 2340
Miami, Florida 33128-1974**

Compliance with the foregoing requirements shall not relieve the Contractor of this liability and obligation under this section or under any other section in this Agreement.

Award of this Contract is contingent upon the receipt of the insurance documents, as required, within ten (10) business days. If the certificate of insurance is received within the specified timeframe but not in the manner prescribed in this Agreement, the Contractor shall have an additional five (5) business days to submit a corrected certificate to the County. If the Contractor fails to submit the required insurance documents in the manner prescribed in this Agreement within fifteen (15) business days, the Contractor shall be in default of the contractual terms and conditions and award of the Contract may be rescinded, unless such timeframe for submission has been extended by the County.

The Contractor shall assure that the certificate of insurance required in conjunction with this section remain in full force for the term of the Contract, including any renewal or extension periods that may be exercised by the County. If the certificate of insurance is scheduled to expire during the term of the Contract, the Contractor shall submit new or renewed certificate of insurance to the County before such expiration. If expired certificate(s) of insurance is/are not replaced or renewed to cover the Contract period, the County may suspend the Contract until the new or renewed certificate is/are received by the County in the manner prescribed herein. If such suspension exceeds thirty (30) calendar days, the County may, at its sole discretion, terminate the Contract for cause and the Contractor shall be responsible for all direct and indirect costs associated with such termination.

ARTICLE 11. MANNER OF PERFORMANCE

- a) The Contractor shall provide the services described herein in a competent and professional manner satisfactory to the County in accordance with the terms and conditions of this Agreement. The County shall be entitled to a satisfactory performance of all services described herein and to full and prompt cooperation by the Contractor in all aspects of the service. At the request of the County, the Contractor shall promptly remove from the Project any Contractor's employee, Subcontractor engaged to provide dedicated services specifically for the County, or any other person performing service hereunder. For any Subcontractor that is not engaged by the Contractor to provide dedicated services specifically for the County and that in the County's opinion is not providing satisfactory performance, the Contractor may either remove the Subcontractor from the Project or promptly resolve the performance in another manner satisfactory to the Parties. The Contractor agrees that such removal of any of its employees does not require the termination or demotion of any employee by the Contractor.
- b) The Contractor agrees to defend, hold harmless and indemnify the County and shall be liable and responsible for all claims, suits, actions, damages, and costs (including attorneys' fees and court costs) made against the County, occurring on account

of, arising from or in connection with the removal and replacement of any Contractor's personnel performing services hereunder at the behest of the County. Removal and replacement of any Contractor's personnel as used in this Article shall not require the termination and/or demotion of such Contractor's personnel.

- c) The Contractor always agrees that it will employ, maintain, and assign to the performance of the Work a sufficient number of competent and qualified professionals and other personnel to meet the requirements to which reference is hereinafter made. The Contractor agrees to adjust its personnel staffing levels or to replace any of its personnel if so, directed upon reasonable request from the County, should the County make a determination, in its sole discretion, that said personnel staffing is inappropriate or that any individual is not performing in a manner consistent with the requirements for such a position.
- d) The Contractor warrants and represents that its personnel have the proper skill, training, background, knowledge, experience, rights, authorizations, integrity, character, and licenses as necessary to perform the Work described herein, in a competent and professional manner.
- e) The Contractor shall always cooperate with the County and coordinate its respective work efforts to maintain the progress most effectively and efficiently in performing the Work.
- f) The Contractor shall comply with all provisions of all federal, state, and local laws, statutes, ordinances, and regulations that are applicable to the performance of this Agreement.

ARTICLE 12. EMPLOYEES OF THE CONTRACTOR

All employees of the Contractor shall be, at all times, employees of the Contractor under its sole direction and not employees or agents of the County. The Contractor shall supply competent employees. Miami-Dade County may require the Contractor to remove an employee it deems careless, incompetent, insubordinate or otherwise objectionable and whose continued employment on County property is not in the best interest of the County. Each employee shall have and wear proper identification.

ARTICLE 13. INDEPENDENT CONTRACTOR RELATIONSHIP

The Contractor is, and shall be, in the performance of all Work and activities under this Agreement, an independent contractor, and not an employee, agent or servant of the County. All persons engaged in any of the Work performed or Services provided pursuant to this Agreement shall always, and in all places, be subject to the Contractor's sole direction, supervision, and control. The Contractor shall exercise control over the means and manner in which it and its employees perform the Work, and in all respects the Contractor's relationship and the relationship of its employees to the County shall be that of an independent contractor and not as employees and agents of the County.

The Contractor does not have the power or authority to bind the County in any promise, agreement, or representation other than specifically provided for in this Agreement.

ARTICLE 14. DISPUTE RESOLUTION PROCEDURE

- a) The Contractor hereby acknowledges that the Project Manager will determine in the first instance all questions of any nature whatsoever arising out of, under, or in connection with, or in any way related to or on account of, this Agreement including without limitations: questions as to the value, acceptability and fitness of the Services; questions as to either party's fulfillment of its obligations under the Contract; negligence, fraud or misrepresentation before or subsequent to acceptance of the Contractor's Proposal; questions as to the interpretation of the Scope of Services; and claims for damages, compensation and losses.
- b) The Contractor shall be bound by all determinations or orders and shall promptly comply with every order of the Project Manager, including the withdrawal or modification of any previous order and regardless of whether the Contractor agrees with the Project Manager's determination or order. Where orders are given orally, they will be issued in writing by the Project Manager as soon thereafter as is practicable.
- c) The Contractor must, in the final instance, seek to resolve every difference concerning the Agreement with the Project Manager. In the event that the Contractor and the Project Manager are unable to resolve their difference, the Contractor may initiate a dispute in accordance with the procedures set forth in this Article. **Exhaustion of these procedures shall be a condition precedent to any lawsuit permitted hereunder.**

- d) In the event of such dispute, the Parties authorize the County Mayor or designee, who may not be the Project Manager or anyone associated with this Project, acting personally, to decide all questions arising out of, under, or in connection with, or in any way related to or on account of the Agreement (including but not limited to claims in the nature of breach of contract, fraud or misrepresentation arising either before or subsequent to execution hereof) and the decision of each with respect to matters within the County Mayor's purview as set forth above shall be conclusive, final and binding on the Parties. Any such dispute shall be brought, if at all, before the County Mayor within ten (10) days of the occurrence, event or act out of which the dispute arises.
- e) The County Mayor may base this decision on such assistance as may be desirable, including advice of experts, but in any event shall base the decision on an independent and objective determination of whether Contractor's performance or any Deliverable meets the requirements of this Agreement and any specifications with respect thereto set forth herein. The effect of any decision shall not be impaired or waived by any negotiations or settlements or offers made in connection with the dispute, whether or not the County Mayor participated therein, or by any prior decision of others, which prior decision shall be deemed subject to review, or by any termination or cancellation of the Agreement. All such disputes shall be submitted in writing by the Contractor to the County Mayor for a decision, together with all evidence and other pertinent information regarding such questions, in order that a fair and impartial decision may be made. Whenever the County Mayor is entitled to exercise discretion or judgement or to make a determination or form an opinion pursuant to the provisions of this Article, such action shall be fair and impartial when exercised or taken. The County Mayor, as appropriate, shall render a decision in writing and deliver a copy of the same to the Contractor. Except as such remedies may be limited or waived elsewhere in the Agreement, Contractor reserves the right to pursue any remedies available under law after exhausting the provisions of this Article.
- f) This Article will survive the termination or expiration of this Agreement.

ARTICLE 15. AUTHORITY OF THE COUNTY'S PROJECT MANAGER

- a. The Contractor hereby acknowledges that the County's Project Manager will determine in the first instance all questions of any nature whatsoever arising out of, under, or in connection with, or in any way related to or on account of, this Agreement including without limitations: questions as to the value, acceptability and fitness of the Services; questions as to either party's fulfillment of its obligations under the Contract; negligence, fraud or misrepresentation before or subsequent to acceptance of the Contractor's Proposal; questions as to the interpretation of the Scope of Services; and claims for damages, compensation and losses.
- b. The Contractor shall be bound by all determinations or orders and shall promptly comply with every order of the Project Manager, including the withdrawal or modification of any previous order and regardless of whether the Contractor agrees with the Project Manager's determination or order. Where orders are given orally, they will be issued in writing by the Project Manager as soon thereafter as is practicable.
- c. The Contractor must, in the final instance, seek to resolve every difference concerning the Agreement with the Project Manager. In the event that the Contractor and the Project Manager are unable to resolve their difference, the Contractor may initiate a dispute in accordance with the procedures set forth in this Article. Exhaustion of these procedures shall be a condition precedent to any lawsuit permitted hereunder.
- d. In the event of such dispute, the parties to this Agreement authorize the County Mayor or designee, who may not be the Project Manager or anyone associated with this Project, acting personally, to decide all questions arising out of, under, or in connection with, or in any way related to or on account of the Agreement (including but not limited to claims in the nature of breach of contract, fraud or misrepresentation arising either before or subsequent to execution hereof) and the decision of each with respect to matters within the County Mayor's purview as set forth above shall be conclusive, final and binding on parties. Any such dispute shall be brought, if at all, before the County Mayor within 10 days of the occurrence, event or act out of which the dispute arises.
- e. The County Mayor may base this decision on such assistance as may be desirable, including advice of experts, but in any event shall base the decision on an independent and objective determination of whether Contractor's performance or any Deliverable meets the requirements of this Agreement and any specifications with respect thereto set forth herein. The effect of any decision shall not be impaired or waived by any negotiations or settlements or offers made in connection with the dispute, whether or not the County Mayor participated therein, or by any prior decision of others, which prior decision shall be deemed subject to review, or by any termination or cancellation of the Agreement. All such disputes shall be submitted in writing by the Contractor to the County Mayor for a decision, together with all evidence and other pertinent information in regard to such questions, in order that a

fair and impartial decision may be made. Whenever the County Mayor is entitled to exercise discretion or judgment or to make a determination or form an opinion pursuant to the provisions of this Article, such action shall be fair and impartial when exercised or taken. The County Mayor, as appropriate, shall render a decision in writing and deliver a copy of the same to the Contractor. Except as such remedies may be limited or waived elsewhere in the Agreement, Contractor reserves the right to pursue any remedies available under law after exhausting the provisions of this Article.

ARTICLE 16. MUTUAL OBLIGATIONS

- a) This Agreement, including attachments and appendices to the Agreement, shall constitute the entire Agreement between the Parties with respect hereto and supersedes all previous communications and representations or agreements, whether written or oral, with respect to the subject matter hereto unless acknowledged in writing by the duly authorized representatives of the Parties.
- b) Nothing in this Agreement shall be construed for the benefit, intended or otherwise, of any third-party that is not a parent or subsidiary of a party or otherwise related (by virtue of ownership control or statutory control) to a party.
- c) In those situations where this Agreement imposes an indemnity obligation on the Contractor, the County may, at its expense, elect to participate in the defense if the County should so choose. Furthermore, the County may at its own expense defend or settle any such claims if the Contractor fails to diligently defend such claims, and thereafter seek indemnity for such defense or settlement costs from the Contractor.

ARTICLE 17. QUALITY ASSURANCE/QUALITY ASSURANCE RECORD KEEPING

The Contractor shall maintain, and shall require that its Subcontractors and suppliers maintain, complete and accurate records to substantiate compliance with the requirements set forth in the Agreement. The Contractor and its Subcontractors and suppliers shall retain such records, and all other documents relevant to the Work furnished under this Agreement for a period of three years from the expiration date of this Agreement and any extension thereof.

ARTICLE 18. AUDITS

The County, or its duly authorized representatives and governmental agencies, shall until the expiration of three years after the expiration of this Agreement and any extension thereof, have access to and the right to examine and reproduce any of the Contractor's books, documents, papers and records and of its Subcontractors and suppliers which apply to all matters of the County. Such records shall subsequently conform to Generally Accepted Accounting Principles requirements, as applicable, and shall only address those transactions related to this Agreement.

Pursuant to Section 2-481 of the Code, the Contractor will grant access to the Commission Auditor to all financial and performance related records, property, and equipment purchased in whole or in part with government funds within five business days of the Commission Auditor's request. The Contractor agrees to maintain an accounting system that provides accounting records that are supported with adequate documentation, and adequate procedures for determining the allowability and allocability of costs.

The County or its duly authorized independent representative may conduct one audit of claim transactions per year upon reasonable notice to Contractor, such audit being completed within two years of the time period being audits. Audits of performance guarantees must be completed in the year following the period to which the performance guarantee results apply. The auditors shall provide their draft audit findings to Contractor, prior to issuing the final report and Contractor shall have a right to review the auditor's final audit report, and include a supplementary statement containing information and material that Contractor considers pertinent to the audit

ARTICLE 19. SUBSTITUTION OF PERSONNEL

In the event the Contractor needs to substitute personnel for the key personnel identified by the Contractor's Proposal, the Contractor must notify the County in writing and request written approval for the substitution at least ten (10) business days prior to effecting such substitution. However, such substitution shall not become effective until the County has approved said substitution.

Notwithstanding anything to the contrary in this Agreement, including any work orders, amendments or addendums thereto, the Contractor agrees and acknowledges that the County may assign, transfer, convey, divide or otherwise dispose of this Agreement or a portion thereof, including the County's rights, title, or interest in or to the same, or any part thereof, to an elected County Constitutional Officer, (i.e., Sheriff, Supervisor of Elections, Property Appraiser, Tax Collector or Clerk of Courts) upon the creation of such office in Miami-Dade County without any further consent from the Contractor. Upon the assignment, transfer or conveyance of the Agreement, or a portion thereof, to the elected County Constitutional Officer and the acceptance of such by the elected County Constitutional Officer, the County shall be relieved of all obligations under this Contract, or such portions of the Agreement assumed by the elected County Constitutional Officer.

Should the County assign, transfer or convey only a portion of this Agreement to an elected County Constitutional Officer, the Agreement shall be divided into two separate Agreements and the elected County Constitutional Officer shall assume all pro-rata rights, benefits and obligations of the portion of the Agreement assigned, transferred or conveyed to the elected County Constitutional Officer as if such portion was a separate agreement entered into between the Contractor and the elected County Constitutional Officer. The elected County Constitutional Officer shall exercise all termination, extension or other contractual rights and shall be responsible for all obligations for such portion of the Agreement as of the date of the acceptance of such assignment, transfer, or conveyance. The County shall provide notice of such action to the Contractor within thirty (30) days of any such assignment, transfer, or conveyance."

ARTICLE 20. CONSENT OF THE COUNTY REQUIRED FOR ASSIGNMENT

The Contractor shall not assign, transfer, convey or otherwise dispose of this Agreement, including its rights, title, or interest in or to the same or any part thereof without the prior written consent of the County.

Notwithstanding anything to the contrary in this Agreement, including any work orders, amendments or addendums thereto, the Contractor agrees and acknowledges that the County may assign, transfer, convey, divide or otherwise dispose of this Agreement or a portion thereof, including the County's rights, title, or interest in or to the same, or any part thereof, to an elected County Constitutional Officer, (i.e., Sheriff, Supervisor of Elections, Property Appraiser, Tax Collector or Clerk of Courts) upon the creation of such office in Miami-Dade County without any further consent from the Contractor. Upon the assignment, transfer or conveyance of the Agreement, or a portion thereof, to the elected County Constitutional Officer and the acceptance of such by the elected County Constitutional Officer, the County shall be relieved of all obligations under this Contract, or such portions of the Agreement assumed by the elected County Constitutional Officer.

Should the County assign, transfer or convey only a portion of this Agreement to an elected County Constitutional Officer, the Agreement shall be divided into two separate Agreements and the elected County Constitutional Officer shall assume all pro-rata rights, benefits and obligations of the portion of the Agreement assigned, transferred or conveyed to the elected County Constitutional Officer as if such portion was a separate agreement entered into between the Contractor and the elected County Constitutional Officer. The elected County Constitutional Officer shall exercise all termination, extension or other contractual rights and shall be responsible for all obligations for such portion of the Agreement as of the date of the acceptance of such assignment, transfer, or conveyance. The County shall provide notice of such action to the Contractor within thirty (30) days of any such assignment, transfer, or conveyance."

ARTICLE 21. SUBCONTRACTUAL RELATIONS

- a) If the Contractor causes any part of this Agreement to be performed by a Subcontractor, the provisions of this Contract will apply to such Subcontractor and its officers, agents and employees in all respects as if it and they were employees of the Contractor; and the Contractor will not be in any manner thereby discharged from its obligations and liabilities hereunder, but will be liable hereunder for all acts, omissions, and negligence of the Subcontractor, its officers, agents, and employees, as if they were employees of the Contractor. The Services performed by the Subcontractor will be subject to the provisions hereof as if performed directly by the Contractor.
- b) The Contractor, before making any subcontract for any portion of the Work, will state in writing to the County the name of the proposed Subcontractor, the portion of the Work which the Subcontractor is to do, the place of business of such Subcontractor, and such other information as the County may require. The County will have the right to require the Contractor not to award any subcontract to a person, firm or corporation disapproved by the County.
- c) Before entering into any subcontract hereunder, the Contractor will inform the Subcontractor fully and completely of all provisions and requirements of this Agreement relating either directly or indirectly to the Work to be performed. Such Work performed by such Subcontractor will strictly comply with the requirements of this Contract.

- d) In order to qualify as a Subcontractor satisfactory to the County, in addition to the other requirements herein provided, the Subcontractor must be prepared to prove to the satisfaction of the County that it has the necessary facilities, skill and experience, and ample financial resources to perform the Work in a satisfactory manner. To be considered skilled and experienced, the Subcontractor must show to the satisfaction of the County that it has satisfactorily performed Work of the same general type which is required to be performed under this Agreement.
- e) The County shall have the right to withdraw its consent to a subcontract if it appears to the County that the Subcontractor will delay, prevent, or otherwise impair the performance of the Contractor's obligations under this Agreement. All Subcontractors are required to protect the confidentiality of the County and the County's proprietary and confidential information. Contractor shall furnish to the County copies of all subcontracts between Contractor and Subcontractors and suppliers hereunder. Within each such subcontract, there shall be a clause for the benefit of the County in the event the County finds the Contractor in breach of this Contract, permitting the County to request completion by the Subcontractor of its performance obligations under the subcontract. The clause shall include an option for the County to pay the Subcontractor directly for the performance by such Subcontractor. Notwithstanding, the foregoing shall neither convey nor imply any obligation or liability on the part of the County to any Subcontractor hereunder as more fully described herein.
- f) Sections (b)-(e) of this Article only apply to Subcontractors engaged by Contractor specifically to provide dedicated services to the County.

ARTICLE 22. ASSUMPTION, PARAMETERS, PROJECTIONS, ESTIMATES AND EXPLANATIONS

The Contractor understands and agrees that any assumptions, parameters, projections, estimates, and explanations presented by the County were provided to the Contractor for evaluation purposes only. However, since these assumptions, parameters, projections, estimates, and explanations represent predictions of future events the County makes no representations or guarantees; and the County shall not be responsible for the accuracy of the assumptions presented; and the County shall not be responsible for conclusions to be drawn therefrom; and any assumptions, parameters, projections, estimates and explanations shall not form the basis of any claim by the Contractor. The Contractor accepts all risk associated with using this information.

ARTICLE 23. SEVERABILITY

If this Agreement contains any provision found to be unlawful, the same shall be deemed to be of no effect and shall be deemed stricken from this Agreement without affecting the binding force of this Agreement as it shall remain after omitting such provision.

ARTICLE 24. TERMINATION AND SUSPENSION OF WORK

- a) This Agreement may be terminated for cause by the County for reasons including, but not limited to, (i) the Contractor commits an Event of Default (as defined below in ARTICLE 24) and fails to cure said Event of Default (as delineated below in ARTICLE 25), or (ii) Contractor attempts to meet its contractual obligations with the County through fraud, misrepresentation, or material misstatement.
- b) This Agreement may also be terminated for convenience by the County. Termination for convenience is effective on the termination date stated in the written notice provided by the County.
- c) If County terminates this Agreement for cause under ARTICLE 24(a) above, the County may, in its sole discretion, also terminate or cancel any other contract(s) that such individual or corporation or other entity has with the County and that such individual, corporation or other entity shall pay all direct or indirect costs associated with such termination or cancellation, including attorneys' fees.
- d) The foregoing notwithstanding, if the Contractor attempts to meet its contractual obligations with the County through fraud, misrepresentation, or material misstatement, the Contractor may be debarred from County contracting in accordance with the County debarment procedures. The Contractor may be subject to debarment for failure to perform and all other reasons set forth in Section 10-38 of the Code.
- e) In the event that the County exercises its right to terminate this Agreement, the Contractor shall, upon receipt of such notice, unless otherwise directed by the County:

- i. stop Work on the date specified in the notice (the "Effective Termination Date");
 - ii. take such action as may be necessary for the protection and preservation of the County's materials and property;
 - iii. cancel orders;
 - iv. assign to the County and deliver to any location designated by the County any non-cancelable orders for Deliverables that are not capable of use except in the performance of this Agreement and has been specifically developed for the sole purpose of this Agreement and not incorporated in the Services;
 - v. take no action which will increase the amounts payable by the County under this Agreement; and
 - vi. reimburse the County a proration of the fees paid annually based on the remaining months of the term per the compensation listed in Appendix B, Price Schedule.
- f) In the event that the County exercises its right to terminate this Agreement, the Contractor will be compensated as stated in the payment Articles herein for the:
- i. portion of the Services completed in accordance with the Agreement up to the Effective Termination Date; and
 - ii. non-cancelable Deliverables that are not capable of use except in the performance of this Agreement and has been specifically developed for the sole purpose of this Agreement, but not incorporated in the Services.
- g) All compensation pursuant to this Article are subject to audit.
- h) In the event the Contractor fails to cure an Event of Default timely, the County may terminate this Agreement, and the County or its designated representatives may immediately take possession of all applicable equipment, materials, products, documentation, reports, and data.

ARTICLE 25. EVENT OF DEFAULT

- a) An Event of Default is a material breach of this Agreement by the Contractor, and includes but is not limited to the following:
- i. the Contractor has not delivered Deliverables and/or Services on a timely basis;
 - ii. the Contractor has refused or failed to supply enough properly skilled staff personnel;
 - iii. the Contractor has failed to make prompt payment to Subcontractors or suppliers for any Services;
 - iv. the Contractor has become insolvent (other than as interdicted by the bankruptcy laws), or has assigned the proceeds received for the benefit of the Contractor's creditors, or the Contractor has taken advantage of any insolvency statute or debtor/creditor law or if the Contractor's affairs have been put in the hands of a receiver;
 - v. the Contractor has failed to obtain the approval of the County where required by this Agreement;
 - vi. the Contractor has failed to provide "adequate assurances" as required under subsection b below;
 - vii. the Contractor has failed in the representation of any warranties stated herein; or
 - viii. the Contractor fails to comply with Attachment 2, HIPPA Business Associate Addendum.
- b) When, in the opinion of the County, reasonable grounds for uncertainty exist with respect to the Contractor's ability to perform the Work or any portion thereof, the County may request that the Contractor, within the timeframe set forth in the County's request, provide adequate assurances to the County, in writing, of the Contractor's ability to perform in accordance with the terms of this Agreement. Until the County receives such assurances, the County may request an adjustment to the compensation received by the Contractor for portions of the Work which the Contractor has not performed. In the event that the

Contractor fails to provide to the County the requested assurances within the prescribed timeframe, the County may:

- i. treat such failure as a repudiation and/or material breach of this Agreement; and
- ii. resort to any remedy for breach provided herein or at law, including but not limited to, taking over the performance of the Work or any part thereof either by itself or through others.

ARTICLE 26. NOTICE OF DEFAULT - OPPORTUNITY TO CURE

If an Event of Default occurs in the determination of the County, the County shall notify the Contractor (the "Default Notice"), specifying the basis for such default, and advising the Contractor that such default must be cured immediately, or this Agreement with the County may be terminated. Notwithstanding, the County may, in its sole discretion, allow the Contractor to rectify the default to the County's reasonable satisfaction within a thirty (30) day period. The County may grant an additional period of such duration as the County shall deem appropriate without waiver of any of the County's rights hereunder, so long as the Contractor has commenced curing such default and is effectuating a cure with diligence and continuity during such thirty (30) day period or any other period which the County prescribes. The Default Notice shall specify the date the Contractor shall discontinue the Work upon the Effective Termination Date.

ARTICLE 27. REMEDIES IN THE EVENT OF DEFAULT

If an Event of Default occurs, whether or not the County elects to terminate this Agreement as a result thereof except as otherwise provided below, the Contractor shall be liable for all substantiated damages resulting from the default, irrespective of whether the County elects to terminate the Agreement, including but not limited to:

- a) lost revenues;
- b) if County terminates the Agreement, the difference between the cost associated with procuring Services hereunder and the amount actually expended by the County for re-procurement of Services, including procurement and administrative costs; and
- c) such other direct damages.

The Contractor shall also remain liable for any liabilities and claims related to the Contractor's default. The County may also bring any suit or proceeding for specific performance or for an injunction.

ARTICLE 28. PATENT AND COPYRIGHT INDEMNIFICATION

- a) The Contractor shall not infringe on any copyrights, trademarks, service marks, trade secrets, patent rights, other intellectual property rights or any other third-party proprietary rights in the performance of the Work.
- b) The Contractor warrants that all Deliverables furnished hereunder, including but not limited to equipment, programs, documentation, software, analyses, applications, methods, ways, processes, and the like, do not infringe upon or violate any copyrights, trademarks, service marks, trade secrets, patent rights, other intellectual property rights or any other third-party proprietary rights.
- c) The Contractor shall be liable and responsible for any and all claims made against the County for infringement of patents, copyrights, service marks, trade secrets or any other third party proprietary rights, by the use or supplying of any programs, documentation, software, analyses, applications, methods, ways, processes, and the like, in the course of performance or completion of, or in any way connected with, the Work, or the County's continued use of the Deliverables furnished hereunder. Accordingly, the Contractor at its own expense, including the payment of attorney's fees, shall indemnify, and hold harmless the County and defend any action brought against the County with respect to any claim, demand, cause of action, debt, or liability.
- d) In the event any Deliverable or anything provided to the County hereunder, or portion thereof is held to constitute an infringement and its use is or may be enjoined, the Contractor shall have the obligation to, at the County's option to (i) modify, or require that the applicable Subcontractor or supplier modify, the alleged infringing item(s) at its own expense, without impairing in any respect the functionality or performance of the item(s), or (ii) procure for the County, at the Contractor's expense, the rights provided under this Agreement to use the item(s).

- e) The Contractor shall be solely responsible for determining and informing the County whether a prospective supplier or Subcontractor is a party to any litigation involving patent or copyright infringement, service mark, trademark, violation, or proprietary rights claims or is subject to any injunction which may prohibit it from providing any Deliverable hereunder. The Contractor shall enter into agreements with all suppliers and Subcontractors at the Contractor's own risk. The County may reject any Deliverable that it believes to be the subject of any such litigation or injunction, or if, in the County's judgment, use thereof would delay the Work or be unlawful.

ARTICLE 29. CONFIDENTIALITY

- a) All Developed Works and other materials, data, transactions of all forms, financial information, documentation, inventions, designs and methods obtained from the County in connection with the Services performed under this Agreement, made or developed by the Contractor or its Subcontractors in the course of the performance of such Services, or the results of such Services, or for which the County holds the proprietary rights, constitute Confidential Information and may not, without the prior written consent of the County, be used by the Contractor or its employees, agents, Subcontractors or suppliers for any purpose other than for the benefit of the County, unless required by law. In addition to the foregoing, all County employee information and County financial information shall be considered Confidential Information and shall be subject to all the requirements stated herein. Neither the Contractor nor its employees, agents, Subcontractors, or suppliers may sell, transfer, publish, disclose, display, license or otherwise make available to others any part of such Confidential Information without the prior written consent of the County. Additionally, the Contractor expressly agrees to be bound by and to defend, indemnify and hold harmless the County, and their officers and employees from the breach of any federal, state, or local law in regard to the privacy of individuals.

County may disclose Contractor's Business Confidential Information to County's representatives who have a need to know such information in relation to the administration of the Plan, but only if such representatives are informed of the confidentiality provisions of this paragraph and agree to abide by them. Unless disclosure is required by law, County may not disclose Contractor's Business Confidential Information to any third party without Contractor's prior written consent and until each recipient has executed a confidentiality agreement reasonably satisfactory to Contractor. The term "Business Confidential Information" as it relates to Contractor means the Contractor's identifiable business proprietary data, rates, fees, provider discount or payment information, procedures, materials, lists and systems.

- b) The Contractor shall advise each of its employees, agents, Subcontractors, and suppliers who may be exposed to such Confidential Information of their obligation to keep such information confidential and shall promptly advise the County in writing if it learns of any unauthorized use or disclosure of the Confidential Information by any of its employees or agents, or Subcontractor's or supplier's employees, present or former. In addition, the Contractor agrees to cooperate fully and provide any assistance necessary to ensure the confidentiality of the Confidential Information.
- c) In the event of a breach of this Article damages may not be an adequate remedy, and the County shall be entitled to injunctive relief to restrain any such breach or threatened breach. Unless otherwise requested by the County, upon the completion of the Services performed hereunder, the Contractor shall immediately turn over to the County all such Confidential Information existing in tangible form, and no copies thereof shall be retained by the Contractor or its employees, agents, Subcontractors, or suppliers without the prior written consent of the County. A certificate evidencing compliance with this provision and signed by an officer of the Contractor shall accompany such materials.

ARTICLE 30. PROPRIETARY INFORMATION

As a political subdivision of the State of Florida, Miami-Dade County is subject to the stipulations of the public records laws of the State of Florida (the "Public Records Law").

The Contractor acknowledges that all computer software in the County's possession may constitute or contain information or materials which the County has agreed to protect as proprietary information from disclosure or unauthorized use and may also constitute or contain information or materials which the County has developed at its own expense, the disclosure of which could harm the County's proprietary interest therein.

During the term of the Contract, the Contractor will not use directly or indirectly for itself or for others, or publish or disclose to any third-party, or remove from the County's property, any computer programs, data compilations, or other software which the County has

developed, has used, or is using, is holding for use, or which are otherwise in the possession of the County (the "Computer Software"). All third-party license agreements must also be honored by the Contractor and its employees, except as authorized by the County and, if the Computer Software has been leased or purchased by the County, all hired party license agreements must also be honored by the contractors' employees with the approval of the lessor or Contractors thereof. This includes mainframe, minis, telecommunications, personal computers, and all information technology software.

The Contractor will report to the County any information discovered, or which is disclosed to the Contractor which may relate to the improper use, publication, disclosure, or removal from the County's property of any information technology software and hardware and will take such steps as are within the Contractor's authority to prevent improper use, disclosure, or removal.

ARTICLE 31. PROPRIETARY RIGHTS

- a) The Contractor hereby acknowledges and agrees that the County retains all rights, title and interests in and to all materials, data, documentation and copies thereof furnished by the County to the Contractor hereunder or furnished by the Contractor to the County and/or created by the Contractor for delivery to the County, even if unfinished or in process, as a result of the Services the Contractor performs in connection with this Agreement, including all copyright and other proprietary rights therein, which the Contractor as well as its employees, agents, Subcontractors and suppliers may use only in connection with the performance of Services under this Agreement. The Contractor shall not, without the prior written consent of the County, use such documentation on any other project in which the Contractor or its employees, agents, Subcontractors, or suppliers are or may become engaged. Submission or distribution by the Contractor to meet official regulatory requirements or for other purposes in connection with the performance of Services under this Agreement shall not be construed as publication in derogation of the County's copyrights or other proprietary rights.
- b) All Developed Works shall become the property of the County.
- c) Accordingly, neither the Contractor nor its employees, agents, Subcontractors, or suppliers shall have any proprietary interest in such Developed Works. The Developed Works may not be utilized, reproduced, or distributed by or on behalf of the Contractor, or any employee, agent, Subcontractor or supplier thereof, without the prior written consent of the County, except as required for the Contractor's performance hereunder.
- d) Except as otherwise provided in subsections a, b, and c above, or elsewhere herein, the Contractor and its Subcontractors and suppliers hereunder shall retain all proprietary rights in and to all Licensed Software provided hereunder, that have not been customized to satisfy the performance criteria set forth in the Scope of Services. Notwithstanding the foregoing, the Contractor hereby grants, and shall require that its Subcontractors and suppliers grant, if the County so desires, a perpetual, irrevocable and unrestricted right and license to use, duplicate, disclose and/or permit any other person(s) or entity(ies) to use all such Licensed Software and the associated specifications, technical data and other Documentation for the operations of the County or entities controlling, controlled by, under common control with, or affiliated with the County, or organizations which may hereafter be formed by or become affiliated with the County. Such license specifically includes, but is not limited to, the right of the County to use and/or disclose, in whole or in part, the technical documentation and Licensed Software, including source code provided hereunder, to any person or entity outside the County for such person's or entity's use in furnishing any and/or all of the Deliverables provided hereunder exclusively for the County or entities controlling, controlled by, under common control with, or affiliated with the County, or organizations which may hereafter be formed by or become affiliated with the County. No such License Software, specifications, data, documentation, or related information shall be deemed to have been given in confidence and any statement or legend to the contrary shall be void and of no effect.

ARTICLE 32. SUPPLIER/VENDOR REGISTRATION/CONFLICT OF INTEREST

- a) **Supplier/Vendor Registration**
The Contractor shall be a registered vendor with the County – Strategic Procurement Department, for the duration of this Agreement. In becoming a registered vendor with Miami-Dade County, the vendor's Federal Employer Identification Number (FEIN) must be provided, via submission of Form W-9 and 147c Letter, as required by the Internal Revenue Service (IRS). If no FEIN exists, the Social Security Number of the owner must be provided as the legal entity identifier. This number becomes Contractor's "County Vendor Number." To comply with Section 119.071(5) of the Florida Statutes relating to the collection of an individual's Social Security Number, be aware that the County requests the Social Security Number for the following purposes:

- **Identification of individual account records**
- **Payments to individual/Contractor for goods and services provided to Miami-Dade County**
- **Tax reporting purposes**
- **Provision of unique identifier in the vendor database used for searching and sorting departmental records**

The Contractor confirms its commitment to comply with the vendor registration requirements and the associated affidavits available in **INFORMS** at <https://supplier.miamidade.gov>.

b) **Conflict of Interest and Code of Ethics**

Sections 2-11.1 (c) and (d) of the Code require that any County official, agency/board member or employee, or any member of his or her immediate family who, through a firm, corporation, partnership or business entity, has a financial interest, direct or indirect, with Miami-Dade County or any person or agency acting for Miami-Dade County, competing or applying for a contract, must first obtain and submit a written conflict of interest opinion from the County's Ethics Commission prior to the official, agency/board member or employee, or his or her immediate family member entering into any contract or transacting any business with Miami-Dade County or any person or agency acting for Miami-Dade County. Any such contract or business transaction entered in violation of these subsections, as amended, shall be rendered voidable. All County officials, autonomous personnel, quasi-judicial personnel, advisory personnel, and employees wishing to do business with the County are hereby advised they must comply with the applicable provisions of Section 2-11.1 of the Conflict of Interest and Code of Ethics Ordinance.

ARTICLE 33. INSPECTOR GENERAL REVIEWS

Independent Private Sector Inspector General Reviews

Pursuant to Miami-Dade County Administrative Order No. 3-20, the County has the right to retain the services of an Independent Private Sector Inspector General (the "IPSIG"), whenever the County deems it appropriate to do so. Upon written notice from the County, the Contractor shall make available to the IPSIG retained by the County, all requested records and documentation pertaining to this Agreement for inspection and reproduction. The County shall be responsible for the payment of these IPSIG services, and under no circumstance shall the Contractor's prices and any changes thereto approved by the County be inclusive of any charges relating to these IPSIG services. The terms of this provision apply to the Contractor, its officers, agents, employees, Subcontractors, and assignees. Nothing contained in this provision shall impair any independent right of the County to conduct an audit or investigate the operations, activities, and performance of the Contractor in connection with this Agreement. The terms of this Article shall not impose any liability on the County by the Contractor or any third-party.

Miami-Dade County Inspector General Review

According to Section 2-1076 of the Code, Miami-Dade County has established the Office of the Inspector General which may, on a random basis, perform audits on all County contracts, throughout the duration of said contracts. The cost of the audit does not apply to this Contract.

Nothing contained above shall in any way limit the powers of the Inspector General to perform audits on all County contracts including, but not limited to, those contracts specifically exempted above. The Miami-Dade County Inspector General is authorized and empowered to review past, present, and proposed County and Trust contracts, transactions, accounts, records, and programs. In addition, the Inspector General has the power to subpoena witnesses, administer oaths, require the production of records, and monitor existing projects and programs. Monitoring of an existing project or program may include a report concerning whether the project is on time, within budget and in conformance with plans, specifications, and applicable law. The Inspector General is empowered to analyze the necessity of and reasonableness of proposed change orders to the Contract. The Inspector General is empowered to retain the services of IPSIGs to audit, investigate, monitor, oversee, inspect, and review operations, activities, performance and procurement process, including but not limited to project design, specifications, proposal submittals, activities of the Contractor, its officers, agents and employees, lobbyists, County staff and elected officials to ensure compliance with contract specifications and to detect fraud and corruption.

Upon written notice to the Contractor from the Inspector General or IPSIG retained by the Inspector General, the Contractor shall make all requested records and documents available to the Inspector General or IPSIG for inspection and copying. The Inspector General and IPSIG shall have the right to inspect and copy all documents and records in the Contractor's possession, custody or control which, in the Inspector General's or IPSIG's sole judgment, pertain to performance of the Contract, including, but not limited to original estimate files,

change order estimate files, worksheets, proposals and agreements form and which successful and unsuccessful Subcontractors and suppliers, all project-related correspondence, memoranda, instructions, financial documents, construction documents, proposal and contract documents, back-charge documents, all documents and records which involve cash, trade or volume discounts, insurance proceeds, rebates, or dividends received, payroll and personnel records, and supporting documentation for the aforesaid documents and records.

ARTICLE 34. FEDERAL, STATE, AND LOCAL COMPLIANCE REQUIREMENTS

As applicable, Contractor shall comply, subject to applicable professional standards, with the provisions of all applicable federal, state and the County orders, statutes, ordinances, rules and regulations which may pertain to the Services required under this Agreement, including, but not limited to:

- a) Equal Employment Opportunity clause provided under 41 C.F.R. Part 60-1.3 in accordance with Executive Order 11246, "Equal Employment Opportunity", as amended.
- b) Miami-Dade County Small Business Enterprises Development Participation Provisions.
- c) The Clean Air Act of 1955, as amended, (42 U.S.C. §§ 7401-7671q.) and the Federal Water Pollution Control Act (33 U.S.C. §§ 1251-1387), as amended.
- d) The Davis-Bacon Act, as amended (40 U.S.C. §3141-3144 and 3146-3148) as supplemented by the Department of Labor regulations (29 C.F.R. Part 5).
- e) The Copeland "Anti-Kickback" Act (40 U.S.C. § 3145) as supplemented by the Department of Labor regulations (29 C.F.R. Part 2).
- f) Section 2-11.1 of the Code of Miami-Dade County, "Conflict of Interest and Code of Ethics Ordinance".
- g) Section 10-38 of the Code of Miami-Dade County, "Debarment of Contractors from County Work".
- h) Section 11A-60 - 11A-67 of the Code of Miami-Dade County, "Domestic Leave".
- i) Section 21-255 of the Code of Miami-Dade County prohibiting the presentation, maintenance, or prosecution of false or fraudulent claims against Miami-Dade County.
- j) The Equal Pay Act of 1963, as amended (29 U.S.C. § 206(d)).
- k) The prohibitions against discrimination on the basis of age under the Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-07) and regulations issued pursuant thereto (24 C.F.R. Part 146).
- l) Section 448.07 of the Florida Statutes "Wage Rate Discrimination Based on Sex Prohibited".
- m) Chapter 11A of the Code of Miami-Dade County (§ 11A-1 *et seq.*) "Discrimination".
- n) Chapter 22 of the Code of Miami-Dade County (§ 22-1 *et seq.*) "Wage Theft".
- o) Any other laws prohibiting wage rate discrimination based on sex.
- p) Chapter 8A, Article XIX, of the Code of Miami-Dade County (§ 8A-400 *et seq.*) "Business Regulations".
- q) Byrd Anti-Lobbying Amendment (31 U.S.C. § 1352).
- r) Executive Order 12549 "Debarment and Suspension", which stipulates that no contract(s) is/are "to be awarded at any tier or to any party which is debarred or suspended or is otherwise excluded from or ineligible for participation in Federal assistance programs".

Pursuant to Resolution No. R-1072-17, by entering into this Contract, the Contractor is certifying that the Contractor is in compliance with, and will continue to comply with, the provisions of items "j" through "o" above.

The Contractor shall hold all licenses and/or certifications, obtain and pay for all permits and/or inspections, and comply with all laws, ordinances, regulations and building code requirements applicable to the work required herein. Damages, penalties, and/or fines imposed on the County or Contractor for failure to obtain and maintain required licenses, certifications, permits and/or inspections shall be borne by the Contractor. The Project Manager shall verify the certification(s), license(s), and permit(s) for the Contractor prior to authorizing Work and as needed.

Notwithstanding any other provision of this Agreement, Contractor shall not be required pursuant to this Agreement to take any action or abstain from taking any action if such action or abstention would, in the good faith determination of the Contractor, constitute a violation of any law or regulation to which Contractor is subject, including but not limited to laws and regulations requiring that Contractor conduct its operations in a safe and sound manner.

ARTICLE 35. NONDISCRIMINATION

During the performance of this Contract, Contractor agrees to not discriminate unlawfully against any employee or applicant for employment on the basis of race, color, religion, ancestry, national origin, sex, pregnancy, age, disability, marital status, familial status, sexual orientation, gender identity or gender expression, status as victim of domestic violence, dating violence or stalking, or veteran status, and on housing related contracts the source of income, and will take affirmative action to ensure that employees and applicants are afforded equal employment opportunities without discrimination. Such action shall be taken with reference to, but not limited to recruitment, employment, termination, rates of pay or other forms of compensation, and selection for training or retraining, including apprenticeship and on the job training.

By entering into this Contract, the Contractor attests that it is not in violation of the Americans with Disabilities Act of 1990 (and related Acts) or Miami-Dade County Resolution No. R-385-95. If the Contractor or any owner, subsidiary or other firm affiliated with or related to the Contractor is found by the responsible enforcement agency or the County to be in violation of the Act or the Resolution, such violation shall render this Contract void. This Contract shall be void if the Contractor submits a false affidavit pursuant to this Resolution or the Contractor violates the Act or the Resolution during the term of this Contract, even if the Contractor was not in violation at the time it submitted its affidavit.

ARTICLE 36. CONFLICT OF INTEREST

The Contractor represents that:

- a) No officer, director, employee, agent, or other consultant of the County or a member of the immediate family or household of the aforesaid has directly or indirectly received or been promised any form of benefit, payment, or compensation, whether tangible or intangible, in connection with the award of this Agreement.
- b) There are no undisclosed persons or entities interested with the Contractor in this Agreement. This Agreement is entered into by the Contractor without any connection with any other entity or person making a proposal for the same purpose, and without collusion, fraud or conflict of interest. No elected or appointed officer or official, director, employee, agent, or other consultant of the County, or of the State of Florida (including elected and appointed members of the legislative and executive branches of government), or a member of the immediate family or household of any of the aforesaid:
 - i) is interested on behalf of or through the Contractor directly or indirectly in any manner whatsoever in the execution or the performance of this Agreement, or in the Services, Deliverables or Work, to which this Agreement relates or in any portion of the revenues; or
 - ii) is an employee, agent, advisor, or consultant to the Contractor or to the best of the Contractor's knowledge any Subcontractor or supplier to the Contractor.
- c) Neither the Contractor nor any officer, director, employee, agency, parent, subsidiary, or affiliate of the Contractor shall have an interest which is in conflict with the Contractor's faithful performance of its obligation under this Agreement; provided that the

County, in its sole discretion, may consent in writing to such a relationship, provided the Contractor provides the County with a written notice, in advance, which identifies all the individuals and entities involved and sets forth in detail the nature of the relationship and why it is in the County's best interest to consent to such relationship.

- d) The provisions of this Article are supplemental to, not in lieu of, all applicable laws with respect to conflict of interest. In the event there is a difference between the standards applicable under this Agreement and those provided by statute, the stricter standard shall apply.
- e) In the event Contractor has no prior knowledge of a conflict of interest as set forth above and acquires information which may indicate that there may be an actual or apparent violation of any of the above, Contractor shall promptly bring such information to the attention of the Project Manager. Contractor shall thereafter cooperate with the County's review and investigation of such information and comply with the instructions Contractor receives from the Project Manager regarding remedying the situation.

ARTICLE 37. PRESS RELEASE OR OTHER PUBLIC COMMUNICATION

Under no circumstances shall the Contractor without the express written consent of the County:

- a) Issue or permit to be issued any press release, advertisement or literature of any kind which refers to the County, or the Work being performed hereunder, unless the Contractor first obtains the written approval of the County. Such approval may be withheld if for any reason the County believes that the publication of such information would be harmful to the public interest or is in any way undesirable; and
- b) Communicate in any way with any contractor, department, board, agency, commission or other organization or any person whether governmental or private in connection with the Work to be performed hereunder except upon prior written approval and instruction of the County; and
- c) Except as may be required by law, the Contractor and its employees, agents, Subcontractors, and suppliers will not represent, directly or indirectly, that any Work, Deliverables or Services provided by the Contractor, or such parties has been approved or endorsed by the County.

ARTICLE 38. BANKRUPTCY

The County may terminate this Contract, if, during the term of any contract the Contractor has with the County, the Contractor becomes involved as a debtor in a bankruptcy proceeding, or becomes involved in a reorganization, dissolution, or liquidation proceeding, or if a trustee or receiver is appointed over all or a substantial portion of the property of the Contractor under federal bankruptcy law or any state insolvency law.

ARTICLE 39. GOVERNING LAW

This Contract, including appendices, and all matters relating to this Contract (whether in contract, statute, tort (such as negligence), or otherwise) shall be governed by, and construed in accordance with, the laws of the State of Florida. Venue shall be in Miami-Dade County.

ARTICLE 40. COUNTY USER ACCESS PROGRAM (UAP)

Not applicable

ARTICLE 41. INTEREST OF MEMBERS, OFFICERS OR EMPLOYEES AND FORMER MEMBERS, OFFICERS OR EMPLOYEES

No member, officer, or employee of the County, no member of the governing body of the locality in which the Project is situated, no member of the governing body in which the County was activated, and no other public official of such locality or localities who exercises

any functions or responsibilities with respect to the project, shall, during his or her tenure, or for one year thereafter, have any interest, direct or indirect, in this Contract or the proceeds thereof.

ARTICLE 42. FORCE MAJEURE

Under applicable law, Force Majeure shall refer to an act of nature (such as, but not limited to, a hurricane, flood, and/or earthquake), war, terrorism, riot, sovereign conduct, strikes, lockouts, fires, epidemics and/or pandemic, adverse governmental conditions or conduct of third parties.

Neither the County nor the Contractor shall be held liable or responsible to the counterparty nor be deemed to have defaulted under or breached this Contract for failure or delay in performing any obligation under this Contract when such failure or delay is caused by an act of Force Majeure. Within twenty-four (24) hours of the occurrence of an act of Force Majeure, the affected party shall notify the counterparty of the act by sending an e-mail message to the Project Manager of the other party. In addition, the affected party shall provide to the counterparty within seven days of determining the cause of the Force Majeure, a written explanation via e-mail concerning the circumstances that caused the act of Force Majeure and the overall impacts to the Contract. Upon receipt of the written explanation, the parties shall mutually agree to any contractual modifications as necessary to continue the Contract with minimal impact to County operations. The County maintains the right to terminate the Contract for convenience or obtain the goods and/or services through a separate contract, taking over the performance of the Work or any part thereof either by itself or through others.

ARTICLE 43. FIRST SOURCE HIRING REFERRAL PROGRAM

Pursuant to Section 2-2113 of the Code, for all contracts for goods and services, the Contractor, prior to hiring to fill each vacancy arising under a County contract shall (1) first notify Career Source South Florida ("CSSF"), the designated Referral Agency, of the vacancy and list the vacancy with CSSF according to the Code, and (2) make good faith efforts as determined by the County to fill a minimum of fifty percent (50%) of its employment needs under the County contract through the CSSF. If no suitable candidates can be employed after a Referral Period of three to five days, the Contractor is free to fill its vacancies from other sources. Contractor will be required to provide quarterly reports to the CSSF indicating the name and number of employees hired in the previous quarter, or why referred candidates were rejected. Sanctions for non-compliance shall include, but not be limited to: (i) suspension of Contract until Contractor performs obligations, if appropriate; (ii) default and/or termination; and (iii) payment of \$1,500/employee, or the value of the wages that would have been earned given the noncompliance, whichever is less. Registration procedures and additional information regarding the First Source Hiring Referral Program are available at <https://iapps.careersourcesfl.com/firstsource/>.

ARTICLE 44. PUBLIC RECORDS AND CONTRACTS FOR SERVICES PERFORMED ON BEHALF OF MIAMI-DADE COUNTY

The Contractor shall comply with the Public Records Laws, including but not limited to, (1) keeping and maintaining all public records that ordinarily and necessarily would be required by the County in order to perform the service; (2) providing the public with access to public records on the same terms and conditions that the County would provide the records and at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law; (3) ensuring that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law; and (4) meeting all requirements for retaining public records and transferring, at no cost, to the County all public records in possession of the Contractor upon termination of the Contract and destroying any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements upon such transfer. In addition, all records stored electronically must be provided to the County in a format that is compatible with the information technology systems of the County. Failure to meet any of these provisions or to comply with Florida's Public Records Laws as applicable shall be a material breach of this Agreement and shall be enforced in accordance with the terms and conditions of the Agreement.

IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS AT (305) 375-5773, ISD-VSS@MIAMIDADE.GOV, 111 NW 1st STREET, SUITE 1300, MIAMI, FLORIDA 33128.

ARTICLE 45. INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION and/or PROTECTED HEALTH INFORMATION

Any person or entity that performs or assists Miami-Dade County with a function or activity involving the use or disclosure of "Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI)" shall comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Miami-Dade County Privacy Standards Administrative Order. HIPAA mandates for privacy, security, and electronic transfer standards, include but are not limited to:

1. Use of information only for performing Services required by the Contract or as required by law;
2. Use of appropriate safeguards to prevent non-permitted disclosures;
3. Reporting to Miami-Dade County of any non-permitted use or disclosure;
4. Assurances that any agents and Subcontractors agree to the same restrictions and conditions that apply to the Contractor and reasonable assurances that IIHI/PHI will be held confidential;
5. Making Protected Health Information (PHI) available to the customer;
6. Making PHI available to the customer for review and amendment; and incorporating any amendments requested by the customer;
7. Making PHI available to Miami-Dade County for an accounting of disclosures; and
8. Making internal practices, books and records related to PHI available to Miami-Dade County for compliance audits.

PHI shall maintain its protected status regardless of the form and method of transmission (paper records, and/or electronic transfer of data). The Contractor must give its customers written notice of its privacy information practices including specifically a description of the types of uses and disclosures that would be made with protected health information.

ARTICLE 46. VERIFICATION OF EMPLOYMENT ELIGIBILITY (E-VERIFY)

By entering into this Contract, the Contractor and its Subcontractors are jointly and severally obligated to comply with the provisions of Section 448.095, Florida Statutes, as amended, titled "Employment Eligibility." The Contractor affirms that (a) it has registered and uses the U.S. Department of Homeland Security's E-Verify system to verify the work authorization status of all new employees of the Contractor; (b) it has required all Subcontractors to this Contract to register and use the E-Verify system to verify the work authorization status of all new employees of the Subcontractor; (c) it has an affidavit from all Subcontractors to this Contract attesting that the Subcontractor does not employ, contract with, or subcontract with, unauthorized aliens; and (d) it shall maintain copies of any such affidavits for duration of the Contract. Registration information is available at: (<http://www.uscis.gov/e-verify>)

If County has a good faith belief that Contractor has knowingly violated Section 448.09(1), Florida Statutes, then County shall terminate this contract in accordance with Section 448.095(5)(c), Florida Statutes. In the event of such termination the Contractor agrees and acknowledges that it may not be awarded a public contract for at least one (1) year from the date of such termination and that Contractor shall be liable for any additional costs incurred by the County because of such termination.

In addition, if County has a good faith belief that a Subcontractor has knowingly violated any provisions of Sections 448.09(1) or 448.095, Florida Statutes, but Contractor has otherwise complied with its requirements under those statutes, then Contractor agrees that it shall terminate its contract with the Subcontractor upon receipt of notice from the County of such violation by Subcontractor in accordance with Section 448.095(5)(c), Florida Statutes.

Any challenge to termination under this provision must be filed in the Circuit or County Court by the County, Contractor, or Subcontractor no later than twenty (20) calendar days after the date of contract termination.

ARTICLE 47. KIDNAPPING, CUSTODY OFFENSES, HUMAN TRAFFICKING AND RELATED OFFENSES AFFIDAVIT

By entering into, amending, or renewing this Contract, including, without limitation, a grant agreement or economic incentive program payment agreement (all referred to as the "Contract"), as applicable, the Contractor is obligated to comply with the provisions of Section 787.06, Florida Statutes ("F.S."), "Human Trafficking," as amended, which is deemed as being incorporated by reference in this Contract. All definitions and requirements from Section 787.06, F.S., apply to this Contract.

This compliance includes the Contractor providing an affidavit that it does not use coercion for labor or services. This attestation by the Contractor shall be in the form attached to this Contract as the Kidnapping, Custody Offenses, Human Trafficking and Related Offenses Affidavit (the "Affidavit") and must be executed by the Contractor and provided to the County when entering, amending, or renewing this Contract.

This Contract shall be void if the Contractor submits a false Affidavit pursuant to Section 787.06, F.S., or the Contractor violates Section 787.06, F.S., during the term of this Contract, even if the Contractor was not in violation at the time it submitted its Affidavit.

ARTICLE 48. SURVIVAL

The Parties acknowledge that any of the obligations in this Agreement will survive the term, termination, and cancellation hereof. Accordingly, the respective obligations of the Contractor and the County under this Agreement, which by nature would continue beyond the termination, cancellation, or expiration thereof, shall survive termination, cancellation or expiration hereof.

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IN WITNESS WHEREOF, the Parties have executed this Agreement effective as of the date identified on the first page of this Agreement.

Contractor

Miami-Dade County

By:



Name:

Catherine R. Aguirre

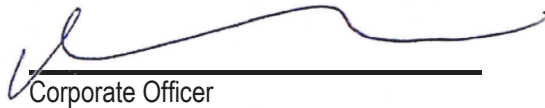
Title:

Market Head/Executive Director, Public & Labor

Date:

7/9/25

Attest:


Corporate Officer

By:

Giselle Cushing, Southeast Market President

By:

for
Daniella Levine Cava

Name:

Title:

Mayor

Date:

Juan Fernandez-Barquin
Clerk of the Court and Comptroller

By:

(Deputy Clerk Signature)

Print Name: _____

Approved as to form
and legal sufficiency

Assistant County Attorney

APPENDIX A**2.0 SCOPE OF SERVICES****1. Minimum Qualification Requirements**

The Contractor shall be licensed by the State of Florida, Office of Insurance Regulation, to provide the plan services listed in **Appendix A, 2.0, Scope of Services**, throughout the contract term.

2. General Information and Scope

A	GENERAL
1.	Contractor will: a. Meet all underwriting requirements and will conform to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), where applicable. b. Review HIPAA Business Associate Addendum. Execute this Agreement as part of any award issued as a result of this Solicitation with no exception.
2.	Contractor will comply with federal guidelines for plan pursuant to IRS Code Section 125, the Patient Protection and Affordable Care Act (PPACA), the Age Discrimination in Employment Act (ADEA), American Disabilities Act (ADA), Medicare Secondary Payer, HIPAA, COBRA, CARES Act and Inflation Reduction Act, GINA, PDA as well as any other applicable federal requirements and all state mandated benefits.
3.	Contractor will be willing to incorporate and comply with all elements of the Senate Bill 1550.
4.	Contractor confirms that their proposal is not through a coalition agreement
5.	Contractor will notify the County of any notable or material change in its financial ratings, by A.M. Best rating service, Standard and Poor's rating service, or any other industry rating service by which it is rated. Notification of such change will be delivered from the Contractor by certified mail to the County no later than 3 (three) business days after the Contractor has been apprised of such change. If the Contractor's subcontractor(s) has/have any notable or materials changes in their financial position, notification will also be provided by the Contractor to the County.
6.	Contractor will adhere to accepted standards (as suggested by the National Committee for Quality Assurance "NCQA") for the consideration and credentialing of physicians in its network, disease management programs, Wellness Programs, behavioral health and substance abuse, and any other applicable Program.
7.	Unless required by law, commissions to agents, brokers, and/or consultants will not be included in any of Contractor's ASO fees, buy-up programs, pharmacy pricing or in any future renewal changes.
8.	Contractor will update pharmacy discount/rebate guarantees as well as medical discount and/or trend guarantees prior to the first Agreement year's effective date of the resulting Agreement to reflect improvements in market conditions and Agreement terms. The County will only allow the Contractor to make improvements to these specific areas.
9.	Upon request by the County, Contractor will provide, at a minimum 2 (two)-years' worth of past claims data, prior authorizations, case management notes, wellness data (personal health assessments), program enrollment data (i.e., disease management) to the new vendor. This includes data from carved-out vendors. Data transfers will be at no cost to the County.
10.	Contractor will timely (i.e., annually or when changes in data or legislation occur) review the County's Programs and experience to make recommendations for potential savings to the County and submit Contractor's recommendations to the County, in writing, with quantified financial and administrative details, cost impacts, member impact and return on investment for consideration. The County may consider the recommendations and further negotiate with the Contractor to incorporate into the Program, any or all the recommendations, at the County's sole discretion.
11.	Contractor will serve as the County's strategic partner in determining reduction of risk and costs on common procedures to meet the needs of a changing economy.
12.	There will be no minimum participation requirement levels, nor corresponding adjustments to fees due to changes in participation levels because during the term of the Agreement, including exercised renewal option, if any. Note: Effective January 7, 2025, the following County departments will become Constitutional Offices: Elections, Clerk of Courts, Sheriff's (Police) Office, Tax Collector and Property Appraiser offices, totaling approximately 5,000-6,000 employees who may elect to continue the County's plans. The Contractor will work with the County to coordinate the implementation, administration, and respective Agreement amendments (if any), for the Constitutional Offices as deemed necessary to succeed.

13.	Contractor will retain all records directly or indirectly related to its performance of services during the term of any Agreement and for a period of 5 (five) years after termination or expiration of any Agreement, or until all pending disputes are resolved. The County has the right to review copies of all records and accounts of the Contractor directly or indirectly related to any Agreements with the County at no cost to the County.
B.	PLAN DESIGN
1.	Contractor will manage the County's multiple benefit plan designs to meet the needs of a unique population and to comply with collective bargaining agreements provisions that include grandfathering of some plans. Attachment 2, Medical Plan Eligibility Matrix provides mapping between medical plans and groups that can enroll in each plan.
2.	Contractor will administer a High Deductible Health Plan (HDHP) paired with a Health Savings Account (HSA) plan or any other plan design of the County's choosing at any time during this Agreement, at the County's sole option.
3.	Contractor agrees that County may contract with carve-out vendors at any time that offer innovative solutions to providing high-quality, cost-effective services to its members.
4.	Contractor agrees that at the County's sole option, the County may elect to supplement and/or carve out managed behavioral health benefits, including any subcontracted/supplemental Programs.
5.	Contractor agrees that the County may change its contribution strategy at any time and agree the Contractor's fees and fee guarantees for the Plan administration will not change. Note: The County's contribution levels/plans and plan options are subject to the terms and conditions outlined in the County's 10 (ten) collective bargaining agreements which are subject to change. Attachment 3, Health Plan Premium Equivalent Rates.
6.	As it relates to Transgender Procedure, Gender Transition, services to treat gender dysphoria, including gender reassignment surgery may be covered for members aged 18 years or over who are diagnosed with gender dysphoria by a Network Provider, when the recommended services are deemed Medically Necessary, and all criteria under Contractor's current coverage guidelines are met. Coverage determinations are made utilizing World Professional Association for Transgender Health (WPATH) criteria for surgery along with documentation of the specific clinical rationale for supporting the Participant's request for surgery.
7.	Contractor will offer national and local Medicare Advantage plans to retirees, including a comprehensive communication plan for open enrollment.
C.	ADMINISTRATION
1.	Contractor will fully administer an integrated self-funded medical/pharmacy program that may include but not limited to: a. disease management programs b. holistic wellness benefit programs c. managed behavioral health benefits d. transparency tools (such as Smart Shopper, HealthCare Bluebook) e. smart technology tools such as a self-service mobile app that contains benefit coverage details, access to member's claim data and member specific deductible information f. virtual tools/benefits including wearables and other monitoring tools g. telemedicine services (such as MDLIVE, SWORD HEALTH, BLOOM) to treat diverse health needs remotely
2.	Contractor will administer the run-out claims for 12 (twelve) months upon termination and that this service is included in your proposed fees for both the medical and pharmacy claims.
3.	Contractor will retain all fiduciary responsibilities, including all of Contractor's subcontractors and for all internal and external appeals.
4.	Contractor will provide the criteria and process for determining "medical necessity" under the Benefit Plan. This criteria and process will be defined and incorporated by reference into any Agreement.
5.	Contractor will provide the criteria for approval of organ transplants in the Plan. This criterion will be defined and incorporated by reference into any Agreement, including the criteria for approval and the definition of Experimental Procedures that will not be covered by the Plan. Agree to provide all explanations in layperson's terms.
6.	Contractor will provide the criteria for approval of the Gastric Bypass Benefit Program at Jackson Health System (JHS) and one additional hospital facility that is currently certified as a Bariatric Surgery Center of Excellence, as defined by the American College of Surgeons (ACS), or the American Board of Metabolic and Bariatric Surgeons (ABMBS). This criterion will be defined and incorporated by reference into any Agreement issued as a result of this Solicitation, including the criteria for approval and the definition of Experimental Procedures that will not be covered by the Plan. The Contractor will also provide the County all explanations in layperson's terms. Note, the County does not cover weight loss services and medications or experimental programs for weight loss.
7.	Contractor will adjudicate claims per the County's direction in instances when the County decides to provide in-network level of care and benefits to a designated employee, and/or retiree, in special catastrophic cases, as determined by

	the County (e.g., amputation of any extremity, brain injury, burn injury requiring hospitalization, electrocution requiring hospitalization, heart attack, stroke, or coma, injury requiring hospital stay, paraplegics/quadruplegics, patient transportation by ambulance or life-flight, reflex sympathetic dystrophy syndrome (RSD), serious spinal cord injuries), even if the provider utilized is not part of the Contractor's network, with no balance billing to the eligible participant.
8.	Contractor will administer the plan such that any deductible satisfied and credited by the Contractor for covered medical expenses in the last 3 (three) months of a calendar year (every Plan Year) will be carried over to satisfy the participant's next year's deductible.
9.	Contractor will: a. Provide credit to the County for pharmacy rebates on a quarterly basis. b. Agree that 100% of earned rebates will be credited to the County even if the Agreement resulting from this Solicitation is terminated. c. Confirm timely, quarterly reporting will be provided to the County showing metric of rebates earned dates and paid dates.
10.	Contractor will: a. Provide credit to the County for rebates for drugs processed through the medical plan on a quarterly basis. b. Agree that 100% of earned rebates will be credited to the County even if the Agreement resulting from this Solicitation is terminated. c. Confirm quarterly reporting showing metric of rebates' earned dates and paid dates.
11.	All of the Contractor's benefit plans will be administered on a self-billing fee/premium rate remittance basis. Agree to accept the County's self-billing process with no future reconciliation of said fees/premiums.
12.	Contractor will: a. Accept bi-weekly bank wire-transfers of claim payments and ASO fees monthly, which will be remitted in arrears. b. Grant a 90-day grace period for active employees, employees on a paid leave, and retirees.
13.	Contractor will: a. Establish an account ("Disbursement Account") with a Qualified Public Depository bank agreed upon between the County and the Contractor. The account will be in the name of the County for the exclusive use of the County's plan. An initial imprest balance will be maintained in the Account. Should it become necessary to increase the imprest amount, the County will agree to do so based on satisfactory evidence, at the County's sole discretion, from the Contractor of insufficient funds. The Account will be funded weekly by the County based on electronic reports of issued checks provided by the Contractor. The County will issue payments via wire transfer. Any interest earned in the Account will be accrued to the County. Banking fees are to be waived or paid for by the Contractor. b. Provide to the County a monthly reconciliation of the Disbursement Account.
14.	Contractor will: a. Pursue Coordination of Benefits (COB) before payment of claims. Agree to administer potential subrogation on a "pay, then pursue" basis. Subrogation action will not be pursued against the County for Workers' Compensation claims that have been denied by the County. b. Provide a report quarterly on claims that have been recovered including the total amount, amount of recovery, fee charged, and the amount reimbursed to the County.
15.	Contractor will administer appropriate procedures to carefully monitor and report the status of over-age, unmarried dependent children and dependent children of Domestic Partner (26 years and older) to ensure satisfactory proof of eligibility is obtained and that coverage complies with Federal and State regulations, including COBRA status. Dependent children and dependent children of Domestic Partner losing group coverage due to age or loss of dependent status must be notified by the Contractor of their COBRA rights. Agree to notify the County within 30 days after the open enrollment effective date (January 1 of each year) of any discrepancies in eligibility including employee name, dependent to be deleted and any change in coverage level.
16.	Contractor will provide all COBRA administration at no additional cost to the County, including mailing of initial COBRA notification after receiving notification of a qualifying event from the County. The services required also include billing of beneficiaries and collection of appropriate premiums that conforms and complies with County eligibility and payroll provisions.
17.	Contractor will issue HIPAA Notices of Privacy Practices to new enrollees and reminder notices to all enrollees and plan participants as required by HIPAA.
18.	Contractor will: a. Verify dependent eligibility at initial enrollment and over age dependents at subsequent open enrollments and notify the County within 60 (sixty) days of any discrepancies in eligibility.

	b. Verify eligibility for new hires and new enrollees within 30 (thirty) days and notify the County in writing of any discrepancies in eligibility within 5 (five) business days.
19.	Contractor will perform a biweekly reconciliation of accounts based on biweekly eligibility files (daily for retirees) provided by the County. Agree to notify the County in writing within 5 (five) business days of any discrepancies, to include member name, member identification number, name of ineligible dependent, and change in coverage level, if any. If any discrepancies are noted, the Contractor will agree to provide an action plan to correct such discrepancies, impacted members, and any cost impacts.
20.	Contractor will utilize its own claims processing system or lease a nationally recognized claims processing system. The claims processing system will be fully integrated with its eligibility system, which receives data feeds from the County.
21.	Contractor will: - Provide all necessary data, reporting, and reconciliation support as needed for the County's participation in the Retiree Drug Subsidy ("RDS") Benefit Program under Medicare Part D. Such support will not include the preparation or submission of the actuarial attestation required for participation in the RDS Benefit Program. - Provide, at no additional cost to the County, Medicare Part D prescription subsidy filing.
22.	Contractor will provide all necessary data, reporting and reconciliation support as needed for the County to comply with the Patient Protection and Affordable Care Act, and any other Acts/Laws at no cost to the County.
23.	Contractor will: - Coordinate directly with Medicare, on behalf of retirees, in processing Medicare supplement plan claims. - Proactively pursue Medicare COB for ESRD and disabled members. - Provide annual reporting to the County.
24.	Contractor's Fraud prevention and detection procedures will be maintained by the Contractor, including appropriate reporting to authorities and adequately staffed based on volume of claims for the Contractor's entire book of business.
D.	AUDIT
1.	Contractor will: - Allow the County, or its representative, to perform an annual audit of all medical utilization management files, financial and rebate data, and any other information relevant to the County's account. The results of this independent audit will determine damages in addition to recoveries, for failure to meet Performance Guarantee Standards. - Maintain appropriate internal audit procedures for claims and customer service administration. Agree to additional audits of Benefit Programs such as pre-disbursement audits, audits of selected providers, and audits of specific services.
2.	Contractor will conduct an annual audit and/or market check of the pharmacy benefit management services inclusive of the rebate agreements.
3.	Contractor will conduct dependent eligibility audits as needed, but no more than biannually, on spouses, domestic partners, and stepchildren in order to verify continued eligibility in the Plan at the Contractor's expense and at the County's sole discretion.
4.	Contractor will allow the County or its representative access to review and audit physician, hospital, and pharmaceutical provider contracts including, at a minimum, the pricing and terms of the contracts.
5.	Contractor will allow the County or its representative to begin a medical/pharmacy audit up to 24 months after plan termination including any pharmacy market checks every 12 months during the term of the Agreement.
E.	ELIGIBILITY
1.	Contractor will administer coverage on the first day of employment for any full-time/part-time County employee deemed eligible by the County.
2.	Contractor will comply with the timing of adding new dependents to the plan. A dependent may be added to the medical plan by submitting an application within 45 days (60 days for newborns) of acquiring the dependent. The employee must enroll the dependent within 45 days (60 days for newborns) after the marriage, registration of Domestic Partnership or birth/adoption of a child. Coverage for a new spouse or Domestic Partner is effective the first day of the month following receipt of the application. Coverage for a newborn, child placed for adoption, or adopted is effective as of the date of the birth, or the earlier of (i) placement for adoption, or (ii) adoption date. The change in premium, if applicable, is effective the pay period in which the birth occurs, or the earlier of (i) placement for adoption, (ii) or adoption date.
3.	Contractor will accept the County's dependent eligibility definitions. Eligibility by union group can be found at the following link: miamidade.gov/humanresources/library/medical-plan-eligibility.pdf . Eligibility based on status can be found at the following link: miamidade.gov/global/humanresources/benefits/dependent-eligibility.page .

4.	Contractor will collect the premiums for all lines of coverage offered to retirees (such as Dental, Vision and Life, in addition to Medical). Employees under age 65 who retire from the County - may continue plan membership for themselves and their dependents until age 65 with remittance of the required premium, collected directly by the Contractor (preferred for the dependents of retirees attaining Medicare eligibility may continue coverage through the retiree group by remitting the appropriate premiums). The dependents of deceased retirees under age 65 may not continue coverage, unless they are dependents of employees who have died in the Line of Duty (ILOD) who can then remain on the plan up to the dependent limiting age. Agree to provide weekly reports of all premiums collected.
5.	Contractor will collect premium remittance for retired employees and their dependents, who have reached age 65, and their dependents, who elect a National Medicare Advantage Plan (EGWP), Medicare Advantage Plan (MA/PD) or Medicare Supplemental Plan offered through the County. The Medicare Eligible dependents of a deceased retiree who are enrolled in these plans would be able to continue coverage with required premium remittance to be collected directly by the Contractor. Under age 65 dependents will not be eligible for coverage under these plans but would be eligible for COBRA. Agree to provide complete administration of the Medicare "Advantage" Plans including but not limited to billing, eligibility, claims adjudication, and payment/billing reconciliation, in association with County retirement processes and internal systems, Centers for Medicare and Medicaid Services (CMS), and the Florida Retirement System (FRS). These services will be provided on a No Loss, No Gain provision due to a change in carrier.
6.	Contractor will: a. Conduct annual open enrollment for retirees. Currently, the process is a paper process, the County is looking for the Contractors to agree to administer plan enrollment changes at retirement, at other life events, and annual open enrollment through the Contractors portal/systems. Retiring employees under age 65 will be provided an opportunity at the time of retirement (no later than 30 days from the retirement date) to change their medical plan election to allow participation in the option which best meets their retirement needs. b. Provide the County with access to an employer administrative portal with supportive training at no additional cost to the County.
7.	Contractor will terminate employee coverage on the last day of the pay period for which applicable payroll deductions are made after the date the employee ceases active status for any reason other than an approved leave of absence or retirement. When an employee is on an Approved Leave of Absence, the County will collect and remit premiums.
8.	Contractor will accept eligibility data, in an electronic format, in the file layout used by the County and/or its third-party administrator. The County uses the 834-file format.
9.	Contractor will: a. Update eligibility data within 1 (one) business day from the receipt of such data. b. Notify the County of any issues/discrepancies arising within 1 (one) business day from the time of the data upload including reporting any impacts.
F.	NETWORK
1.	Contractor will: a. Perform a GeoAccess analysis and present this report to the County at their request. This will, at a minimum, occur annually. b. Make reasonable efforts to contract with additional physicians and hospital providers where minimum access standards are not met and solely determined by the County. c. Accommodate County and/or employee requests at any time for additional recruitment efforts for providers of specific services necessary to meet the needs of the County's unique workforce.
2.	The County currently has a county-specific custom local hospital provider "Select Advantage" network (Refer to www.avmed.org/mdc - 2024 Benefit Guide, page 8 for the differences in these facilities). Agree to make reasonable efforts to provide comparable networks that offer the same or improved provider discounts. Agree to offer proof of an existing contract or a properly executed letter of intent with custom network providers; or demonstrate to the County's satisfaction, at its sole discretion, the inability to contract with custom network providers was out of the Contractor's direct control or not its decision. Note: Any plan design and/or network changes are subject to collective bargaining agreements.
3.	Contractor will: a. Have full-service provider contracts with Jackson Health Systems (JHS) and University of Miami (UM). JHS/UM, as providers, are subject to the Plan design approved by the County and standard credentialing methods. b. Agree to allow members to use all health care services (i.e., primary, secondary, and tertiary services) offered by JHS/UM.

	Provider contract between JHS/UM and the Contractor should: 1. become effective no later than December 1st, prior to plan start date; 2. remain in force for the duration of the Contractor's contract with the County, and any renewals or extensions thereof; 3. not contain any provision restricting or limiting a member's use of these providers in any way that is not imposed on other physician or hospital provider within the Contractor's network; 4. ensure that through hospital and providers contracting that there is electronic data sharing between the parties (hospital and providers within hospital systems); and 5. ensure members will have the ability to access their own medical electronic medical records generated by this system. c. Offer proof of an existing contract or a properly executed letter of intent with JHS/UM; or demonstrate to the County's satisfaction, at its sole discretion, the inability to contract with JHS/UM was out of the Contractor's direct control or not its decision.
4.	Contractor will: a. Match the County's custom prescription drug formularies that are available to retirees in specific plans. At the County's sole option, the County may opt to discontinue the custom formulary. The POS plan's custom formulary does not have a mandatory generic requirement. Refer to the following link for this data avmed.org/web/mdc/tools-and-resources/preferred-medication-lists. Some retirees' drugs have been grandfathered in the custom formularies. b. Continue to grandfather these retirees' drugs if requested by the County.
5.	The County's EAP Program (or third-party EAP program) will have full authority to refer members to the health plan network for mental, behavioral, and substance abuse services when necessary. Contractor will accept bills by the EAP and be reimbursed by the Contractor according to negotiated fees. Agree that special accommodations for first responders- Corrections, Police Officers and others with special needs must be made for member privacy. Agree to offer first responders focused programs to support critical incidents and mental health related services.
6.	Contractor will keep the County apprised on a timely basis of any issues/discussions surrounding its network of hospitals, pharmacy providers/contracts or any other owned/subcontracted network which would have an impact on the County employees. This includes a disruption report of members that would be impacted at a minimum of 90 days prior to any group/hospital leaving the network.
7.	Contractor will: a. Prior to any provider changes, provide the County of any material changes in contracted rates that specifically impact the County. This would include material changes in provider bonuses, increased fees passed onto the County due to providers/facilities being acquired by private equity firms, or other ownership structural changes, etc. b. Agree that, if proper notice is not provided to the County, then such incurred expenses will be at the Contractor's expense.
8.	Contractor will allow pregnant employees/dependents who are beyond the first trimester to continue with their current attending OB/GYN provider, through the time of delivery, and such coverage will be considered at the in-network level of benefits, with no balance billing to the member.
9.	Contractor will offer all plans on an open access basis (no referral requirements).
10.	Contractor will notify the County within 60 (sixty) days of changes in the drug formularies prior to the change. Agree to provide a report with the number of members affected by the change and what other drug options will members have going forward. Positive additions to the drug formularies are permitted by the Contractor at any time during the Plan Year with prior notification provided to the County. Deletions of drug formularies, other than those resulting from Federal Drug Administration (FDA) requirements or by law, are only permissible one time per Plan Year with a 60-day notification to the County, including an impact report of the number of members affected and cost impact to the member and the County.
G.	COMMUNICATIONS AND ENROLLMENT
1.	Contractor will prepare, coordinate or manage a project plan for a January 1 st implementation. Confirm the annual project plan will commence no later than August 1 with open enrollment starting in October.
2.	Contractor will provide a dedicated implementation team with sufficient depth that includes, at a minimum: a. Benefit programming b. Eligibility and ID card programming c. Communication specialist for development open enrollment materials as well as SPDs and SBCs

	d. Account manager and back-up account manager accessible at all times e. Team to manage initial open enrollment questions f. Systems people to ensure eligibility file layouts and transfers g. Systems people to accept and convert current carrier data h. Systems people to ensure all County divisions are included (such as union indicator) i. Transition of care team – pregnancy, prior authorizations, catastrophic, for both medical and pharmacy,
3.	Contractor will provide: a. Enrollment materials at a minimum of 45 (forty-five) days prior to the start of the County's annual open enrollment period in October. b. Provide enrollment materials in printed format, in an adequate amount (approximately 5,000 copies), at the County's discretion. Agree to provide the County enrollment materials in alternate formats (i.e., Americans with Disabilities Act of 1990 (ADA), Braille, different languages (Spanish/French/Creole), and/or large print.) c. Electronic version of enrollment materials, as well as a customized benefits website that will be made available to all eligible employees/retirees during initial enrollment and to new enrollees. Materials will include, but are not limited to, the Summary Plan Design (SPD), Summary of Benefits and Coverage (SBC), Evidence of Coverage (EOC) and other materials, as deemed necessary by the County. Agree that the costs of printing and producing materials, in all formats, are the sole responsibility of the Contractor.
4.	Contractor will: a. Provide the County draft Summary Plan Descriptions (SPD), Summary of Benefits and Coverages (SBC), and Evidence of Coverage (EOC), prior to the Plan effective date. b. Upon approval and acceptance of the SPD/SBC/EOC by the County, the Contractor will print and mail the SPD/SBC/EOC and other plan related materials directly to member homes, upon the County's request or required by law, it is preferred to have this information to the members within 45 (forty-five) days of member's effective date. c. Provide final electronic versions to be placed on the County website and on the Contractor's dedicated website prior to open enrollment each year. Additional print copies may be requested to accommodate other meetings throughout the year (such as Benefit/Wellness Fairs). d. Maintain an updated secure dedicated website.
5.	Contractor will utilize the County-specific forms, such as retiree's enrollment form, proof of overage dependents and any other County produced form. Currently, most of the County's data and forms are in an electronic format.
6.	Contractor will mail ID cards to members 15 days prior to the annual open enrollment effective date.
7.	Contractor will provide ID cards to each enrolled member and that ID cards -are generated and distributed within 5 (five) business days, when any of the following events occur: a. Change in coverage option or group b. A replacement/duplicate card is requested c. New Enrollment
8.	Contractor will provide the following electronic capabilities through a single dedicated website and mobile app: a. Access to directories b. Access to ID card and print capabilities c. Access to claim data d. Access to Wellness Programs and member rewards
9.	Contractor's Plan will identify members/subscribers by social security number, employee ID number, applicable bargaining unit, and demographic information as required by the County. All social security numbers will be maintained for all members/subscribers enrolled in the Plan, and as such, will bear the responsibility of protecting the privacy and legal rights of all members/subscribers.
10.	Contractor will provide the County copies of all member communications for approval prior to distribution. The County will retain the right to prohibit distribution of any materials that make false or misleading statements, refer to any plan other than the Contractor's plan, or any other materials or "giveaways" which the County deems to be inappropriate.
11.	Contractor will review the plan specific information in the County's Employee Benefits Handbook for accuracy on an annual basis and provide any updates to the County no later than 45 (forty-five) days prior to open enrollment (or an agreed upon date to ensure changes are incorporated in a timely fashion). The County will retain final approval authority over all communication materials, not limited to the Employee Benefits Handbook.

12.	In accordance with the agreed upon annual open enrollment project plan, the Contractor will utilize the existing online enrollment platform, including testing of the of the enrollment data.
13.	Contractor will provide: a. Sufficient personnel to attend all initial open enrollment period meetings and subsequent open enrollment meetings on a schedule set by the County. b. Personnel to attend meetings scheduled by the County between such annual periods, assuming reasonable notice is given, including any necessary materials. At a minimum, there are 10 - 20 in-person meetings and 20 - 25 virtual meetings annually.
H.	MEMBER SERVICES
1.	Contractor will provide: c. Representative who will be allowed access to the County employees on the County premises as determined by the County for events such as onsite benefit fairs/wellness fairs. d. Virtual representation as well.
2.	Contractor will provide: a. An off-site, dedicated (i.e., exclusive to Miami-Dade County) Member Service Team located in the County or County-accepted location within the United States, based on 1 (one) dedicated member service team representative per 5,000 members enrolled in the plan(s). b. Internal Contractor training on all the specifics of the County's Plans and contracted programs. c. A dedicated phone number, fax number, webpage link, and mobile app link to access the member services team.
3.	Contractor's Member Customer Service Team will have a dedicated recorded toll-free telephone line located in Miami-Dade County or mutually agreed-upon location within the United States. There will also be a dedicated Interactive Voice Response phone number for County employees to access 24/7, 365 days a year.
4.	Contractor will: a. Provide the County information on any significant changes in Member Services (e.g. phone messages or prompts and personnel) to the County in advance. b. Receive the County's approval prior to implementing such changes (to Member Service Center and unit structure).
5.	Contractor will: a. Develop and administer an employee/member satisfaction survey specific to the County's self-funded program. survey results will be work with the County to develop the survey where the County will sign off on the survey document prior to distribution. b. Conduct the survey quarterly sending to members until there is a statistically valid number of employees/retirees respond. c. Share survey results with the County and they will be used for measurement purposes of the standards included in Appendix E, Medical Performance Guarantees.
6.	Contractor will: a. Provide the member its standard grievance procedure (included in the SPD or other County preferred method) for members' claims disputes when services are denied. b. Confirm every new member will receive notification of a detailed explanation of grievance procedures within 30 days of the effective date of coverage.
7.	Contractor's dedicated member services team will have on-line access to eligibility, demographic data, and individual claim information as well as a history of member interactions with the member services team.
I.	WELLNESS / DISEASE MANAGEMENT
1.	Contractor will at a minimum, match the County's current wellness and disease management programs described at the following link: secure.miamidade.gov/employee/wellness-works/home.page
2.	Confirm there will be onsite Health Coaches with all applicable certifications and trainings as required by law, available to be effective advisors for participating members. Onsite Health Coaches will travel to the County's designated locations.
3.	Contractor will: a. Coordinate and facilitate approximately a minimum of 100 annual wellness events (i.e. pop-up clinics or pop-eye exams), fairs workshops and seminars. The intent of the wellness events is to focus on improved overall health/wellbeing for the County's members. b. Provide sufficient material and staff as needed and mutually agreed upon by Contractor and the County, at the County's sole discretion to be utilized at said meetings for the benefit of County employees and Labor Union representatives.
4.	Contractor will:

	a. Accept biometric screenings from the members' doctors in lieu of the same test being performed by the Wellness team. b. Provide members' providers with test results performed by the Wellness team. c. Alternatively, provide the member with paper (if requested) or electronically so member can share results with the provider.
5.	Contractor will administer flu shots – limited to interested employees on a voluntary basis, at County designated onsite location, who are enrolled in the County's health plans.
6.	Contractor will: a. Contribute \$1 million annually towards the County's Wellness Initiative and related activities with funding managed and reconciled by the Contractor. This is in addition to the staff positions that are also part of the current carrier's staff. Confirm that if any funds not utilized during the year will be rolled over into the next Plan Year. At the sole option of the County, the first-year wellness fund, should include additional monies to promote the program. b. Provide a wellness portal and mobile app that is included within the Contractor's portal and mobile app to track activities, earn points, training, and other wellness activities.
7.	Contractor will provide identified members currently enrolled in disease management programs using data from the prior carrier (if applicable) and provide the members with information on the new disease management programs within the first quarter of the Plan Year.
8.	Confirm Contractor can administer a robust disease management and/or point solutions products that include but are not limited to targeted programs for the following conditions at a minimum: a. Diabetes, pre-diabetes b. Dyslipidemia, Hyperlipidemia c. Hypertension d. Tobacco use e. Weight management f. Stress g. Asthma
9.	At the County's sole option, the County can pursue stand-alone wellness/disease management programs. Contractor will coordinate all administrative/technical processes with the third-party provider(s) and County staff.
10.	Contractor will provide ADA compliant communications materials (subject to County approval) that includes program details and updates to designated County locations and labor organization's locations.
11.	Contractor will provide monthly informative and actionable communications highlighting the progress of Wellness and Disease Management programs indicating trends and utilization. Communications should summarize high-level macro trends including participation, program enrollment, and key behavior and biometric benchmarks. Provide identified performance data (in conformance with 45 CFR Section 165.514 which in form and substance protects the privacy of County employees) to the County once a quarter; such reports must conform to the HIPAA requirements.
12.	Contractor will develop a communication campaign around all wellness events encouraging participation and provide multiple avenues of scheduling (telephonically, online, in person), at no additional cost to the County.
J.	TECHNOLOGY AND INNOVATION
1.	Contractor will provide education and online health savings tools/mobile app, to help workforce make smarter health care decisions and to reduce financial burden.
2.	Contractor will: a. Have a technology-enabled solution to support reduction in cost of care through an accountable care delivery system. The intent is also to enable timely, value-based health care decisions that accomplish better health outcomes, costs, and improved patient/physician satisfaction, shifting focus from volume to value. b. Submit examples of cost savings delivery items along with quantified savings calculations as industry best practices. Benchmarked savings to comparable governmental organizations should be presented.
3.	Contractor will provide solutions that can support and educate members with food insecurities, educating members on the importance proper food management improved overall health and maintenance of chronic conditions.
4.	Contractor will have technology in place for members to access all their medical records in a single location, without needing to navigate multiple provider systems. All data will belong to the member and the member can access the data after leaving the County, share data with other providers, download data and can grant access to providers.

5.	Contractor will have advocate services 24/7/365 to assist members in understanding their health, managing conditions, assist with providing both local, community and other resources available to members to assist with improving their overall health. In addition, assist with setting up appointments with cost-effective providers and services.
6.	Contractor will inform the County throughout the term of the Agreement of new unique innovate programs and providing related member and cost impacts to the County. The County will have the sole option to implement these programs.
7.	Contractor will provide a single comprehensive mobile app for employees, dependents, and retirees inclusive of all relevant information including Wellness/Disease Management programs, claims look up, provider directories, cost estimation tools, SmartShoppers, and link to the Contractor's dedicated County healthcare website.
K.	REPORTING
1.	Contractor will comply with the County's preference in receiving full transparency from the Contractor on provider discounts and billed charges and provider/facility contract terms.
2.	Contractor will provide the County with full transparency on the Plan's healthcare quality and pricing schematic, upon request by the County.
3.	Contractor will provide full pricing and utilization transparency for all claims including but not limited to those paid under fee-for-service, capitated or value-based arrangements, and/or services provided by an Accountable Care Organization (ACO), processed by third parties and details on claims subject to shared savings. Services that are under a capitated arrangement, monthly utilization reporting will be provided and is subject to performance guarantees.
4.	Contractor will: a. Review the Medical and Pharmacy Performance Guarantee Standards Provisions as provided in Appendix E, Medical Performance Guarantees and Appendix D, Pharmacy Workbook. b. Provide annual results based on the County's data and not the Contractors Block of Business within 60-days of the close of the Plan Year. Non-compliance penalties will be payable to the County within 60 days of Plan Year-end. The Contractor will identify any deviations from the Medical and Pharmacy Performance Guarantees wording.
5.	Contractor will provide: a. The County (and its designated consultant, if any) with on-line access to the Contractor's reporting system to retrieve standard and ad hoc claims and utilization reports. b. A timeline as to when the data will be available to the County within 60 days of the Agreement effective date and will train the County's team on the use of the reporting system.
6.	Contractor will submit monthly reports within 20 days from the close of the month.
7.	Contractor will submit reports on program savings resulting from programs that manage County and member cost (such as diabetes management, advanced imaging site selection sleep studies) no later than semi-annually 60 days after the end of the 6-month period. Reports will include utilization, County cost and a return-on-investment calculation.
8.	All claim and census data will be reported based on plan, member status, tier, bargaining unit, gender, and age at a minimum.
9.	Contractor will provide the County's designated consultant quarterly data dumps/transfers that will be accessible by the consultant to analysis and respond to the County's inquiries, of the County's claims and eligibility, at no cost to the County, within 30 days of the close of the month. In a format specified by the County or designated consultant.
L.	STAFFING
1.	Contractor will provide a dedicated local account representative (who will be physically located in the Tri-County area and be approved by the County) with full account management capabilities. The account representative will assist the County in the administration of the Plan approved by the County, in providing all necessary and related services for employees, in obtaining the appropriate resolution of issues including but not limited to claims problems, and in any other way requested, related to the Services stated herein.
2.	Contractor will: a. Provide 4 (four) County dedicated onsite customer service representatives. Confirm on-site representatives will be housed at the County administration building and/or other County designated locations in adherence with County requested scheduling. b. Provide computer terminals, printers and fax machines for its representatives that have on-line access capabilities of employees' eligibility and claims information, provide customer service-related functions, and assist in plan administration. c. Contractor's on-site representatives will adhere to regular business days/hours pursuant to the County's business schedule in order to be easily accessible to employees.

	If an on-site representative is on vacation, or otherwise absent for an extended period, a replacement representative will be provided. The County may request replacement of the on-site representative if he/she is not performing in a satisfactory manner, at the County's sole discretion. The County will advise the Contractor of any performance concerns and allow adequate time to resolve them before requesting such replacement.
3.	Contractor will, in addition to the above staff, provide the following dedicated staff along with necessary computer terminals, printers and fax machines to allow access to members' eligibility, claims and program encounters to provide seamless, one-stop customer service responses: - Three (3) full-time onsite Wellness/Health coaches - One (1) full-time onsite dietician - One (1) full-time onsite fitness center manager – Potentially New Position for 2025 - One (1) full-time off-site dedicated Wellness/Health Coach Manager - Back-up staff in the event vacation or other time-off During the term of the Agreement the County may either change the above staff positions or add additional staff position to address the needs of the County. Note: The preference is to have the current staff hired by the Contractor or that the Contractor have these positions staffed by October for the upcoming Plan Year. The County reserves the right to modify staff needs. Note: During the term of the Agreement, at the County's sole discretion, the County reserves the right to require additional staff certifications based on member needs, if any, the Contractor's staffing changes and/or replacements, the County will have input into such changes/replacements.
4.	Contractor will agree that the County, at its sole discretion, can interview, approve or disapprove the Contractor's designated staff and, request replacement of the outlined above Wellness staff if staff is not performing at a satisfactory level allowing time to address and resolve issues before such request.
M.	Enhancements
	The following enhancements have been negotiated and incorporated into the Agreement.
1.	Medicare Advantage Plans Options: Contractor will agree to provide full administration services either through Retiree First Services or directly. Contractor agrees to offer a national PPO Group Medicare Advantage Plan, with input from the County on plan design and cost. In addition, Contractor will agree to offer local Medicare Advantage Individual Plans based on CMS approved plan options (zero cost, if applicable) for several Florida Counties.
2.	Contractor agrees to provide all Medical and Pharmacy rebates on a quarterly basis. The Contractor will waive early termination provisions and any earned rebates on the Pharmacy will be paid to the County. All Medical earned rebates will be paid by September 30 following the year of termination.
3.	Contractor agrees to provide assistance and reporting as needed for the County to submit Retiree Drug Subsidy application.
4.	Contractor agrees to grandfather all members in the custom formularies without any financial administration cost or impact to overall rebates. Any new members enrolling in the plans with the custom formularies will also be grandfathered the ability to maintain their current medications. The County reserves the right to modify the custom formulary during the term of this Agreement.
5.	Dedicated Staff – the County reserves the right during the term of the Agreement to modify the number of dedicated staff assisted to the County. If the staff is reduced, the Contractor will adjust the ASO fees accordingly. In addition, the Contractor will provide live customer services 24/7/365.
6.	Contractor agrees to reduce ASO fees by \$2.76 PEPM for weekly claims wire transfers.
7.	Performance Guarantees – the Medical and Pharmacy annual maximum cap is independent of each other.
8.	Contractor agrees for the term of the Agreement to offer a Medical Provider Discount Guarantee of no less than 73%, for three years (2026, 2027 and 2028). Additionally, agrees to increase the penalty to 4% for each 1% below guarantee after the corridor. In addition, of such discounts increase, the Contractor agrees to increase the overall Medical Provider Discount Guarantee.
9.	Contractor agrees to offer a robust Disease Management program that includes Lifestyle Condition Coaching at \$4.60 PEPM. Contractor further agrees to a \$4.60 PEPM at risk for not meeting metrics for the term of the Agreement.
10.	Data Interface / Feeds – Contractor agrees to provide up to 4 monthly universal data feeds at no cost to the County.

11.	Pharmacy Market Checks – Contractor agrees to allow annual Pharmacy Market Checks and improved pricing to take effect the following calendar year through the term of the Agreement.
12.	Personal Health Solutions – Contractor agrees through its personal health solutions platform to offer services that are target to specific conditions through multiple vendors. These services include, but are not limited to Virtual Physical Therapy, Women's Health, Weight Watchers, etc.
13.	Prudent RX – at the County sole discretion during the term of the Agreement, the County can elect to add Prudent Rx as a cost savings Pharmacy program.
14.	Contractor agrees to cap the NAP program at \$50,000 per claim.
15.	Contractor agrees to provide the CVS Telehealth services and CVS Virtual PCP programs, as outlined in Appendix B – Price Schedule.
16.	At the County sole option, the County can elect to offer the APCN (a tiered network through the Contractor to offer a premier network), the cost is outlined in Appendix B – Price Schedule.
17.	Contractor agrees to offer Cobra for the term of the Agreement at a flat rate of \$.92 PEPM.
18.	Contractor agrees to assist the County with any provider direct contracting.
19.	Contractor agrees to offer a Generic Dispensing Rate guarantee through the term of the Agreement.
20.	At the sole option of the County, the County can add any of the additional programs/plans during the term of the Agreement to be effective on any given Calendar Year. In addition, the County can remove or discontinue any optional programs/plans as outlined in Appendix B during the term of the Agreement to be effective on any given Calendar Year.
21.	At the sole option of the County, the County can elect the NACO pharmacy program to be effective on any given calendar year. The County may discontinue the NACO pharmacy program on any given calendar year.

APPENDIX B.1

PRICE SCHEDULE

A. ASO Fees

ASO Fees	2026	2027	2028	Comments / Described in Question Number
Base ASO Fee	\$32.89	\$32.89	\$32.89	Additional included programs are reflected within the Appendix B-2.
COBRA Administration – PEPM	\$0.92	\$0.92	\$0.92	Appendix A. Scope of Services. C. Administration. #16. Appendix C. Proposer Information C.2 Benefit Administration #6. \$0.92 PEPM in years 4 and 5.
Total ASO Fee	\$33.81	\$33.81	\$33.81	Appendix B-2 provides additional details of all the programs and services included within the ASO fee.

ASO Fees	Fee	Fee Escalator (%)*
ASO Fee 2029	\$34.21 (COBRA admin fee not included)	4% Escalator
ASO Fee 2030	\$35.57 (COBRA admin fee not included)	4% Escalator

HSA Fee	Fee	Fee Basis*
HSA Fee Administration	\$1.25	Per Participant Per Month (PPPM)

B. Capitated Services

Capitated Services Description	2026	2027	2028	2029	2030	Billed Through (Invoice or Wire)
N/A	N/A	N/A	N/A	N/A	N/A	N/A

C. Cost Containment Fees

Cost Containment Programs	Fee	Fee Basis	Optional?	Billing Methodology (Invoice or Wire)	Described in Question(s)?	ROI Guarantee?
SmartShopper Program: Smart Shopper	\$2.00	PEPM	Yes – Selected for 1/1/2026	Invoice	Appendix A. Scope of Services. C. Administration. #1. Appendix	N/A

Cost Containment Programs	Fee	Fee Basis	Optional?	Billing Methodology (Invoice or Wire)	Described in Question(s)?	ROI Guarantee?
					C. Proposer Information C.2 Benefit Administration #5 and C.1.Network #17.	
NIA High Tech Radiology Pre-Authorization Program: Enhanced Clinical Review Program	\$0.80	Per Member Per Month	Yes – Selected for 1/1/2026	Wire	Appendix C. Proposer Information C.2 Benefit Administration #5 and # 18.	N/A
Sword Virtual Physical Therapy Program: Kia Health, Sword, SworKit Health	\$1.70 PEPM for Aetna Personal Health Solutions. Estimate \$400 per engaged member per program year.	PEPM, Per Engaged Member	Yes – Selected for 1/1/2026	Invoice PEPM and Wire for the per engaged	Appendix A. Scope of Services. C. Administration. #1. Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 20.	N/A
Bloom Health Women's Care Program: SimpliFed, Origin, Visana, Restorebalance, Frame	Part of Aetna Personal Health Solutions bundle. See above.	PEPM, Per Engaged Member	Yes – Selected for 1/1/2026	Invoice PEPM and Wire for the per engaged	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 19.	N/A
Healthy Expectations Pregnancy Program: Enhanced Maternity Program	\$0.75	Per Employee Per Month	Yes	Invoice	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 1 and #21.	N/A
Prescription for Healthy Living Diabetes Drug Discounts Program:	Included in the base	N/A	No	Please refer to Pharmacy RFP Appendix D.	Appendix C. Proposer Information C.2 Benefit Administration	N/A

Cost Containment Programs	Fee	Fee Basis	Optional?	Billing Methodology (Invoice or Wire)	Described in Question(s)?	ROI Guarantee?
	medical fee.				#5 and C.4 Wellness # 22.	
Discount Vision Program	Included in the base medical fee.	N/A	No	N/A	Appendix C. Proposer Information C.4 Wellness # 23.	N/A
Weight Watchers Reimbursement	Part of Aetna Personal Health Solutions bundle. See above.	PEPM, Per Engaged Member	Yes – Selected for 1/1/2026	Invoice PEPM and Wire for the per engaged	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 1.	N/A
Other: Maven Maternity Program Foundation (requires purchase of enhanced maternity program)	\$950	Per Case	Yes	Claim	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 1 and #21.	Yes

D. Wellness Program

Wellness Program Features	Fee	Fee Basis	Billing Methodology (Invoice or Wire)	Described in Question(s)?	Comments
Personal Health Assessments	Included as part of the Aetna Health Your Way Elite Program.	Included in administrative fee.	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.4 Wellness # 1 and 6.	
Biometric Screening	Health Plan Allowance can be utilized or the vendor charges for Quest or LabCorp services	On-site / Patient Service Center Pricing per participant is per B7 and B8	Wire	Appendix C. Proposer Information C.4 Wellness # 1.	Refer to Quest and LabCorp Rate Sheets attached.

Wellness Program Features	Fee	Fee Basis	Billing Methodology (Invoice or Wire)	Described in Question(s)?	Comments
	can be passed to you via wire.				
On-site Flu Shots	Health Plan Allowance can be utilized.	Vendor Invoices are sent to Aetna.	Invoices are then applied towards the Health Plan Allowance.	Appendix C. Proposer Information C.4 Wellness # 1	
Health and Wellness Fairs	Health Plan Allowance can be utilized.	Vendor invoices are sent to Aetna.	Invoices are then applied towards the Health Plan Allowance	Appendix C. Proposer Information C.4 Wellness # 1	
Newsletters	Health Plan Allowance can be utilized.	Vendor invoices are sent to Aetna.	Invoices are then applied towards the Health Plan Allowance	Appendix C. Proposer Information C.4 Wellness # 1	
Educational Seminars	Health Plan Allowance can be utilized.	Vendor invoices are sent to Aetna.	Invoices are then applied towards the Health Plan Allowance	Appendix C. Proposer Information C.4 Wellness # 1	
Fitness workshops and classes	Included with the Aetna Health Your Way Elite Program.	Included in Administrative Fee.	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.4 Wellness # 1, 4, 7.	
Telephonic Coaching	\$4.60	PEPM	Yes – Selected for 1/1/2026	Included in the administrative fee that is invoiced.	LCC Lifestyle and Condition Coaching – Engagement begins upon a two-way interaction (i.e., telephonic, email, secured messaging, virtual group coaching event etc.) with a member of the Lifestyle and Condition coaching team

Wellness Program Features	Fee	Fee Basis	Billing Methodology (Invoice or Wire)	Described in Question(s)?	Comments
					(i.e. Registered Dietician, Behavioral Health Specialist, Exercise Physiologist, Tobacco Cessation Specialist, Certified Wellness Coach, Registered Nurse, or Certified Diabetes Educator) during the calendar month.
Discount Gym Program	Included with the Aetna Health Your Way Elite Program.	Included in Administrative Fee.	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 1, 4, and 24.	
Wellness Mobile App	Included with the Aetna Health Your Way Elite Program.	Included in Administrative Fee.	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness #4.	
Other Fitness Reimbursement Program	\$0.60	PEPM	Invoice	Appendix C. Proposer Information C.2 Benefit Administration #5.	Optional service would be an increment to the fees.
EAP	Varies	PEPM	Invoice	Appendix C. Proposer Information C.4 Wellness #36.	See Aetna Resources for Living Document under Additional Aetna Programs.

E. Disease Management and Other Point Solution Programs

Disease Management / Point Solutions	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Wire)	Described in Question(s)?	Comments
Asthma	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness #7 and 11.	LCC Lifestyle and Condition Coaching – Engagement begins upon a two-way interaction (i.e., telephonic, email, secured messaging, virtual group coaching event etc.) with a member of the Lifestyle and Condition coaching team (i.e. Registered Dietician, Behavioral Health Specialist, Exercise Physiologist, Tobacco Cessation Specialist, Certified Wellness Coach, Registered Nurse, or Certified Diabetes Educator) during the calendar month.
Coronary Artery Disease	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness #7 and 11.	See above
Diabetes / Pre-Diabetes	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative	Appendix C. Proposer Information C.2 Benefit	See above

Disease Management / Point Solutions	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Wire)	Described in Question(s)?	Comments
				fee that is invoiced.	Administration #5 and C.4 Wellness # 11.	
Chronic Obstructive Pulmonary Disease (COPD)	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 11.	See above
Congestive Heart Failure	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 11.	See above
Dyslipidemia / Hyperlipidemia	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 11.	See above
Hypertension	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness #7.	See above
Tobacco Use	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 7 and 11.	See above
Weight Management	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 11.	See above

Disease Management / Point Solutions	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Wire)	Described in Question(s)?	Comments
Stress	\$4.60	PEPM	No – Selected as PEPM for 1/1/2026	Included in the administrative fee that is invoiced.	Appendix C. Proposer Information C.2 Benefit Administration #5 and C.4 Wellness # 11.	See above
Other :First Responders	\$0.65	PEPM	Yes	Invoice	Appendix C. Proposer Information E. Innovative Approaches # 13.	

F. Shared Savings Fees

Shared Savings Programs	Fee % or Fixed Fee Amount	Optional? (Y or N)	Billing Methodology (Invoice or Claims)	Maximum Charge per Incident	Estimate of Retained Savings PEPM
Subrogation and Contracted Services (Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits)	37.5%	No	Claims	N/A	These fees are primarily to support vendor costs and/or internal administrative costs of Aetna, or its affiliates associated with these programs. Estimate of total retained savings is \$4.00 PEPM.
Claim and Code Review Program	37.5%	No	Claims	N/A	These services may be performed by Aetna and or its affiliates and/or an external vendor. Estimate of total retained savings is \$9.00 PEPM.
National Advantage Program includes Facility Charge Review and Itemized Bill Review, and Data iSight	35%	No	Claims	Cap of \$50,000 Per Individual Claim	Estimate of total retained savings is \$1.48 PEPM.

G. Miscellaneous Other

Miscellaneous Other	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Claims)	Described in Question(s)?	Comments
MDLive or other Telehealth Program Program Name CVS Health Virtual Primary Care	\$1.65	PEPM	Yes – Selected for 1/1/2026	Wire	Appendix A. Scope of Services. C. Administration. #1. Appendix C. Proposer Information C1 - Network and Network Management #13 and C.2 Benefit Administration #5.	
No Surprise Act Administration	\$94	Per NSA Eligible Claim	No	Wire	Appendix C. Proposer Information C.3 Claims Processing #9.	The No Surprise Act IDR initial fee for arbitration as well as arbitration per case fees are set by law and pass through to the plan. The No Surprise Act per NSA Eligible Claim fee is \$94 and is subject to \$4 annual increases per each renewal year.
On-Site Kiosk	Health Plan Allowance can be utilized.	Vendor invoices are sent to Aetna.	Yes	Invoices are then applied towards the Health Plan Allowance.	Appendix C. Proposer Information E. Innovative Approaches # 8.	
Dependent Eligibility Audit (cost per audit)	Included in Administrative Fee.	Included in Administrative Fee	No	Invoice		

Miscellaneous Other	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Claims)	Described in Question(s)?	Comments
Ad-hoc Reporting	Will vary based on requested project.	Per Project Basis	Yes	Invoice or CWB	Appendix C. Proposer Information D. Member Services #15.	We anticipate the reporting package included in administrative fees will meet Miami Dade County Governments' needs.
Data Interface Fee Range – Any Carve-Out Vendors	If Pharmacy is not awarded. Importing 3 rd -party Pharmacy Data to support care management – Annual charge \$15,000. Integrating 3 rd -party Pharmacy data to support benefit accumulators \$0.60 PEPM. Integrating 3 rd -party pharmacy data to support benefit accumulators a one-time initial setup fee of \$5,000.	Fee basis will vary depending on service requested (Annual or PEPM)	Yes	Invoice		Increment to the medical administrative fee if pharmacy is carved out.
On-Site mobile mammogram van	The mammogram van services are paid via claims.	Claims	Yes	Wire	Appendix C. Proposer Information C.2 Benefit Administration #11.	
Other On-Site Services	Health Plan Allowance can be utilized.	Vendor invoices can be sent to Aetna	Yes	Invoices will be sent to Aetna to apply towards the	Appendix C. Proposer Information C.2 Benefit	Onsite services include, but are not limited to, blood pressure

Miscellaneous Other	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Claims)	Described in Question(s)?	Comments
				Health Plan Allowance.	Administration #5 and #11.	screenings, health education, massage therapy, financial wellness, fitness classes and healthy cooking demonstrations
On Spot Dermatology	Can be funded via claims.	Claims	Yes	Wire		
Third Party Vendor Interface	Third party vendor reporting charges are monthly universal claim file (initial set-up fee) \$500. The Monthly Universal Claim Annual Charge is \$6000. Monthly stop loss reports are an annual charge of \$6,000.	Fees	Yes	Invoice or Claim Wire Billed		First four (4) files included at no additional cost.
COBRA Administration – billing options other than PEPM	\$0.92	Fees	Yes	Invoice	2.0 Scope of Service 3. C. 16. Appendix C. Proposer Information C.2 Benefit Administration #6.	Refer to Appendix B.
Ad-Hoc Reporting	Will vary based on requested project.	Per Project Basis	Yes	Invoice or CWB	Appendix C. Proposer Information D. Member Services #15.	We anticipate the reporting package included in administrative fees will meet

Miscellaneous Other	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Claims)	Described in Question(s)?	Comments
						Miami Dade County Government's needs
Stop Loss for Gene Therapy Medications/Services	\$3.62- Approved and Pipeline and \$3.22- for approved only	PEPM	Yes	Invoice		Refer to Appendix B.
Stand-alone Gene Therapy Services	\$3.62- Approved and Pipeline and \$3.22- for approved only	PEPM	Yes	Invoice		Refer to Appendix B.
Surgical Carveouts Type of surgery :N/A	N/A	N/A	N/A	N/A	N/A	Surgical carveouts are not recommended due to separating surgical benefits from the main medical plan could disrupt care coordination and lead to inefficiencies and poorer health outcomes.
Enhanced customer service concierge models	We are committed to providing exceptional service to your members resulting in member calls and correspondence being onshore.	Included in administrative Fee.	No	Included in the administrative fee that is invoiced.		
Data Warehouse Fees	Monthly universal claim file (initial set-	Fees	Yes	Invoice or Wire		First four (4) files included at no

Miscellaneous Other	Fee	Fee Basis	Optional? (Y or N)	Billing Methodology (Invoice or Claims)	Described in Question(s)?	Comments
	up fee) \$500. The Monthly Universal Claim Annual Charge is \$6000.					additional cost.
Other: Accountable Care Organization	\$3.40	PEPM	Yes	Invoice	Appendix C. Proposer Information D. Member Services #11, E. Innovative Approaches # 15.	not available in South Florida as of 2025.
Other: Aetna Premier Care Network (APCN) concentric network	\$0.95	PEPM	Yes	Invoice		
Other: Aetna Premier Care Network (APCN) Plus Multi-tier	\$1.45	PEPM	Yes	Invoice		

H. Guarantees

Proposer should provide the attachment name for any guarantee included in the medical portion of the Proposal.

Guarantees	Attachment Name
Medical Trend	N/A
Medical Discount	Refer to Appendix B.
Provider Recruitment	Appendix E Medical Performance Guarantees.
Custom Network Development	We have entered into an agreement with UM to mirror your current custom network at a significant savings. We have developed a partnership with Jackson Health Systems to mirror your current JHS arrangement.
Other :N/A	Not Applicable

I. Staff Allowances

Staff Allowances	2026	2027	2028	2029	2030	Comments
Three on-site, full-time wellness/health coaches	\$1.62 PEPM	\$1.62 PEPM	\$1.62 PEPM	\$1.62 PEPM	\$1.62 PEPM	
One on-site, full-time dietician	\$0.50 PEPM	\$0.50 PEPM	\$0.50 PEPM	\$0.50 PEPM	\$0.50 PEPM	
One on-site, full-time fitness center manager	\$0.44 PEPM	\$0.44 PEPM	\$0.44 PEPM	\$0.44 PEPM	\$0.44 PEPM	

Staff Allowances	2026	2027	2028	2029	2030	Comments
One off-site, full-time wellness/health manager	\$0.51	\$0.51	\$0.51	\$0.51	\$0.51	
One on-site, full-time account manager	\$0.68 PEPM	\$0.68 PEPM	\$0.68 PEPM	\$0.68 PEPM	\$0.68 PEPM	
Four on-site, full-time customer service representatives and equipment	\$1.84 PEPM	\$1.84 PEPM	\$1.84 PEPM	\$1.84 PEPM	\$1.84 PEPM	
Other :Wellness Health Coach	\$0.51	\$0.51	\$0.51	\$0.51	\$0.51	
Customer Service Rep	\$0.44	\$0.44	\$0.44	\$0.44	\$0.44	

J. Fee Holidays and Allowances

Fee Holidays and Allowances	2026	2027	2028	2029	2030	Comments / Description
ASO Fee Holiday	\$1,000,000	\$1,000,000	N/A	N/A	N/A	
Implementation Credit	Health Plan Allowance \$2,150,000	N/A	N/A	N/A	N/A	Year 1 allowances include the ability to cover costs associated with implementation.
General Allowance	Health Plan Allowance \$2,150,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan includes Wellness, Implementation, Audits, Communication, Technology.
Wellness Allowance	Health Plan Allowance \$2,150,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan includes Wellness, Implementation, Audits, Communication, Technology.
Medical Audit	Health Plan Allowance \$2,150,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan includes Wellness, Implementation, Audits, Communication, Technology.
Pharmacy Audit						Refer to Appendix B.
Implementation Audit	Health Plan Allowance \$2,150,000	N/A	N/A	N/A	N/A	Year 1 allowances include the ability to cover costs associated with implementation.

Fee Holidays and Allowances	2026	2027	2028	2029	2030	Comments / Description
Communication Allowance	Health Plan Allowance \$2,150,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan Allowance \$1,950,000	Health Plan includes Wellness, Implementation, Audits, Communication, Technology.
Other :N/A	N/A	N/A	N/A	N/A	N/A	



An Aetna Proposal
Presented to

Miami Dade County Government

January 1, 2026

MDC079

Miami Dade County Government

Why Aetna?

Effective Date: January 01, 2026

We're more than products and programs. **We offer a health care experience that's more caring, more** connected and closer to home. With a holistic approach we join members on their personal health journey, removing barriers along the way. And we work proactively to help every member achieve their goals and stay on a path to better health.

Because you have unique needs we offer customized, tailored solutions. And we have a plan to take care of each of your employees, helping to increase engagement, improve outcomes and boost productivity.

We know health care can be overwhelming. So we work together with you to help make each member of your team a stronger individual. Stronger individuals lead to a stronger workforce. And when you have a stronger workforce, you can achieve stronger results.

You can learn more about Aetna here:

<https://www.aetna.com/about-us.html>

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

The Aetna companies include:

Aetna Health Inc., Aetna Health of California Inc., Aetna Health of the Carolinas Inc., Aetna Health of Washington Inc., Aetna Health Insurance Company of Connecticut, Aetna Health Insurance Company of New York, Corporate Health Insurance Company; Aetna Life Insurance Company; Aetna Dental Inc.; and/or Aetna Dental of California Inc.; Aetna Health of Utah Inc.

Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Managed care plans may not cover all health care expenses. Contracts should be read carefully to determine which health care services are covered. While this material is believed to be accurate as of the print date, it is subject to change. For more specific information about the coverage details, including limitations, exclusions, and other plan requirements, please contact an Aetna representative.

Aetna has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which Aetna has made to your producer, or other material relationships your producer may have with Aetna, you may contact your producer or your Aetna account representative. Information regarding Aetna's program compensating producers is also www.aetna.com

The information contained in this proposal is confidential and should not be shared with anyone other than your broker or benefit plan consultant.

Miami Dade County Government

Contact Information/Assumptions

Account Executive:	Renthia Jackson	SIC Code: 9199
Email:	rxjackson@aetna.com	Mem/EE Ratio: 1.76
Telephone:	954-375-1577	

Administrative Service Fees Effective Date: January 01, 2026 End Date: December 31, 2026

	Year 1	Year 2	Year 3
Guarantee Period Effective Date	January 01, 2026	January 01, 2027	January 01, 2028
Fee Basis	Mature	Mature	Mature

Medical Fees as Billed (PEPM)*	Estimated Enrollment	Year 1	Year 2	Year 3
Open Access Aetna Select	26,820	\$32.89	\$32.89	\$32.89
Choice POS II	1,158	\$32.89	\$32.89	\$32.89
MDCR Direct Indemnity (COB Plan)	485	\$32.89	\$32.89	\$32.89
Illustrative Composite Service Fees (PEPM)	28,463	\$32.89	\$32.89	\$32.89
Plan Year Service Fees	28,463	\$11,233,777	\$11,233,777	\$11,233,777

Service Fee Summary (Plan Year)	Year 1	Year 2	Year 3
Administrative Service Fees	\$11,233,777	\$11,233,777	\$11,233,777
Service Fee Guarantee % Change*		0.0%	0.0%
Fee Credit*	(\$1,000,000)	(\$1,000,000)	\$0
Illustrative Composite Total Fees (incl Discounts, Credits, Broker Comp, Other Chrgs) (PEPM)	\$32.89	\$32.89	\$32.89
Total Fees (incl Discounts, Credits, Broker Comp, Other Chrgs)	\$10,233,777	\$10,233,777	\$11,233,777

Additional Service Fee Guarantee* (Excludes Other Charges)	Composite Fee	% Change
Year 4 of 5 (January 01, 2029) Mature	\$34.21	4.0%
Year 5 of 5 (January 01, 2030) Mature	\$35.57	4.0%

*Clarifications

- PEPM is defined as Per Employee Per Month
- Please see Programs and Services for additional information. Some services may come at additional cost to the fees shown above.
- Broker Compensation, is not applicable, and subject to customer approval.

Service Fee Guarantee

Our offer includes a service fee guarantee for the guarantee period January 01, 2026 to December 31, 2030. The guaranteed service fees excluding broker compensation are listed above. The service fee guarantee is subject to the terms and conditions as stated in the caveats and is contingent upon the customer maintaining all lines of business with Aetna.

Fee Credit

We have included an administrative service fee credit. You agree to pay us the total amount of the fee credit issued if you terminate your medical plan(s) or any of the additional product(s) quoted (if applicable) prior to the end of the multi-year Guarantee Period. Refer to your fee credit letter for specific details.

This document is not intended to supercede any contractual provisions or scope of services Aetna has agreed upon in our response to this RFP. If any conflicts arise MDCG documents take precedence. The RFP response documents provided had limited space, therefore this document was created.

Miami Dade County Government

Administrative Fee Credit Letter

Effective Date: January 1, 2026

We are offering you a fee credit which will save you \$2,000,000.

We are offering you an administrative fee credit as shown in the chart below.

Administrative Fee Credit	Year 1	Year 2
Plan Year Effective Date	01/01/2026	01/01/2027
Fee Credit	\$1,000,000	\$1,000,000

The fee credit will be subject to the following provisions:

- Our self-funded medical Agreement will remain in effect for the duration of the Guarantee Period.
- You are required to make the medical fee payments in accordance with your Agreement.
- Standard termination provisions apply.
- All of the plan caveats as stated on the Caveats page in the final proposal are met.
- Any producer compensations will be excluded from the medical fee credit.
- Future renewals will be calculated based on the annualized medical fees before giving any effect to the
- Contingent upon Aetna being the sole provider for all quoted lines of coverage.

You agree to pay us the total amount of the fee credit issued for the multi-year Guarantee Period within 31 days of notice of non-compliance if any of the following occur:

- Any of the above provisions are not met
- You terminate the Agreement prior to the end of the multi-year Guarantee Period

The fees shown on the accompanying Fee Schedule will be billed every month of the Guarantee Period. The fee credit will be shown as a separate line item. When you accept our quote, the Fee Schedule will become part of your Agreement with us.

You may wish to consult with your legal advisors about any changes that you may need to make in the administration of your plan as a result of this credit consistent with your fiduciary obligations such as making adjustments to participant contributions.

Miami Dade County Government

Programs and Services – Self-Funded

Effective Date: January 01, 2026

Program Summary	Open Access Aetna Select	Choice POS II	MDCR Direct Indemnity (COB plan)
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Programs & Services Included in the Service Fee

Mature Base Service Fee	\$32.89	\$32.89	\$32.89
General Administration			
Experienced Account Management Team	Included	Included	Included
Designated Implementation Manager	Included	Included	Included
Designated billing, eligibility, plan set up, underwriting	Included	Included	Included
Onsite Open Enrollment Meeting Preparation	Included	Included	Included
Open Enrollment Marketing Material (non-customized)	Included	Included	Included
ID Cards*	Included	Included	Included
Review or draft plan documents	Included	Included	Included
Summary of Benefits and Coverage (SBC)	Included	Included	Included
Claim Fiduciary Option 1	Included	Included	Included
External Review	Included	Included	Included
Non-ERISA	Included	Included	Included
Claim Administration	Included	Included	Included
Alternate Banking Arrangement- Wednesday Weekly ACH (funds requested Wednesday, paid Thursday)	Included	Included	Included
Plan Sponsor Liaison	Included	Included	Included
Special Investigations / Zero Tolerance Fraud Unit	Included	Included	Included
Plan Sponsor-specific surveys	Included	Included	Included
Aetna Personal Health Solutions Platform	Included	Included	N/A
MDCG Annual Survey	Included	Included	Included
Network Services			
Full National Reciprocity*	Included	Included	N/A
Custom Network - Medium (300 - 499 providers)	Included	Included	N/A
Institutes of Excellence™ *	Included	Included	Included
Institutes of Quality® (IOQ) Network	Included	Included	N/A
No Cost/Low Cost Designated Walk In Clinic (MinuteClinic®)*	Included	Included	N/A
Gene-Based, Cellular and other Innovative Therapies (GCIT®) network	Included	Included	N/A
National Medical Excellence Program®	Included	Included	Included
Network access	Included	Included	N/A
Care Management			
Aetna Compassionate Care SM	Included	Included	Included
Aetna One® Essentials	Included	Included	Not Included
Aetna Advice	Included	Included	Not Included
Preventive Care Considerations (Electronic)	Included	Included	Included
Utilization Management (Inpatient Precertification, Concurrent Review, Discharge Planning, Retrospective Review)	Included	Included	Included

Miami Dade County Government

Programs and Services – Self-Funded

Effective Date: January 01, 2026

Program Summary	Open Access Aetna Select	Choice POS II	MDCR Direct Indemnity (COB plan)
Member Resources			
Designated Service Center	Included	Included	Included
Aetna Concierge (includes First Impression Treatment)	Included	Included	Included
24/7 After-Hours Support	Included	Included	Not Included
CVS extracare+™ membership program	Included	Included	N/A
Member Website and Mobile Experience	Included	Included	Included
MindCheck SM	Included	Included	Included
Online Programs	Included	Included	Included
Wellness			
24-Hour Nurse Line: 1-800# Only	Included	Included	Included
Aetna Health Your Way™ Health Assessment and Digital Support	Included	Included	Included
Aetna Health Your Way™ Elite	Included	Included	N/A
LCC Lifestyle and Condition Coaching*	Included	Included	N/A
Allowances			
Health Plan Allowance- \$2,150,000 Year 1 Only, \$1,950,000 Ongoing (implementation, wellness, communication, tech, meal plan, and audit expenses)	Included	Included	Included
Reporting and Integration			
Analytic Consultation from Plan Sponsor Insights (350 Hours)	Included	Included	Included
Clinical Consultation from Plan Sponsor Insights (240 Hours)	Included	Included	Included
ART Reports - New analytic reporting platform	Included	Included	Included
Aetna Health Information Advantage™ (AHIA)	Included	Included	Included
Monthly Financial Claim Detail Reports	Included	Included	Included
Monthly Banking Reports	Included	Included	Included
Behavioral Health			
Managed Behavioral Health	Included	Included	Indemnity Network Applies
Behavioral Health Condition Management Program - Standard	Included	Included	
Applied Behavior Analysis (ABA)	Included	Included	
AbleTo Network - member cost share may apply	Included	Included	
Medical Pharmacy			
Medical Pharmacy Rebate Share 100%	Included	Included	Included
Medical Pharmacy Program Administration	Included	Included	Included

Miami Dade County Government

Programs and Services – Self-Funded

Effective Date: January 01, 2026

Program Summary	Open Access Aetna Select	Choice POS II	MDCR Direct Indemnity (COB plan)
Dedicated Resources			
One (1) Account Manager	Included	Included	Included
Four (4) Customer Service Reps	Included	Included	Included
Three (3) Wellness Health Coach	Included	Included	Included
One (1) Health Coach Dietitian	Included	Included	Included
One (1) Fitness Center Manager	Included	Included	Included
One (1) Offsite Dedicated Wellness Health Coach Manager	Included	Included	Included
One (1) Wellness Health Coach	Included	Included	Included
One (1) Customer Service Rep	Included	Included	Included
Aetna Discount Program			
at home products, fitness, hearing, LifeMart® shopping website, natural products and services, oral health care, vision, weight	Included	Included	Included
Total Fees			
	\$32.89	\$32.89	\$32.89
Additional Available Programs & Services (per employee, per month unless otherwise noted)			
Care Management			
Aetna Enhanced Maternity Program	\$0.75	Not Included	N/A
Wellness			
First Responder Peer Support Program*	\$0.65	\$0.65	N/A
Reporting and Integration			
Other Reporting and Integration			
Annual 3rd Party Stop Loss Vendor Reports (12 total reports)	\$6,000	\$6,000	\$6,000
Pharmacy Integration Services (if not provided by Aetna)			
Importing 3rd-party Pharmacy data to support care management programs – Annual Charge	\$15,000		Not Included
Integrating 3rd-party Pharmacy data to support benefit accumulators (Ongoing) PEPM	\$0.60	\$0.60	Not Included
Integrating 3rd-party Pharmacy data to support benefit accumulators (Initial Setup fee)	\$5,000		Not Included
Behavioral Health Integration Services (if not provided by Aetna)			
Integrating 3rd-party Behavioral Health data to support benefit accumulators (Ongoing) PEPM	\$0.05	\$0.05	Not Included
Integrating 3rd-party Behavioral Health data to support benefit accumulators (Initial Setup fee)	\$5,000	\$5,000	Not Included

Miami Dade County Government

Programs and Services – Self-Funded

Effective Date: January 01, 2026

Program Summary	Open Access Aetna Select	Choice POS II	MDCR Direct Indemnity (COB plan)
Custom Medical Programs			
Aetna Custom Connections- Enhanced (PEPM)	\$0.60	\$0.60	Not Included
Smart Shopper (PEPM)	\$2.00	\$2.00	Not Included
Programs & Services Included in the Claim Wire*			
No Surprises Act - Fees*			
No Surprises Act (NSA) claim administration fee (per NSA eligible claim)	\$94	\$94	\$94
No Surprises Act (NSA) Independent Dispute Resolution (IDR) initial fee (per arbitration case)	Applicable fees are as set by law and passed through to the plan	Applicable fees are as set by law and passed through to the plan	Applicable fees are as set by law and passed through to the plan
No Surprises Act (NSA) Independent Dispute Resolution (IDR) arbitration expenses (per arbitration case)	Applicable fees are as set by law and passed through to the plan	Applicable fees are as set by law and passed through to the plan	Applicable fees are as set by law and passed through to the plan
Network Services			
CVS Health Virtual Care™ (PEPM) *	\$0.65	\$0.65	N/A
CVS Health Virtual Primary Care™ (PEPM) *	\$1.00	\$1.00	N/A
Subrogation*	37.5% of savings	37.5% of savings	37.5% of savings
Contracted Services* (Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits)	37.5% of savings	37.5% of savings	37.5% of savings
Claim and Code Review Program*	37.5% of savings	37.5% of savings	37.5% of savings
National Advantage™ Program (NAP)*	We will retain 35% of savings (includes FCR, IBR, DiS)	We will retain 35% of savings (includes FCR, IBR)	We will retain 35% of savings (includes FCR, IBR)
National Advantage™ Program Cap (includes Facility Charge Review, Itemized Bill Review, and Data iSight™ when applicable)	Cap of \$50,000 per individual claim	Cap of \$50,000 per individual claim	Cap of \$50,000 per individual claim
Enhanced Clinical Review Program – High Tech Imaging (PMPM)*	\$0.35	\$0.35	N/A

Miami Dade County Government

Programs and Services – Self-Funded

Effective Date: January 01, 2026

Program Summary	Open Access Aetna Select	Choice POS II	MDCR Direct Indemnity (COB plan)
Enhanced Clinical Review Program – Diagnostic Cardiac (PMPM)*	\$0.10	\$0.10	N/A
Enhanced Clinical Review Program – Sleep Management (PMPM)*	\$0.05	\$0.05	N/A
Enhanced Clinical Review Program – Cardiac Implantable Devices (PMPM)*	\$0.05	\$0.05	N/A
Enhanced Clinical Review Program – Interventional Pain (PMPM)*	\$0.10	\$0.10	N/A
Enhanced Clinical Review Program – Hip and Knee Arthroplasties (PMPM)*	\$0.05	\$0.05	N/A
Enhanced Clinical Review Program – SmartChoice (PMPM)*	\$0.10	\$0.10	N/A
Additional Available Programs & Services Included in the Claim Wire*			
Care Management			
Transform Diabetes Care® 2.0 (per diabetic, per month)*	\$14.15	\$14.15	N/A
Transform Oncology (per engaged member, per month)*	\$79	\$79	N/A
Member Resources			
Aetna Second Opinion powered by 2nd.MD (charges are billed quarterly)	One-time \$1.00 per member activation fee; \$2,500 per consult	One-time \$1.00 per member activation fee; \$2,500 per consult	Not Included
Aetna Back and Joint Care™† Chronic	\$995 per engaged member, per year (PEMPY)	\$995 per engaged member, per year (PEMPY)	Not Included
Aetna Back and Joint Care™† Accute	\$250 per engaged member	\$250 per engaged member	Not Included
Maven Maternity Foundation (per case, per 12-month period) - billed quarterly*	\$950.00	\$950.00	Not Included
Maven End to End Maternity (per case, 21 Month program) - billed quarterly*	\$1,300.00	\$1,300.00	Not Included

Additional Program Details*Claim Wire Billing, ID Cards, Subrogation, Contracted Services, Claim and Code Review**

Details can be found in our UW Disclosure document located at the following URL:

<https://www.aetna.com/content/dam/aetna/pdfs/aetna.com/legal-notice/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-05-01-2024.pdf>

No Surprises Act - Fees

The NSA claim administration fee will increase at each annual renewal and apply to NSA eligible claims paid on or after that renewal date. Refer to the NSA Payment Practices in our Caveats for information on our payment practices for NSA eligible claims.

No Surprises Act - IDR Fees

IDR fees are required by the NSA rules and are payable to the IDR entity. There is an initial fee to begin an arbitration, which applies to each case. There is also an additional fee for the arbitration expenses; the losing party within the dispute is liable for this fee. For batch cases, the NSA permits IDR entities to charge a different arbitration fee based on a set fee range and/or percentage of the batch fee. The fees are passed through (with no mark up by Aetna) to a customer based on the number of line items for their plan that were included in the batch case. The current NSA fees are set by federal agencies. Both the initial fee and the arbitration expense fee are subject to future adjustments by the agencies (and any such adjustments shall be applied to your plan).

CVS Health Virtual Care™

In addition to the administrative fees as outlined above, there is a per consultation charge which will be shared by the member and plan sponsor based on type of service provided and member's benefit plan. Specific charges are available upon request.

CVS Health Virtual Primary Care™ (CVSH VPC)

CVSH VPC requires CVS Health Virtual Care™. CVSH VPC is not available on gated plans (plans requiring a primary care physician referral.) CVSH VPC cannot be offered with some narrow network arrangements. Specific exclusions are available upon request.

Enhanced Clinical Review

This fee will only be charged based upon those members who fall into service areas where the program is available.

First Responder Peer Support Program

First Responder Peer Support program fee assumes 2547 First Responders. We may adjust the program fee if the actual First Responder enrollment varies by more than 10 percent.

Full National Reciprocity

Excludes some standalone Aetna Whole Health networks. Details are available upon request.

Institutes of Excellence™ (IOE)

This program includes a steerage component by educating members on the benefits of using an IOE designated facility. However, benefit differential steerage is not supported for IOE Infertility network.

LCC Lifestyle and Condition Coaching

LCC requires the purchase of Aetna Health Your Way™ Elite or Member Engagement Platform.

Engagement includes a two-way interaction (i.e. telephonic, email, secured messaging, virtual group coaching event, etc.) with a member of the Lifestyle and Condition Coaching team (i.e. Registered Dietician, Behavioral Health Specialist, Exercise Physiologist, Tobacco Cessation Specialist, Certified Wellness Coach, Registered Nurse, or Certified Diabetes Educator) during a calendar month.

Medical specialty pharmacy rebate share

We agree to share 100% of the medical specialty rebates generated under your medical program.

National Advantage™ Program (including the Contracted Rates, Facility Charge Review and Itemized Bill Review Components)

NAP includes a Contracted Rates component and two optional components: Facility Charge Review (FCR) and Itemized Bill Review (IBR). In addition, some plans also elect DataSight (DiS) as their out-of-network plan rate for professional services. NAP's Contracted Rates component offers access to contracted rates for many medical claims from non-network providers (including claims for emergency services and claims by hospital-based specialists such as anesthesiologists and radiologists who do not contract with insurers) and ad hoc negotiations (when a contracted rate is not available). We retain a percentage of savings achieved through NAP, including savings achieved through FCR, IBR, and DiS, if elected. This NAP Fee is in addition to the per employee, per month administrative service fees.

No Cost/Low Cost Designated Walk In Clinic (MinuteClinic®)

Access to no/low cost MinuteClinic is included, where available. A list of included networks will be provided upon request.

Transform Diabetes Care® 2.0

Members are identified for the program based on diabetes diagnosis codes and at least one other identifier which corroborates diabetes. Additional identifiers may include but are not limited to pharmacy claims for antidiabetic medication, and/or laboratory test results.

Transform Oncology

Engagement begins upon the second two-way call with a Personal Navigator, regardless of timeframe. After one month without a two-way call with a Personal Navigator a member is no longer considered engaged. Reengagement occurs after the first two-way call with a Personal Navigator for a member that was previously engaged. The minimum duration for engagement-based billing is 2 months.

Maven Maternity Foundation

Maven Maternity requires Aetna Enhanced Maternity Program.

Aetna Back and Joint Care™

Includes Aetna predictive analytics and care management coordination and digital MSK therapy programs from Hinge Health.

For any single engaged member, the maximum fee per year is \$995, regardless of how many programs the member has engaged in.

For Chronic Care - The fee associated with an enrolled member in the Chronic program and their Cohort will be paid in accordance with the 3 milestones for member engagement and pain reduction noted below. "Cohort" means all enrolled members under your plan who sign up for the program within any given month.

Milestone Payments

Milestone 1: A member enrolls in the program, receives the kit, and completes at least 1 exercise therapy session with a Hinge Health coach.

Milestone 2: Cohort completes at least 4 exercise therapy sessions within the first 30 days of enrolling in the program and such Cohort achieves at least a 20 percent reduction in pain.

Milestone 3: Cohort completes at least 8 exercise therapy sessions within the first 60 days of enrolling in the program and such Cohort achieves at least a 30 percent reduction in pain.

With respect to each member enrolled in the program, the Milestone 1 payment of \$331 is due once the member achieves Milestone 1; the Milestone 2 payment of \$332 is due when the member's Cohort achieves Milestone 2; and the Milestone 3 payment of \$332 is due when such Cohort achieves

Milestone 3. If the applicable Cohort does not achieve Milestone 2 or Milestone 3 then payment for such Milestone is not due.

For Acute Care - The fee associated with an enrolled member in the Acute program is \$250 per year. This fee is not subject to Milestone payments.

For Prevention - There is no fee associated with enrolled members in the Prevention Program.

Aetna Personal Health Solutions

In addition to the administrative fee for Aetna Personal Health Solutions included above, there are additional costs billed through the claim wire based on program participation and will vary based on condition severity and member participation, estimated at \$400 per engaged member per program per year.

Miami Dade County Government

Allowances - Self-Funded

Effective Date: January 01, 2026

We are including allowance(s) for your Aetna plans applicable to each year of the Guarantee Period as outlined in the chart below. Allowance dollars must be used for your commercial Aetna medical plans and Aetna medical members.

Annual Allowance Type	Year 1	Year 2	Year 3	Year 4	Year 5
Plan Year Effective Date	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Health Plan	\$2,150,000	\$1,950,000	\$1,950,000	\$1,950,000	\$1,950,000
Total	\$2,150,000	\$1,950,000	\$1,950,000	\$1,950,000	\$1,950,000

Health Plan Allowance

- The **Health Plan allowance** can be used to offset reasonable documented expenses applicable to the Guarantee Period(s) for which it is offered. Your allowance can be used for implementation, communication, reporting, and audit associated with your Aetna Medical plan. Examples of reimbursable expenses include:
 - implementing your contract with us
 - promoting our products, programs or services, such as, educational content and materials for enrollees or prospective enrollees
 - Aetna required technology platforms or our system front-end charges to support our plans
 - communicating with our members
 - auditing our readiness
 - recurring or ad hoc reporting with us
 - reporting costs to integrate our data with third-party vendors.
- Your allowance can also be used to offset reasonable documented wellness-related programs or activities incurred during the Guarantee Period for which the allowance is offered. Wellness allowance expenses must be for wellness-related programs or activities that are reasonably designed to promote the health and well-being of Aetna members, or to educate Aetna members about healthy lifestyles and/or prevent disease. This means that there must be a connection to the health and well-being of the members, with a focus on preventative measures or healthy living (i.e., diet, exercise), not on acute care. Wellness programs and activities funded by allowance funds are not covered benefits under your Aetna plan.
- Claims audit expenses must be incurred during the Guarantee Period for which the allowance is offered.
- Should you terminate your contract with us, the allowance cannot be used to fund implementation/communication expenses related to the new carrier's contract.
- Any expenses associated with the implementation, administration or communication of another carrier's plans, programs or services are also ineligible.
- Aetna has agreed to allow roll-over for any remaining balance of the \$1,250,000 designated for the County's wellness allowance.

The above referenced fund(s) will be available after the effective date of each plan year. Only those expenses performed and billed by a third party are payable. Reimbursement for time and materials incurred directly by the plan sponsor (e.g., hours worked by the plan sponsor's own employees) are not eligible. Your normal business operation expenses, including employee salaries and overtime, are not eligible under the allowance. Our preferred method of payment is directly to the third-party vendor. We require submission of appropriate documentation detailing charges for the services provided by the vendor. Acceptable documentation includes, but is not limited to, detailed vendor invoices itemizing services provided, specific cost-elements and associated line-item charges.

On an exception basis, we can reimburse you directly provided you submit both the detailed invoice and receipt showing payment to the third-party vendor.

You should submit documentation within 60 days of the invoice date. We must receive all documentation no later than 60 days following the close of the plan year to be considered for reimbursement.

The allowance amounts indicated above for the following Allowance Type(s) are available for the years indicated in the chart. Any unused amounts from a plan year can be rolled over for use in the following plan year. The amount(s) rolled over in any year cannot exceed the original allowance amount for that plan year. Unused amounts remaining at the end of the multi-year Guarantee Period will be forfeited. If you have elected to offer wellness incentives through a product reward site, unredeemed vouchers are forfeited at the end of each plan year.

- Health Plan

We assume the funding of any allowance dollars is either at the request of your Plan Administrator acting in its fiduciary capacity or for the exclusive benefit of your Plan. You are responsible for determining that your use of allowance dollars is appropriate and legally compliant. With respect to allowance dollars that are used in connection with a wellness program, you are responsible for ensuring that the program and any incentives/rewards comply with applicable laws, including limitations on maximum allowable incentives/rewards. We will pay any allowances in accordance with applicable law. We suggest you seek appropriate accounting and legal counsel for all payments to ensure they comply with applicable accounting principles and laws.

If you terminate your medical plan with us in whole or in part (defined as a 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year Guarantee Period, you'll be responsible for remitting payment for any allowance amounts used. Payment is due to us within 31 days of the invoice.

Miami Dade County Government

Caveats - Self-Funded

Effective Date: January 01, 2026

For the purposes of this document, Aetna may be referred to using "we", "our" or "us" and Miami Dade County Government may be referred to using "you" or "your".

If fees are adjusted, the caveats below will apply and be based on the new assumptions.

Underwriting Caveats

Your pricing considers all the products, programs and services you have with us and will be in effect for the full 12 months of the plan year. Pricing for some programs and services are amortized over a 12-month period. Therefore, fees will not be reduced if termination occurs prior to the end of the plan year. We also assume the proposal assumptions below remain consistent throughout the plan year. We require notice to properly terminate before the plan year ends in accordance with the Termination provision in your Agreement. Otherwise, you may be charged for the cost until that notice is met.

During the Guarantee Period we may adjust your Guaranteed Fees if:

Quoted Benefits and Administration

A material change is initiated by you or by legislative or regulatory action which materially affects the cost of the plan. This includes, but is not limited to, changes impacting standard contract provisions, claim settlement practices, plan administration, plan benefits or changes to the programs and services we offer you.

National Advantage™ Program

You change or terminate the National Advantage™ Program (NAP), Facility Charge Review (FCR), Itemized Bill Review (IBR), or Data iSight™ (DiS) programs.

Multi-Year Provision

You place the products, programs and services included in this multi-year fee guarantee out to bid with an effective date prior to December 31, 2030, then this guarantee is no longer valid.

Total Replacement

Any of the quoted lines of coverage are offered with an additional carrier.

We're relying on information from you and your representatives in establishing the fees and terms of this proposal. If any of this information is inaccurate and has an impact on the cost of the programs, we reserve the right to adjust our fees and terms upon the receipt of corrected information.

Assumptions

Underwriting

Agreement Provisions

Our quotation assumes our standard Agreement provisions and claim settlement practices apply unless otherwise stated, in MDCG contract, scope of services, RFP and addendums.

Plan Design

This proposal is based on the current benefit plan designs, plus any noted deviations, subject to the terms of our Benefit Review document.

Claim Fiduciary - Option 1

Our proposal assumes we've been delegated claim fiduciary responsibilities. As claim fiduciary, we'll be responsible for final claim determination and the legal defense of disputed benefit payments. Our appeal administrative services are automatically included when we've been delegated claim fiduciary responsibilities.

External Review

We've included external review in our proposal. External review uses outside vendors who coordinate medical review through their network of outside physician reviewers.

Non-ERISA

For non-ERISA plan, the risk and responsibilities are different from those under ERISA plans, since the ERISA preemption and ERISA standard of performance do not apply. Our charge for non-ERISA plans must account for the additional liability risk as compared to known risks under an ERISA plan.

Member Communications

Pricing assumptions include direct communications access to Aetna membership through both ongoing Aetna Health communications and relevant ongoing included product/program specific communications. These communications can reduce member and plan costs by guiding in care navigation, managing chronic conditions, promoting preventive services, and more.

Wellness Incentives and Rewards

We offer several different wellness incentives and rewards programs that you may choose from to offer to your members. We, or our third-party vendors, will administer and distribute to your members any wellness incentives or rewards earned based on the programs selected under the direction and control of your plan. The wellness incentives and rewards earned through these programs may be taxable for your members. We will provide you with reporting which will identify members who have earned such wellness incentives or rewards. These reports will provide the data needed for any tax information reporting requirements that you determine are necessary.

With regard to these wellness incentives and rewards, you, as the Plan Sponsor have the following responsibilities:

- Ensure any incentives or rewards offered to your members comply with applicable law and any limitations imposed thereunder. This includes but is not limited to, the Health Insurance Portability Act (HIPAA), the Americans With Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).
- Distribute notices and/or obtain any authorizations required by law.
- Comply with all tax information reporting requirements regarding any wellness incentives or rewards earned through these programs (cash, cash equivalent, or other tangible property) and provided by us or our third-party vendor to your members.
- Assume any and all liability for your noncompliance with any tax withholding or information reporting requirements.

You may wish to consult with your legal counsel or other advisors as to the proper tax treatment of such wellness incentives or rewards and to ensure that the incentives or rewards offered under your program comply with applicable law.

Third-Party Audits

We don't typically charge to recoup internal costs associated with a third-party audit. We reserve the right to recover these expenses if significant time and materials are required.

Mental Health/Substance Abuse Benefits

Our quotation assumes that mental health/substance abuse benefits are included.

Prescription Drug Benefits

Our quotation assumes that prescription drug benefits are included and will be provided by Aetna.

You may also be subject to additional charges to integrate data with external Pharmacy vendors. Refer to the reporting charges outlined in the Programs and Services exhibit for more information.

Stop Loss Reporting

Our quotation assumes stop loss coverage is not provided by Aetna and reporting to an external vendor is excluded.

- The cost for 12 annual reports is not included in your PEPM fees and is displayed on the Programs & Services exhibit.

Medical Pharmacy Rebates

As requested, we will share 100 percent of the medical pharmacy rebates generated under your medical program.

If you terminate your medical plans with us prior to the end of the multi-year Guarantee Period, we shall retain any earned but unpaid Medical pharmacy rebates as of the early termination date.

Additional Products, Programs and Services

Costs for special services rendered that are not included or assumed in the pricing guarantee will be billed through the claim wire, on a single claim account, when applicable, to separately identify charges. Additional charges that are not collected through the claim wire during the year will either be direct-billed or reconciled in conjunction with the year-end accounting and may result in an adjustment to the final administration charge. For example, you will be subject to additional charges for customized communication materials, as well as costs associated with custom reporting, booklet and SPD printing, etc. The costs for these types of services will depend upon the actual services performed and will be determined at the time the service is requested.

Billing Information

Advanced Notification of Fee Change

We'll notify you of any off-anniversary fee change within 31 days of the fee change.

Late Payment

We reserve the right to assess a late payment charge at a 12 percent annual interest rate as follows:

- if you fail to pay plan benefit payments the same day of the request.
- if you fail to pay administrative service fees within the agreed upon extended grace period of 90 days.

We'll notify you of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to us under the Agreement or at law or in equity for failure to pay.

Incurred late wire interest charges will be added to a future wire request and collected through your claim wire billing account. Incurred late fee payment interest charges will be collected through the year-end accounting process.

We reserve the right to change the extended period for paying Service Fees at any time. We'll provide you with 30 days written prior notice in the event we decide to change the arrangement. Any Service Fees due after the end of the 30-day notice period will be subject to the new arrangement. We reserve all rights to enforce Agreement remedies as to any Service Fees overdue.

Claim and Member Services

Run-In Claim Processing

Our proposal excludes run-in claim processing from the prior carrier (claims incurred before the effective date of the plan).

Runoff Claims Processing

Your administrative service fees are mature. The expenses associated with processing runoff claims following termination are covered for one year.

Medical Service Center

We've assumed that claim administration and member services for the quoted plans will be managed centrally by the Tampa Service Center. Members will be able to reach the Member Service representatives Monday through Friday, from 8 a.m. to 6 p.m., local time (based on where the member resides).

For members calling after-hours, calls are handled by an offshore team of customer service representatives.

Summary Plan Description (SPD) Modification

We've assumed that the standard SPD language will be used and any customization may require an additional cost. The healthplan allowance can be used for any communication cost. Our standard brochures are included.

Reporting and Data Transfer

Aetna Intellectual Property

Under the Agreement, you may have access to certain of Aetna's Plan Sponsor reporting systems. Aetna represents that it has either the ownership rights or the right to use all of the intellectual property used by Aetna in providing the Services under the Agreement ("Aetna IP"). Aetna will grant you, as the Plan Sponsor, a nonexclusive, non-assignable, royalty free, limited right to use certain of the Aetna IP for the purposes described in the Agreement. You agree not to modify, create derivative product from, copy, duplicate, decompile, disassemble, reverse engineer or otherwise attempt to perceive the source code from which any software component of the Aetna IP is compiled or interpreted. Nothing in the Agreement shall be deemed to grant any additional ownership rights in, or any right to assign, sublicense, sell, resell, lease, rent, or otherwise transfer or convey, the Aetna IP to you.

Claims History Transfer

These files are used to administer deductible and internal maximums. There is no cost associated with receiving claim history files electronically from the prior carrier for initial implementation. There is a charge for files received in a format other than electronically; costs are based on the complexity and format of the data.

Data Integration (Historical)

Our proposal assumes one historical medical and one historical pharmacy data integration feed. Additional fees will apply if feeds from more than one historical vendor are required.

Data Integration (Ongoing)

Options and pricing for integrating claims data from an external vendor into one or more of our systems will vary depending on the scale of your integration needs.

Data Transfer at Termination

Upon Agreement termination, we agree to cooperate with succeeding administrators in producing and transferring required claim and enrollment data. Data will be transferred within 30 days after determination of specific format and content requirements, subject to a charge that is based on direct labor cost and data processing time.

Banking

We've assumed that you provide funds through a bank initiated Fedwire wire transfer for drafts issued under the self-funded arrangement assumed in this proposal. All claims paid must be on Aetna check stock.

Our standard banking arrangement is to request funds when claims have accumulated to more than \$20,000. In this arrangement, a wire request is sent to you and/or your bank requesting funds for the total claims from the previous day(s). For most customers, this would mean daily claim wire transfers. In place of this arrangement, we'll request funds for claims weekly on Wednesday ACH (funds requested Wednesday, paid Thursday). In addition, there will be a month end close out request on the first banking day of each subsequent month. We've included an estimated cost for this service in your Guaranteed Fees. During the year-end reconciliation, we'll calculate the actual cost and refund or collect the difference.

The proposed banking arrangement is subject to change based on results of a credit risk evaluation. We will complete an evaluation upon notification of sale.

We've assumed you'll use no more than three primary banking lines which are shared across all self-funded products, excluding Flexible Spending Account (FSAs). Additional wire lines and customized banking arrangements will result in an adjustment to the proposed pricing.

Network Services

Custom Network

We've quoted a Custom Network in order to support your specific needs. A Custom Network can include, but is not limited to:

- Providers that we add to our standard network at your request
- Providers that you add through a third-party network to our standard network
- You negotiate a different reimbursement contract with providers

A Custom Network may assume:

- You designate certain providers, either added to or already in our standard network, for purposes of benefit level
- You incent members, through plan design steerage, to use the designated hospital(s) and affiliated physician(s) for their care

Typically, this plan design provides for two in-network benefit levels where a higher reimbursement level is associated with a set of providers designated by you. The Custom Network with the corresponding incentives through plan design steerage is an Integrated Delivery System.

Our quoted fees include the cost for establishing and maintaining your Custom Network. Our charge is partially based on the actual number of physicians and hospitals in the Custom Network. For purposes of our quote, we assume that your Custom Network has 300 to 500 hospitals/physicians. Our charge may change if the number of physicians and hospitals differs from our assumption.

If your Custom Network includes adding providers not currently in our network ("customer-specific provider"), we assume these customer-specific providers will be in addition to our standard network.

Our pricing for administration of claims associated with the customer-specific providers assumes that we'll receive this data in one electronic file in our standard layout from one administrator. If the information required for automated claims adjudication:

- is not provided by your vendor, or
- more than one electronic file is provided, or
- the files come from more than one administrator,

we may charge additional amounts. If we don't receive the required data and contracts by the date in the implementation timeline provided or 60 days before the effective date of our administration, we may not be able to pay claims on the effective date. If so, related performance guarantees may no longer be applicable.

Final pricing will be determined after we have assessed the overlap between our standard network and your Custom Network along with additional administrative requirements and specifications.

Additional

Please review the additional important information found at the following URL. This information is incorporated by reference into this package and considered part of your Agreement. This quote is subject to all the terms and conditions set forth in this URL. In the event that any information contained herein conflicts or is inconsistent with the information in the Underwriting Disclosure Document, the information in your package prevails.

<https://www.aetna.com/content/dam/aetna/pdfs/aetnacom/legal-notice/documents/large-group-and-public-labor-self-funded-medical-underwriting-disclosures-as-of-05-01-2024.pdf>

Legislative and Regulatory Requirements

Affordable Care Act (ACA) Taxes and Fees - Notice to Self-Funded Group Health Plan's Financial Liability

The Affordable Care Act (ACA) imposed Patient-Centered Outcome Research Trust Fund fee (PCORI) on the issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans. The fee was set to end in 2019, but it was extended for 10 years through 2029. The fee applies to policy or plan years ending on or after October 1, 2012, and before October 1, 2029.

Any taxes or fees (assessments) related to the Affordable Care Act that apply to the self-insured health plans are your obligation. The Administrative Service Fee does not include any such liability or the remittance of the fees on your behalf.

NSA Payment Practices

The No Surprises Act (NSA) applies to certain out of network claims at participating facilities when the member doesn't have a choice or is unaware the provider is out of network. The law protects plan participants by limiting cost sharing to the preferred benefit level and prohibits balance billing by out of network providers. For NSA eligible claims, we will pay the out of network provider an initial payment amount. In most cases, the initial payment will be an amount equal to the qualifying payment amount as defined in NSA regulations (generally, the median contracted rate for a specific service in a geographic area). A provider may choose to go to independent dispute resolution (IDR) if the provider does not accept our payment as payment in full. During the IDR process, you authorize us to pay more than the qualified payment amount in order to reasonably settle the matter when it appears expedient to do so.

Recovery of Overpayments

Our process of recovering overpayments attempts to recoup money in the most accurate, effective, and cost-efficient manner.

When seeking recovery of overpayments from a provider, we have established the following process: If unable to recover the overpayment through other means, we may offset one or more future payments to that provider for services rendered to Plan Participants by an amount equal to the prior overpayment. We may reduce future payments to the provider (including payments made to that provider involving your or other health and welfare plans that are administered by us) by the amount of the overpayment, and we will credit the recovered amount to the plan that overpaid the provider. By entering into an agreement with us, you are agreeing that its right to recover overpayments shall be governed by this process and that it has no right to recover any specific overpayment unless otherwise provided for in the Agreement.

Miami Dade County Government

Guarantee Summary

Effective Date: January 01, 2026

We believe that measuring the activities described below is an important indicator of how well we service your account, as such, we have included the following performance guarantee(s) as part of our proposed offering.

This information pertains to any performance guarantee(s) shown below, or for any additional guarantees which may be offered for the same Guarantee Period. Refer to the guarantee documents for additional conditions and details.

The performance guarantee(s) described herein will not apply if the Agreement is terminated prior to the end of the Guarantee Period. In addition, all included performance guarantee(s) are subject to enrollment requirements as outlined in the financial conditions of each included guarantee.

Aggregate Maximum

The maximum payout for all guarantees combined is 75 percent of the fees at risk based on the calculation as noted in the provisions below.

General Guarantee Provisions

1. Fees at risk are calculated at the year-end reconciliation, using the paid medical administrative service fees for employees covered under each guarantee for the Guarantee Period and excludes:
 - Allowance(s)
 - The cost assumed in pricing to cover any Dedicated Resources
 - Any charges for services performed which are not included on the monthly administrative service fee bill
2. Results are estimated to be available at the end of the quarter noted below, following the close of the Guarantee Period:

Second Quarter

 - Service Performance Guarantee

Third Quarter

 - Discount Guarantee
3. If the guarantee(s) have not been met, we will either:
 - Provide reimbursement to you for the amount due, or
 - Reduce future administrative fee payment(s) by the amount due to you.
4. We reserve the right to revise or remove these guarantee(s) if a material change to the plan is initiated by you or legislative or regulatory action which:
 - Impacts our standard claim adjudication process, member services functions, medical management or network management
 - Changes the products, programs and services we offer you
5. The guarantee(s) are considered met if:
 - You terminate participation in products, programs and services tied directly to guarantee(s), prior to the end of the Guarantee Period.
 - You terminate your Aetna medical plan in whole or in part (defined as 50 percent or greater membership reduction from the membership we assumed in this proposal) prior to the end of the multi-year Guarantee Period, December 31, 2028.
 - You fail to meet your obligations under the Agreement (for example, a submission of incomplete eligibility or failure to fund claim payments)
 - We do not receive all of the necessary information in the allotted timeframe, as outlined in the guarantee document(s).

Service Performance Guarantees

We guarantee the administration of your medical and behavioral health product(s) in the following areas:

Performance Category	Minimum Standard	Maximum Fees at Risk
Performance Guarantees Outlined in Appendix E Medical Performance Guarantees	Details Outlined in Appendix E	25.00%

Discount Guarantee

We guarantee that your in-network discount for the Guarantee Period will be 73 percent or better, assuming current enrollment and book-of-business service mix.

LCC Lifestyle and Condition Coaching Guarantees

Total PEPM at risk for Guarantee	\$4.60
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Miami Dade County Government

Self-Funded Medical Guarantee(s) Summary

Guarantee Period: January 1, 2026 through December 31, 2026

We believe that measuring the activities described below is an important indicator of how well we service your account, as such, we have included the following performance guarantee(s) as part of our proposed offering:

- Discount Guarantee

This information pertains to any performance guarantee(s) shown below, or for any additional guarantees which may be offered for the same Guarantee Period. Refer to the guarantee documents for additional conditions and details.

The performance guarantee(s) described herein will not apply if the Agreement is terminated prior to the end of the Guarantee Period. In addition, all included performance guarantee(s) are subject to enrollment requirements as outlined in the financial conditions of each included guarantee.

Aggregate Maximum

The maximum payout for all guarantees combined is percent of the fees at risk based on the calculation as noted in the provisions below.

General Guarantee Provisions

- Fees at risk are calculated at the year-end reconciliation, using the paid medical administrative service fees for employees covered under each guarantee for the Guarantee Period and excludes:
 - Allowance(s)
 - The cost assumed in pricing to cover any Dedicated Resources
 - Any charges for services performed which are not included on the monthly administrative service fee bill
- Results are estimated to be available at the end of the quarter noted below, following the close of the Guarantee Period:
Third Quarter
 - Discount Guarantee
- If the guarantee(s) have not been met, we will either:
 - Provide reimbursement to you for the amount due, or
 - Reduce future administrative fee payment(s) by the amount due to you.
- We reserve the right to revise or remove these guarantee(s) if a material change to the plan is initiated by you or legislative or regulatory action which:
 - Impacts our standard claim adjudication process, member services functions, medical management or network management
 - Changes the products, programs and services we offer you
- The guarantee(s) are considered met if:
 - You terminate participation in products, programs and services tied directly to guarantee(s), prior to the end of the Guarantee Period.
 - You terminate your Aetna medical plan in whole or in part (defined as 50 percent or greater membership reduction from the membership we assumed in this renewal prior to the end of the Guarantee Period, December 31, 2026).
 - You fail to meet your obligations under the Agreement (for example, a submission of incomplete eligibility or failure to fund claim payments)
 - We do not receive all of the necessary information in the allotted timeframe, as outlined in the guarantee document(s).

Medical Discount Guarantee

We guarantee your discounts will improve over the prior period by 73 percent

Guarantee Period	Composite Discount	% of Fees at Risk
January 1, 2026 through December 31, 2026	73% Composite Discount	75.0%
January 1, 2027 through December 31, 2027	73% Composite Discount	75.0%
January 1, 2028 through December 31, 2028	73% Composite Discount	75.0%

Miami Dade County Government

Medical Discount Guarantee

Guarantee Period: January 1, 2026 through December 31, 2026

We guarantee your discounts will improve over the prior period by 73 percent

Product(s):

- Aetna Choice® Point of Service II (CPII)
- Open Access Aetna SelectSM (OA-AS)

Discount improvements we guarantee

We guarantee the discounts from our negotiated provider arrangements will improve over the prior year by:

January 1, 2026 through December 31, 2026	73%
January 1, 2027 through December 31, 2027	73%
January 1, 2028 through December 31, 2028	73%

We calculate the discount achieved on an aggregate basis, using the service type (hospital inpatient, hospital outpatient, physician/other) discounts based upon billed eligible charges by market.

How discounts are calculated

The achieved discount percentage is calculated using the following calculation:

$$\frac{\text{In-network provider discounts in dollars}}{\text{Total in-network billed eligible charges}}$$

We calculate the discount using data from our Aetna Informatics® data warehouse. Three months of runout data will be included in the calculation. The guarantee reconciliation excludes each medical case where the claims in that medical case exceed \$100,000. A medical case summarizes clinical events by linking or associating all of the claims submitted for a member during the same treatment event. For example, all claims associated with an Inpatient Acute hospital stay or an Outpatient Facility based procedure.

The guarantee results combine the product noted above and we report in aggregate for purposes of this guarantee reconciliation.

How discount improvements are calculated

1. We obtain the discounts for the current year using current year billed eligible charges by service type, by market.
2. We obtain the discounts for the prior year using prior year billed eligible charges by service type, by market.
3. We compare billed eligible charges by service type, by market, between the current year and the prior year. Billed eligible charges by market, by service type, must be present in both the prior year and current year to be included in the guarantee.
4. We develop adjusted prior year discounts by applying the prior year discounts to the current year billed eligible charges. We also use current year billed eligible charges for the prior year to account for shifts in demographics, geography, service type and/or the addition or deletion of a custom network.
5. When completed, we add the guaranteed discount improvement percentage to the prior year adjusted discounts. We then compare the prior year adjusted discounts with the guaranteed improvement to the current year discounts to determine the results of the performance guarantee.

Miami Dade County Government

Medical Discount Guarantee

*Billed eligible charges are charges prior to application of plan design, discounts and member cost sharing (copays and deductibles). Billed eligible charges exclude the following:

- Duplicate or other ineligible/not covered/denied claims
- Claims paid by coordination of benefits where we are not primary (e.g. Medicare)
- Claims on members age 65 and over
- Claims incurred in passive network
- Behavioral health claims
- Non-medical claims (e.g. dental and vision hardware claims, pharmacy and specialty pharmacy claims, including some of those specialty pharmacy claims paid under the medical plan)
- Charges where the provider billed at or below the allowed amount
- All pay for performance payments, including but not limited to, accountable care payments (ACP) and coordination of care (COC) payments.

Guarantee reconciliation

We compare the guaranteed discount against the total achieved discount. The guaranteed discount is based on the actual enrollment by product and market, and billed eligible charges by product and service type. Based on the outcome of the comparison, we will make any applicable fee adjustments as shown in the table below.

Fee adjustment	Maximum Guarantee Period adjustment
4.0% fee reduction for each full 1.0% the achieved discount falls below risk-free corridor†	75%

†Prior year adjusted discount is prior year discount plus guaranteed discount improvement.

There is a risk-free corridor of 1.0 percentage points less than the guaranteed discount.

Conditions for the guarantee

We rely on information from you and your representatives in creating and reconciling the terms of this guarantee. If any of this information is inaccurate, it may have an impact on the guaranteed network discounts. We reserve the right to revise or remove the guarantee if any of the following conditions are not met.

- **Group Composition**
You do not close any acquisitions or divestitures during the Guarantee Period.
- **Minimum enrollment**
You must enroll a minimum of 1,000 active employees in the quoted Aetna self-funded medical products.
- **Pharmacy claims**
Pharmacy and specialty pharmacy claims, including some of those specialty pharmacy claims paid under the medical plan, are excluded.
- **In-Network Claim Utilization**
Our discount guarantee requires at least 80 percent of claims paid are in-network.
- **Provider Practice**
Guarantee Year provider billing and reimbursement practices remain consistent with current practices.

Miami Dade County Government

Self-Funded Medical Guarantee(s) Summary

Multi-Year Guarantee Period: January 1, 2026 through December 31, 2030

Year 1: January 1, 2026 - December 31, 2026

Year 2: January 1, 2027 - December 31, 2027

Year 3: January 1, 2028 - December 31, 2028

Year 4: January 1, 2029 - December 31, 2029

Year 5: January 1, 2030 - December 31, 2030

We believe that measuring the activities described below is an important indicator of how well we service your account, as such, we have included the following performance guarantee(s) as part of our proposed offering:

- Clinical/Care Management Guarantees

This information pertains to any performance guarantee(s) shown below, or for any additional guarantees which may be offered for the same Guarantee Period. Refer to the guarantee documents for additional conditions and details.

The performance guarantee(s) described herein will not apply if the Agreement is terminated prior to the end of the Guarantee Period. In addition, all included performance guarantee(s) are subject to enrollment requirements as outlined in the financial conditions of each included guarantee.

Aggregate Maximum

The maximum payout for all guarantees combined is 75 percent of the fees at risk based on the calculation as noted in the provisions below.

General Guarantee Provisions

- Fees at risk are calculated at the year-end reconciliation, using the paid medical administrative service fees for subscribers covered under each guarantee for the Guarantee Period and excludes:
 - Allowance(s)
 - Any charges for services performed which are not included on the monthly administrative service fee bill
- Results are estimated to be available at the end of the quarter noted below, following the close of the Guarantee Period:
 - Clinical/Care Management Guarantees
- If the guarantee(s) have not been met, we will either:
 - Provide reimbursement to you for the amount due, or
 - Reduce future administrative fee payment(s) by the amount due to you.
- We reserve the right to revise or remove these guarantee(s) if a material change to the plan is initiated by you or legislative or regulatory action which:
 - Impacts our standard claim adjudication process, member services functions, medical management or network management
 - Changes the products, programs and services we offer you
- The guarantee(s) are considered met if:
 - You terminate participation in products, programs and services tied directly to guarantee(s), prior to the end of the Guarantee Period.
 - You terminate your Aetna medical plan in whole or in part (defined as 50 percent or greater membership reduction from the membership we assumed in this proposal prior to the end of the multi-year Guarantee Period, December 31, 2030).
 - You fail to meet your obligations under the Agreement (for example, a submission of incomplete eligibility or failure to fund claim payments)
 - We do not receive all of the necessary information in the allotted timeframe, as outlined in the guarantee document(s).

Miami Dade County Government

Self-Funded Medical Guarantee(s) Summary

Clinical/Care Management Guarantees

We guarantee our clinical performance in the following areas:

Guaranteed Medical Metric	Guaranteed Target	PEPM at Risk
Lifestyle and Condition Coaching		
Tobacco Cessation	25%	\$0.95
Weight Management	25%	\$0.95
Stress Management	50%	\$0.95
CAD members using statins	Reporting Only	\$0.25
Diabetic members using statins	Reporting Only	\$0.25
Diabetic HbA1c testing	Reporting Only	\$0.25
Diabetic HbA1c less than 8%	Reporting Only	\$0.25
Diabetic nephropathy	Reporting Only	\$0.25
Asthma-controller medications	Reporting Only	\$0.25
Hypertension members blood pressure under control	Reporting Only	\$0.25
Total PEPM at risk for Guarantee	\$4.60	
Total Estimated Subscribers	28,460	
Medical: Total Estimated Annual Amount at Risk	\$1,570,992	

Miami Dade County Government

LCC Lifestyle and Condition Coaching Guarantees

Guarantee Period: January 1, 2026 through December 31, 2026

Lifestyle and Condition Coaching

The Lifestyle and Condition Coaching program is billed on a per engaged member, per month basis. The per engaged fee is estimated at \$4.60 PEPM based on book of business engagement and member to employee ratio. We have allocated the estimated PEPM across the metrics noted below.

Tobacco Cessation

Guarantee:

We will guarantee the tobacco cessation program will achieve a 2-month tobacco quit rate of 25 percent or more for those program participants who attend at least 4 sessions of the program.

Customer specific results will be used to reconcile this guarantee annually. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 20 program participants or the guarantee will revert to book of business results.

Payment and Measurement Criteria:

An adjustment of \$0.19 PEPM will apply for each full one percent the Tobacco Cessation rate is below the target. The maximum adjustment is \$0.95 PEPM.

Weight Management

Guarantee:

We will guarantee the weight management program will achieve a decline in Body Mass Index of at least 1 point in 25 percent of participants who attend at least 4 calls with a nurse telephonically of the program when measured and reported at 3 to 6 months.

Customer specific results will be used to reconcile this guarantee annually. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 20 program participants or the guarantee will revert to book of business results.

Payment and Measurement Criteria:

An adjustment of \$0.19 PEPM will apply for each full one percent the Weight Management rate is below the target. The maximum adjustment is \$0.95 PEPM.

Stress Management

Guarantee:

We will guarantee the stress management program will decrease stress by at least 1 level in 50 percent of the participants who attend at least 4 sessions of the program when measured and reported at 1 to 3 months. We use telephonic responses to measure stress levels:

- Good (Most of the time I handle the stress in my life very well)
- Fair (I sometimes have trouble handling the stress in my life)
- Poor (I often have trouble handling the stress in my life)

Customer specific results will be used to reconcile this guarantee annually. This guarantee assumes that you will have a minimum of 5,000 medical subscribers and 20 program participants or the guarantee will revert to book of business results.

Payment and Measurement Criteria:

An adjustment of \$0.19 PEPM will apply for each full one percent the Stress Management rate is below the target. The maximum adjustment is \$0.95 PEPM.

Miami Dade County Government

LCC Lifestyle and Condition Coaching Guarantees

Lifestyle and Condition Coaching Clinical Outcomes

Guarantee:

These guarantees offer a year over year improvement. Since this is the first year of your Lifestyle and Condition Coaching program, this year is a reporting-only guarantee.

For each of the measures itemized in the table below:

- (1) If the measure in the prior year is at the target or higher, we guarantee the target.
- (2) If the measure in the prior year is below the target, we guarantee a minimum 5 percent improvement in the difference between the prior year result and the target. The minimum improvement calculation is:

$$(\text{Target} - \text{Prior Year}) \times 5 \text{ percent}$$

To be included in the guarantee measure, members measured during each measurement period must be:

- Enrolled for at least 11 months in the Guarantee Period
- Identified as having the chronic condition for at least 6 months

Lifestyle and Condition Coaching Clinical Outcomes Metrics	Minimum Target	Maximum Reduction
CAD members using statins	Reporting Only	\$0.25
Diabetic members using statins	Reporting Only	\$0.25
Diabetic members receiving an HbA1c Test in past 12 months	Reporting Only	\$0.25
Diabetic members with HbA1c less than 8%	Reporting Only	\$0.25
Diabetic members screened for or having evidence of nephropathy in the past 12 months	Reporting Only	\$0.25
Persistent asthmatic members using appropriate controller medications in the past 12 months	Reporting Only	\$0.25
Hypertension members blood pressure under control (140/90)	Reporting Only	\$0.25

Reconciliation example for minimum targets:

If the prior year rate is 50 percent and the target compliance rate for the metric is 70 percent, the guarantee will be to improve the rate from the current 50 percent to 51 percent in the following year $[50 \text{ percent} + (70 \text{ percent} - 50 \text{ percent}) \times 5 \text{ percent}]$.

Because you implemented the Lifestyle and Condition Coaching program this year, this is a reporting only guarantee. If this guarantee is offered next year, customer specific results will be used to reconcile this guarantee. This guarantee assumes that you will have a minimum of 3,000 medical subscribers and 30 members measured in both the current Guarantee Period and prior year. Otherwise, book of business results will be used to reconcile the guarantee.

Payment and Measurement Criteria:

For each clinical outcome metric, an adjustment of \$0.05 PEPM will apply for each full one percent the metric is below the target or 5 percent improvement. The maximum adjustment is \$0.25 PEPM.

LCC Lifestyle and Condition Coaching Guarantees

General Performance Guarantee Provisions

You may receive reporting throughout the year relative to utilization or operational data. The data contained in those reports may differ from the actual performance guarantee results due to the timing of the reports and/or auditing of performance guarantee results.

These guarantees do not apply to non-Aetna benefits or networks.

Changes in Clinical Practice Guidelines

Medical knowledge is dynamic and as research progresses the recommendations for evidence-based clinical guidelines change. Such changes may involve:

- A test, service or medication is no longer recommended
- A change in the frequency or intensity of a test or service, or dosage of a medication
- A change in the clinical goal or target
- A change in the specifications for the denominator population

When a recognized national organization changes clinical practice guidelines that impact these performance guarantees, we reserve the right to amend or eliminate the performance guarantees. This is necessary because physicians will start to manage their patients in accordance with the revised guidelines. If a test, service or medication is no longer recommended, then the performance guarantee will be eliminated since we cannot recommend to physicians and patients to have a test done or a medication be taken. When the service continues to be recommended, but at a different frequency or with a new target, we will modify the associated metric accordingly.

We will notify you when such changes are being made. It may be necessary to recalculate performance for the baseline year to reflect changes in clinical target or specifications for denominator population. This is required to accurately calculate improvement from baseline.

Financial Conditions

We reserve the right to revise or remove any or all of the performance guarantees described herein if any of the following conditions are not met:

- Actual Aetna medical enrollment does not vary by more than 15 percent from the total estimated employees. In addition, turnover will be less than 20 percent.
- The average member age of your enrolled Aetna medical plan participants is greater than 34.0.
- Your member to employee ratio is at least 1.7.
- We service both the medical and pharmacy products.
- If you utilize an external Case Management (CM) and/or Utilization Management (UM) vendor.
- If you utilize an external vendor for biometric screenings or other wellness programs, we require receipt of those external feeds.
- If you have a direct contract with Quest or LabCorp, you will need to notify them to provide us the lab data.
- Under age 65 retiree population is structured separately from the over age 65 Medicare prime population for accounting/reporting purposes with us. This guarantee excludes populations that are over age 65 with Medicare primary.
- Member eligibility (complete, accurate and viable enrollment data, including employee email address and member phone numbers) is fully loaded in our eligibility system 35 days prior to the effective date.
- We currently have or will receive a minimum of 24 months of prior carrier medical and pharmacy experience.

LCC Lifestyle and Condition Coaching Guarantees

- The prior carrier medical claim and pharmacy data must be received by us in our stated acceptable format for data feeds within 45 days of the program effective date. If we do not receive acceptable file feeds within 45 days of the programs effective date, then the basis of the guarantee will be book of business results for the Guarantee Period.
- You agree to not prevent or otherwise restrict us from contacting your members for purposes of the Aetna Advice® program, except where required by law or regulation.
- You do not turn off any of the Aetna Advice® campaigns.
- For Lifestyle and Condition Coaching metrics, we assume our health assessment is used and standard program features are being administered.

Miami Dade County Government

Account Management Evaluation Survey Tool

Effective Date: January 01, 2026

Evaluation Period:

We would like to better understand how you view your relationship with us. In responding to this survey, we ask you to look at the services received from your Account Management Team for the time period listed above. Your feedback will enable us to better meet your needs. Thank you for your participation.

Knowledge: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
• understands your plan of benefits	Please Select	
• understands the business needs of your company	Please Select	
• understands the service expectations of your company	Please Select	
• displays knowledge regarding our products and services	Please Select	
• clearly explains report results	Please Select	
Total Rating		0.0

Professionalism: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
• actively listens to and acknowledges your issues and concerns	Please Select	
• provides appropriate verbal communication	Please Select	
• provides appropriate written communication	Please Select	
• works with you to develop a positive working relationship	Please Select	
Total Rating		0.0

Proactive Management: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
• monitors your account on an on-going basis	Please Select	
• communicates potential problematic issues	Please Select	
• provides viable alternatives to meet your business needs	Please Select	
• manages system conversions and changes in plan design in an organized	Please Select	
• sets realistic expectations regarding turn-around time	Please Select	
• sets realistic expectations regarding cost	Please Select	
Total Rating		0.0

Accessibility: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
• is available to you	Please Select	
• allocates appropriate time when meeting with you	Please Select	
• demonstrates flexibility with regard to schedule changes	Please Select	
• provides/communicates alternate contacts in the event of their absence	Please Select	
• advises you of schedule limitations	Please Select	
Total Rating		0.0

Responsiveness: Indicate the extent to which you agree that your Account Management Team:

	Rating	For any "Disagree" or "Strongly Disagree" responses, please provide specific comments in the area below
• responds to your inquiries in a timely manner	Please Select	
• provides thorough responses to your inquiries	Please Select	
• follows-through regarding outstanding issues/items	Please Select	
• solicits the assistance of our product experts when needed	Please Select	
Total Rating		0.0

Overall Account Management Team Evaluation:

Total Overall Rating	0.0
Average Overall Rating	0.00

Any other comments or suggested action steps:

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Effective Date: January 01, 2026

Pharmacy Service and Fee Schedule to the Master Services Agreement

**Effective January 01, 2026
Miami Dade County Government**



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Pharmacy Discounts & Fees

Management or administration of prescription drug benefits selected by the Customer will be performed by CaremarkPCS Health, L.L.C. and/or its affiliates (CVS Caremark), each of which is an affiliated, licensed pharmacy benefit manager.

Pricing Arrangement	Pass Through at Retail
Network	Aetna National with Extended Day Supply (Retail 90) Network
Employees	28,618

RETAIL 30					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Brand Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%	AWP - 20.30%	AWP - 20.40%
Generic Discount	AWP - 86.50%	AWP - 86.70%	AWP - 86.90%	AWP - 87.10%	AWP - 87.30%
Dispensing Fee	\$0.60 per Script	\$0.60 per Script	\$0.60 per Script	\$0.60 per Script	\$0.60 per Script

RETAIL 90					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Brand Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%	AWP - 20.30%	AWP - 20.40%
Generic Discount	AWP - 87.25%	AWP - 87.45%	AWP - 87.65%	AWP - 87.85%	AWP - 88.05%
Dispensing Fee	\$0.45 per Script	\$0.45 per Script	\$0.45 per Script	\$0.45 per Script	\$0.45 per Script

MAIL ORDER PHARMACY					
Mail Benefit Type	Mail Order Pharmacy				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Brand Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%	AWP - 20.30%	AWP - 20.40%
Generic Discount	AWP - 92.00%	AWP - 92.20%	AWP - 92.40%	AWP - 92.60%	AWP - 92.80%
Dispensing Fee	\$0.00 per Script	\$0.00 per Script	\$0.00 per Script	\$0.00 per Script	\$0.00 per Script

SPECIALTY PHARMACY					
Network	Specialty Regional Network				
Product List	Aetna Specialty Product List				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Discount	AWP - 22.75%	AWP - 22.85%	AWP - 22.95%	AWP - 23.05%	AWP - 23.15%

GENERIC DISPENSING RATE (GDR) GUARANTEE					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Retail GDR	85.00%	85.25%	85.50%	85.50%	85.50%
Mail GDR	86.25%	86.50%	86.75%	86.75%	86.75%
Annual Maximum	\$750,000	\$750,000	\$750,000	\$750,000	\$750,000

ADMINISTRATIVE FEES					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Admin Fee	\$2.00 PEPM	\$2.00 PEPM	\$2.00 PEPM	\$2.00 PEPM	\$2.00 PEPM

CLINICAL PROGRAM FEES*					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Vaccine Program Management Fee	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM

*Clinical Program Fees may be billed on a substantially equivalent PEPM Basis

ALLOWANCES					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Implementation Allowance	\$5.00 PMPY	N/A	N/A	N/A	N/A
General Allowance	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY
Audit Allowance	\$80,000	N/A	N/A	N/A	N/A

Rebates

REBATES					
Formulary	Aetna Standard Formulary				
Plan Design	3 Tier Qualifying* (In Force Today)				
Rebate Terms	Customer will receive the following minimum rebate guarantees:				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029*	01/01/2030*
Retail	Greater of 100% or \$432.58 Per Brand Script	Greater of 100% or \$464.43 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script
Retail 90	Greater of 100% or \$938.65 Per Brand Script	Greater of 100% or \$991.86 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script
Mail Order	Greater of 100% or \$749.13 Per Brand Script	Greater of 100% or \$785.94 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script
Specialty	Greater of 100% or \$3,400.26 Per Brand Script	Greater of 100% or \$3,633.72 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script

*Pricing for 1/1/2029 and 1/1/2030 will be evaluated at a later time, in advance of the 1/1/2029 and 1/1/2030 renewal dates.

REBATES					
Formulary	Aetna Standard Formulary				
Plan Design	3 Tier Non-Qualifying* (In Force Today)				
Rebate Terms	Customer will receive the following minimum rebate guarantees:				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029*	01/01/2030*
Retail	Greater of 100% or \$432.58 Per Brand Script	Greater of 100% or \$464.43 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script
Retail 90	Greater of 100% or \$938.65 Per Brand Script	Greater of 100% or \$991.86 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script
Mail Order	Greater of 100% or \$749.13 Per Brand Script	Greater of 100% or \$785.94 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script
Specialty	Greater of 100% or \$3,400.26 Per Brand Script	Greater of 100% or \$3,633.72 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script

*Pricing for 1/1/2029 and 1/1/2030 will be evaluated at a later time, in advance of the 1/1/2029 and 1/1/2030 renewal dates.

REBATES					
Formulary	Aetna Standard Formulary				
Plan Design	2 Tier* (In Force Today)				
Rebate Terms	Customer will receive the following minimum rebate guarantees:				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029*	01/01/2030*
Retail	Greater of 100% or \$432.58 Per Brand Script	Greater of 100% or \$464.43 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script
Retail 90	Greater of 100% or \$938.65 Per Brand Script	Greater of 100% or \$991.86 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script
Mail Order	Greater of 100% or \$749.13 Per Brand Script	Greater of 100% or \$785.94 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script
Specialty	Greater of 100% or \$3,400.26 Per Brand Script	Greater of 100% or \$3,633.72 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script

*Pricing for 1/1/2029 and 1/1/2030 will be evaluated at a later time, in advance of the 1/1/2029 and 1/1/2030 renewal dates.

Capitalized terms in the pricing charts above are not intended to reflect defined terms except where specifically noted in the Prescription Drug Services Schedule.

Standard core as well as additional and third-party service options are described in the Aetna Pharmacy Program Summary incorporated herein by reference.

In the event of any inconsistencies between the terms and conditions set forth in this Pharmacy Service and Fee Schedule and the terms and conditions set forth in the Prescription Drug Services Schedule, the term and conditions of this Pharmacy Service and Fee Schedule shall prevail.

Terms & Conditions

The pricing and services set forth herein are subject to the following Terms & Conditions:

- To the extent the pricing and services outlined in this document is part of a proposal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- This pricing has an effective date of January 1, 2026. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- Our proposal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Participating Pharmacy shall give the Plan Participant the benefit of the lesser of (i) the Participating Pharmacy's Usual and Customary Charge, (ii) MAC (where applicable) or (iii) discounted AWP cost. Participating Pharmacy shall collect and retain from the Plan Participant at the time of dispensing the lesser of (i) the Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, (iii) MAC (where applicable) or (iv) discounted AWP cost.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
 - Pricing guarantees are measured and reconciled as four separate channels with the channels defined as retail network, mail pharmacy, specialty pharmacy, and rebates.
 - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within ninety (90) days following the guarantee period.
 - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant Cost Share and include zero balance due claims.
 - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein:
 - Compound Prescription claims
 - Direct Plan Participant reimbursement / out-of-network claims
 - Coordination of Benefits (COB) or secondary payor claims
 - In-house pharmacy claims
 - Vaccines (including for COVID) and other COVID testing-related claims
 - 340B claims
 - Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.
 - Single Source Generic Drugs are included in the Generic Discount guarantees.

- Only Specialty Products dispensed by a Specialty Pharmacy are included in the Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are not included in any Discount guarantee listed above.
 - Aetna has assumed 0.00% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
 - Pricing and terms in this proposal assume the Customer has elected the Aetna Standard formulary and the Choose Generics program. In addition, for Miami's Dade County's collective bargained populations, the elected Aetna Standard formulary also includes claims-initiated prior use exemption (PUE) or grandfathering of existing utilizers, as well as member-initiated PUE for new utilizers added to the specific plan(s) after 1/1/2026. Both PUEs will apply until the CBA is renegotiated.
 - The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members.
 - Specialty Regional Network means that Plan Participants are required to use participating Specialty Pharmacies (no fills at retail allowed), with the exception of the HIV class which is not required to be dispensed at CVS Specialty Pharmacies.
 - Non-Specialty Claims dispensed by a CVS Specialty Pharmacy will adjudicate as a Retail Non-Specialty Claim.
 - The Overall Effective Discount (OED) offer is conditioned on Plan Participants exclusively using the Aetna Specialty Regional Network comprised of only CVS Specialty Pharmacies with the exception of the HIV class and Customer implementing and maintaining a generics first plan design for specialty. The Aetna Specialty Regional Network option may not be available to Plan Participants in certain states. If Aetna Specialty Performance Network is no longer available in certain states, then Customer must select an alternate Specialty Pharmacy network option made available by Aetna. Aetna may equitably adjust the financial terms in this Agreement to account for the impact of any such network change. The rates quoted herein apply to Specialty Products dispensed from CVS Specialty Mail Order Pharmacies, including through the Specialty Connect process. Aetna may amend the individual Specialty Product Discounts to manage the financial guarantee. The financial guarantee is measured and reconciled annually across all Specialty Products dispensed by CVS Specialty pharmacy, including through the Specialty Connect process, with the exception of the following exclusions (in addition to the Discount and Dispensing Fee exclusions). Note: New to market and existing Biosimilars are included in the discount guarantees.
 - New to Market Specialty Products
 - Limited and exclusive distribution drugs
- For the items noted here, the following quoted rates shall apply.
- New to Market Specialty Products: AWP -16.00%;
 - New to Market Limited and exclusive distribution drugs: AWP -15.00%

MAC: Certain dosage forms and strengths may not be included on the MAC List and shall be priced at the specialty default rate.

In the event retail leakage increases by a percentage change of 10%, or more, from the effective date of the agreement, Aetna reserves the right to amend pricing.

- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.
- Rebate guarantees may be subject to:
 - The adoption of Specialty Guideline Management (SGM) program
 - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- The above rebate guarantees exclude:
 - Any other Claim identified as having received 340B program wholesale pricing
 - Compound Drug Claims
 - Paper or Member Submitted Claims
 - Coordination of Benefits (COB) or secondary payor Claims
 - Vaccine and vaccine administration Claims
 - COVID treatment Claims
 - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
 - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
 - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.
 - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a \$15.00 co-payment differential between preferred and

non-preferred Brand Drugs, at least a \$15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).

- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within 12 months following the end of the Plan year; a surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.
- The GDR guarantees are based upon plan design, membership, and demographics as represented by Customer, and changes to these aspects may materially affect Aetna's ability to meet the GDR guarantees. In the event of a change to the Plan design, or the Plan's demographics, both parties agree to work in good faith to determine if the GDR guarantees should be adjusted to account for such change, whether higher or lower, depending on the actual impact of such change. An example of this would be situations where generically available medications are excluded from the benefit, such as OTC equivalent strengths. If a brand does not lose patent protection when expected due to unforeseen circumstances, including but not limited to litigation, the parties acknowledge and agree an adjustment may need to be made to the GDR guarantees. The GDR guarantees will be measured and reconciled in the aggregate. The following are excluded from the GDR guarantees calculation: Specialty Drugs, Compound claims, Direct Plan Participant reimbursement / out-of-network claims, COB claims, DAW 1, 2, and 7, and Vaccines. Any potential amount owed will be determined based on the following formula: (Average Amount Paid per Brand claim - Average Amount Paid per Generic claim) multiplied by (GDR guarantee - GDR measured) multiplied by total claims. Penalties for a shortfall on the GDR guarantees will be paid on a dollar-for-dollar basis, with a maximum annual payment cap of \$750,000.00.
- The Aetna Extended Day Supply Network provides the flexible option of a nationwide network of retail pharmacies that can fill up to a 90 days' supply of medications. Aetna's Retail-90 Network pricing is applicable for non-specialty claims equal to or greater than an 84 days' supply filled by a participating Aetna Retail-90 Network pharmacy.

Market Check

On an annual basis, in the second quarter of each Contract Year, and at Customer's reasonable request, Aetna and Customer or a mutually agreed upon third party with a signed non-disclosure agreement may review the financial terms of Customer compared to financial offering presented to similar employers in the marketplace as deemed appropriate. The parties agree for the purpose of this market check that Aetna or Customer's representative will compare, among other things, the following factors to determine whether Customer is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable customers of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, rebates and guarantees; (ii) the services provided by Aetna to such customers; and (iii) the plan design of such customers, which may

include plan formulary, brand/generic utilization information and mail and retail utilization information, available to Aetna. Customer, or its representative, shall provide Aetna with a report to substantiate its findings. Should the comparison demonstrate that the current market conditions would yield a savings of 2% or more in net costs (i.e. gross costs net of administration fees and rebate guarantees), then the parties will discuss in good faith a revision to the current pricing terms and other applicable contract provisions. If Customer and Aetna agree to any revisions to the financial terms as a result of this review (i) the agreement shall be amended and (ii) shall be effective January of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply.

Allowances

Allowances which are based on the information available to Aetna during this process will be available as of the Effective Date of the Pharmacy Services and Fee Schedule. Aetna will pay related expenses directly to a third-party vendor once the Customer sends the invoice(s) outlining the expenses incurred to Aetna. Invoices must be submitted before the end of each Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of each Plan year will be forfeited. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, this credit shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A). The parties acknowledge and agree that the allowances provided by Aetna are commercially reasonable and necessary services related to this Agreement, including without limitation, implementation, audit, communication and/or external data file/feeds, and represent fair market value for the services provided.

Implementation Allowance

Aetna shall provide the Customer with an Implementation Allowance of up to \$5.00 per member per year. The Customer can use this allowance to pay for reasonable implementation and enrollment services incurred during the first Plan year.

Audit Allowance

Aetna is including an audit allowance of up to \$80,000.00 on a 1st year only basis. The Customer can use this allowance to pay for the costs associated with an audit performed to review claim transactions for the purpose of assessing the accuracy of the benefit determination.

General Allowance

Aetna is including a general allowance up to \$3.00 per enrolled member per year on an Annual basis. The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

Additional Disclosures

The Customer acknowledges that the Discounts and Dispensing Fees contained in this Agreement reflect a Transparent or Pass Through pricing arrangement at Retail. Transparent or Pass Through Pricing means the amount charged to the Customer and Plan Participants for network claims shall equal the amount paid to Participating Retail Pharmacy. Maintenance Choice claims dispensed at CVS/pharmacy, if applicable, are exempt from the Transparent Pricing requirements under this Agreement. The amount billed to the Customer will be equal to the amount paid to the participating pharmacies.

The financial provisions in this Agreement are based upon Claims data and membership information provided by Customer (or Customer's authorized representative) during the pricing request process, which shall serve as the baseline. Aetna reserves the right to make an equitable adjustment to modify or amend the financial provisions set forth herein in a manner designed to account for the impact of specific triggering events identified below ("Equitable Adjustment").

1. Greater than 15% change in total membership or Claims volume as compared to the baseline
2. Customer-initiated change to the Benefit Plan Design, or Formulary alignment. To the extent applicable, Aetna will notify Customer in advance of any proposed Equitable Adjustment
3. Product offering decisions by drug manufacturers that result in a reduction of rebates, including the introduction of a lower cost alternative product which may replace an existing rebateable brand product; an unexpected launch of an interchangeable version of a brand product; or a branded product converted to OTC status, recalled or withdrawn from the market; or a material reduction in the Wholesale Acquisition Cost (WAC); or
4. Other events triggering an Equitable Adjustment as detailed below:
 - Legal and/or regulatory changes specific to customers which negatively affects the economic value of the Agreement to a party or the parties under the Agreement, for example restrictions on preferred or limited network arrangements; policy changes impacting drug manufacturers which negatively affect the economic value of the Agreement including the ability to provide or maintain discounts or Rebates; and/or
 - An inability to access, or changes to, industry pricing information (e.g. AWP) required to support the current economic structure of the Agreement.

If one or more of such triggering events occurs, Aetna may initiate a review to determine if an Equitable Adjustment to any of the financial provisions is warranted as a direct result of the triggering event(s). Aetna will conduct an analysis based upon Customer-specific Claims, utilization, and membership data demonstrating how the triggering event(s) result in the proposed Equitable Adjustment. Any such Equitable Adjustment based upon events #1 or #2 described above shall be effective on the first day that the triggering event occurred. Any such Equitable Adjustment based upon events #3 or #4 described above shall be effective 30 days after notification to Customer. Aetna will provide documentation of the reason for the proposed Equitable Adjustment in addition to a summary analysis demonstrating that the Equitable Adjustment is solely related to the impact of the specific triggering event. Aetna will disclose necessary facts and data to an independent auditor for validation.

Aetna reserves the right to modify its products, services, and fees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or fees (assessments) applied to self-funded benefit Plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the Customer. The pharmacy pricing contained herein does not include any such Customer liability.

Rebate Payment Terms

Rebates will be distributed on a quarterly basis by claim wire credit.

Rebate collections are paid quarterly one hundred and twenty (120) days after the quarter ends. Rebates are calculated and paid in accordance with the terms and conditions of this Agreement. Earned Rebates are distributed in March, June, September and December each contract year.

Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

When remitting and reconciling minimum Rebate guarantees, Aetna may add "Rebate Credit" value to the total Rebates remitted to Customer for each respective Rebate component (e.g., Retail, Mail, Retail 90, and Specialty). "Rebate Credits" shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Drug, including but not limited to a Biosimilar, ("Low Cost Brand") Claim processed, and the WAC of the reference Brand Drug, subject to the below cap; and/or (ii) the value of WAC reductions for rebateable products that have experienced a material WAC decrease and material rebate reduction, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is processed, subject to the below cap. The "Baseline WAC" will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

Rebate Credit will be capped in two ways: First, the WAC of the reference Brand Drug will be capped at a pre-determined WAC inflation rate communicated at time the eligible product is added to the list of products eligible for the Rebate Credit. Second, in no way will the Rebate Credit exceed the Baseline Rebate less the earned Rebates on either the Low Cost Brand or the rebateable product that has experienced a WAC decrease. "Baseline Rebate" is calculated as follows: in the year the price reduction occurred, Baseline Rebate will be the Rebate available for coverage of the product prior to the WAC reduction or, as applicable, for Low Cost Brands the Baseline Rebate will be the Rebate available for coverage of the reference Brand Drug on the date of Claim processing. For a product experiencing a WAC reduction in subsequent years, the Baseline Rebate will increase over the prior year Baseline

Rebate at the average WAC inflation rate of the GPI subclass (GPI-6) of the impacted product. Aetna shall perform all Rebate Credit calculations at a Claim level based on the unit quantity attached to the Claim, and shall map Low Cost Brand NDCs to the NDCs of reference Brand Drugs with the most equivalent attributes (e.g., strength, package size).

The following products will be eligible for the Rebate Credit: (1) Any Biosimilar product processed where Humira or Stelara are the reference Brand Drug; (2) any Insulin product (GPI-4 2710) that experienced a WAC decrease; and (3) any other products as mutually agreed in writing by Customer and Aetna.

Aetna will provide 60 days' advance notice of product(s) that qualify(ies) for Rebate Credits and will be added to the list of products eligible for the Rebate Credit. Customer may otherwise elect a minimum Rebate guarantee adjustment. Aetna shall provide reporting, upon Customer request, demonstrating the net-cost impact in the therapeutic category(ies) of the product(s) eligible for the Rebate Credit and the proposed adjustment to the minimum Rebate guarantee. A Covered Drug Claim will only be eligible for the Rebate Credit if a minimum Rebate guarantee adjustment has not already been made by Aetna.

Customer's authorized auditor may validate the application of the Rebate Credit value as part of the Customer Rebate Audit set forth in [Section ___ of] the Agreement. If Rebate Credits are applied based on manufacturer contracts that are not included within auditor's sample selection, Aetna will make available all additional manufacturer contracts that are necessary to validate and reconcile Aetna's Rebate Credit adjustment. For each additional manufacturer contract provided to validate the Rebate Credit, auditor's review will be limited to only the product impacting the Rebate Credit calculation. With respect to Low Cost Brands, Aetna shall not apply Rebate Credit unless the differential between the Low Cost Brand WAC and the reference Brand WAC is at least twenty-five percent (25%). With respect to rebateable products experiencing a reduction in WAC, Aetna shall not apply Rebate Credit unless the actual drop in WAC is at least twenty-five percent (25%). If Customer disagrees with Aetna in its decision that a change is necessary, Customer may terminate the Agreement without being assessed any penalties (e.g., loss of Rebates earned but not yet paid).

Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

If this Agreement is terminated by Aetna for the Customer's failure to meet our obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall be entitled to deduct deferred administrative fees or other plan expenses from any future rebate payments due to the Customer following the termination date.

Formulary Management

Aetna offers several versions of formulary options for Customer to consider and adopt as Customer's Formulary. The formulary options made available to Customer will be determined and communicated by Aetna prior to the implementation date. Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Customer the right to use one of our Formulary options during the term of the Agreement solely in connection with the Plan, and to

distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan. Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors. Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

For Miami-Dade County we have agreed, on an exception basis, to only allow a one time of year formulary change. However, in the event of a material market event (i.e introduction of new biosimilars), we reserve the right to update the formulary outside of this once a year exception. Aetna will provide notification in the event of a significant market event.

Other Payments

The term Rebates as defined in the Prescription Drug Services Schedule includes any manufacturer administrative fees that may be paid by pharmaceutical manufacturers to cover the costs related to the reporting and administration of the pharmaceutical manufacturer agreements. Such manufacturer administrative fees are shared with Customer hereunder.

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with Customers.

Aetna may also receive network transmission fees from our network pharmacies for services we provide for them. These amounts are not considered Rebates and are not shared with Customers. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees, if applicable.

Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or CVS Caremark and instead are received by Aetna in connection with network contracting, provider education and other activities Aetna conducts across our book of business. Customer further agrees that the amounts described above belong exclusively to Aetna or its affiliate, CVS Caremark, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or CVS Caremark.

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Payments or rebates from

drug manufacturers that compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

Early Termination

In the event of an Early Termination, the pharmacy guarantees described hereunder, if any, shall be considered null and void for the Plan year and, therefore, not subject to reconciliation.

In addition, in the event Customer terminates the Agreement prior to the expiration of the initial term for any reason other than for Aetna's material breach, Customer shall refund, prior to the termination date, to Aetna all allowances described herein and received by Customer for the unfulfilled term on a prorated basis

Aetna's remedies as described immediately above are liquidated damages and shall not be characterized as a penalty (collectively, the "Early Termination Fee"). Unless otherwise agreed in writing by the parties, such Early Termination Fee will be due and paid in full within sixty (60) days after the termination effective date.

Late Payment Charges

If the Customer fails to provide funds on a timely basis to cover benefit payments and/or fails to pay service fees on a timely basis as required in the Agreement, Aetna will assess a late payment charge. The current charges are outlined below:

- i. Late funds to cover benefit payments (e.g., late wire transfers): 12.0% annual rate
- ii. Late payments of Service Fees: 12.0%, annual rate

In addition, Aetna will make a charge to recover our costs of collection including reasonable attorney's fees. We will notify the Customer of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay.

Pharmacy Audit Rights and Limitations

Customer is entitled to one annual Rebate audit, subject to the audit terms and conditions outlined in the Prescription Drug Services Schedule.

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the Prescription Drug Services Schedule.

Pharmacy audits shall be conducted at the Customer's own expense unless otherwise agreed to between the Customer and Aetna.



Aetna Pharmacy Program summary – Core Services

Unless otherwise specified, the services outlined below are available at no additional cost for our Customers and Members.

PBM Services	
<i>Included in Core Services</i>	
PBM Benefit Administration	Member Services
• Maintenance Choice • Aetna Standard Preventive Drug List (HDHP) • Aetna Standard Preventive Drug List (ACA) • Integrated retail, mail and specialty claims with medical benefit claims in real-time • Benefit Automation • Loading Client Benefit Plan • RxSavingsPlus Savings Program • Generic Substitution/DAW Penalties	• Member Services Call Center – Available 24/7 • Real-Time Benefits • Aetna Health Mobile App and Internet Tools • Price-A-Drug Tool available at aetna.com or through our mobile app, Aetna Health
Member Communication Materials	Customer Services
• Initial Implementation benefits communication materials, printed and online support • Member specific e-mail communications • Aetna Integrated Pre- and Post-enrollment materials • Clinical program member letters, including transition letters for formulary changes/updates • Informational brochures for using the CVS Caremark Mail Service Pharmacy, including order forms • Member-specific formulary and plan design • Aetna Health website and app brochures	• Claim funding and banking arrangements integrated with your Aetna medical plan • Consultative services • Education materials on key healthcare topics • Implementation support including eligibility loading and ongoing additions/deletions • Regulatory and compliance support by specific line of business • Meetings to discuss program performance • Account Management • Client Authorized Override • Member Satisfaction Surveys • Post Rejection Communications (PRC) • Proactive Retail Refill Notice
Claims Processing Services	Mail Service Pharmacy
• Online, Point-of-Service (POS) claims adjudication with real-time integration with medical claims	• Use of CVS Caremark Mail Service Pharmacies • Information System Infrastructure & Maintenance • Profile/order form and return envelope • Member counseling labels – drug specific • First time fill prescription processing
Online Customer Access	
• Online Services (on-site eligibility maintenance and prior authorization overrides-viewing member claims history)	

- Website Access allowing customized dashboard creating for members--keep



AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Analytics and Reporting	
Included in Core Services	
Analytic Support	Analytic Support cont.
• Aetna Report Rx self-service reporting tool suite for up to 10 Customer users • RxNavigator Self-Service Reporting Tool Suite • E Tool Access (Self Service for Rx Insight Reports)	• Claim detail reporting combined with medical reporting through the new reporting tool, ART
• Account Team Supported Reporting • Clinical Program Opportunity Analysis	• Quarterly clinical and financial reports based on aggregate customer utilization

Formulary	
Included in Core Services	
Standard Formulary Administration	Standard Formulary Administration cont.
• Formulary maintenance	• Rebate administration
• Formulary exclusions lists	• Point of Sale (POS) Rebates Type 3
• Hyperinflation management	• Compound Management

Clinical Programs and Utilization Management Edits	
Included in Core Services	
Clinical Solutions	Clinical Solutions cont.
• Diabetic Meter Program • Standard Utilization Management edits, including quantity limits and step therapy • Pharmacy Advisor Support – Automatic refill and renewal programs	• Dose Optimization • Core Medication Management: Closing Gaps in Medication Therapy • Retrospective Safety Review • Point of Sale (POS) Drug Safety Alerts
• Pharmacy Advisor Support – Adherence to Drug Therapy	• Member and Physician clinical education
• Smart Edit overrides	• Global safety edits
• Opioid safety edits	• Compound drugs management
• Maximum pay edits	• Select OTC Coverage
• Mail Order DAW Solution	



AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Specialty	
Included in Core Services	
Specialty Clinical Solutions	Specialty Support cont.
- Specialty Starter Fill AccordantCare Specialty - Proactively supports and empowers Members with rare conditions to manage their whole condition, not just adherence to their medication (beyond traditional specialty pharmacy care). Members identified by Aetna Specialty dispense for nine (9) specialty conditions. Available to Customers who use the Aetna Specialty Performance Network.	- Specialty Expedite - Specialty Connect - Digital - Secure Messaging - First time fill prescription processing - Specialty CareTeam - Patient Assistance Program
Specialty Benefit Administration	Specialty Pharmacy
Specialty Guideline Management (SGM) – criteria development and maintenance	- Use of the CVS Specialty Pharmacy network with full integration of retail, mail and specialty claims - Information System Infrastructure & Maintenance
- Specialty Copay Card Plan Designs - Standard Specialty Product List	- Member Onboarding - Member counseling label – drug specific
Exclusive Specialty Grace Fill Member Letter (Under Member Communication Materials)	- Supply Management Optimization (SMO) (Exclusive and Preferred Specialty Customers) - Specialty Connect - Digital Secure Messaging - Specialty Expedite - Specialty CareTeam

Digital	
Included in Core Services	
Standard Digital Services	Standard Digital Services cont.
Open enrollment links	Single Sign on (SSO)
Aetna.com configurations	Integrated medical and pharmacy websites



AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Mandatory Fees

The services outlined below are associated with meeting federal, state, and local regulatory compliance requirements

Regulatory Programs	Member Threshold, if any	Fee	Basis
State Regulatory Impact Assessment ¹		\$0.30	Per Retail Claim Only
Retail Network Pharmacy Third Party Appeal		Pass through Fees Per Review	

¹Applies to claims in select states with relevant regulatory requirements. The current list of states includes AL, AR, AZ, CO, DE, FL, GA, IA, LA, MD, MI, ND, NM, OK, SD, MS, NJ, TN, VA, TX, WA, WV, WY and is subject to change



AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Custom Formulary	Fee	
Custom Formulary and Maintenance , including services such as: • Custom UM Criteria • Custom Exclusion Lists • Custom Preventive Lists • Hyperinflation Management • Compound Management • Net Cost Analysis and Consultation	\$100,000	
Enhanced Safety, Adherence and Gaps in Care Programs	Fee	Basis*
Pharmacy Advisor Counseling at CVS Pharmacy ¹	\$0.25**	PMPM
Pharmacy Advisor Counseling All Channels ¹	\$0.60**	PMPM
Pharmacy Advisor Counseling Retail All Channels ¹	\$0.60**	PMPM
Integrated Fraud and Safety Solutions	\$0.06	PMPM
Drug Savings Review (DSR) (2:1 ROI over 1 year) ²	\$0.30	PMPM
Precertification	Fee	Basis
Clinical and Non-Clinical Review		
• Precertification	\$45.00	Per review
• Formulary Exceptions	\$45.00	Per review
• Wegovy Cardiovascular	\$45.00	Per review
Specialty Precertification	Fee	Basis
Specialty Guideline Management (SGM) Precertification	\$45.00	Per review
Initial Reviews & Appeals	Fee	Basis

Initial Clinical and Non-Clinical Reviews, including Prior Authorization and Exceptions ⁴	\$45.00	Per review
Appeals		
• First Level Appeals	\$100.00	Per review
• Second Level Appeals	\$500.00	Per review
• Urgent Appeals (Combination of 1st & 2nd Level Appeals)	\$600.00	Per review
• External Review	\$500.00	Per review
Vendor Transition Files	Fee	Basis
Termination files for all open mail service and specialty pharmacy refill files (one test and two production files)	\$5,200	As listed
Specialty User Report (SUR) – specialty pharmacy file	\$1,500	Per file
Refill Transfers upon termination	\$4,500	Per file
Precertification history	\$3,500	Per file
Accumulator files	\$1,000	Per file
Historical claims data	\$1,000	Per file
Additional Services	Fee	Basis
Custom programming (includes customer-specific data file formats, reporting, or IT systems work)	\$150	Per Hour
Standard on-going claim files to third-parties (includes Universal Pharmacy Claim File)	\$500	\$500 for initial set up and \$500 per file for ongoing frequencies.
Optional pre-transition Open Refill Transfer	\$1,500	Per file
Audit Claim Files for data over 24 months old	\$5,000	Per file
Open enrollment site: applicable link changes not included	\$150	Per hour

Prior Authorization Microsite	\$150	Per hour
Prescription Drug Data collection - annual reporting	\$0.02	PMPY
Aetna Report Rx Self-Service Reporting Tool License over 10 Customer users	\$1,500	Per License
Caremark Cost Saver™ 3	\$0.00	Optional
Vaccine Program Management Fee	\$0.05	PMPM
Manual Claim Administration Fee	\$1.50	Per claim
Shipping and Handling of Temperature Sensitive Products	\$22.00	Per Non-Specialty Mail Rx Temperature Sensitive



AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Additional Specialty Programs	Fee	Basis
Custom Specialty Network - When Accreditation Support is Required		Quoted Upon Request

Charges for services not identified above and/or changes in financial terms resulting from a change in the scope of services shall be quoted upon request.

Pricing noted above for programs not implemented within twelve (12) months from the time of pricing negotiations is subject to change.

NOTES:

¹ Pharmacy Advisor Counseling Additional Terms:

- (a) Customer may terminate the Pharmacy Advisor Counseling program by providing Aetna at least 60-days prior written notice.
- (b) The pricing described above for Pharmacy Advisor Counseling program is based on the following conditions:
 - (i) In the event Customer desires to include additional lines of business, implement a portion of the Plan Participants, or reduces the Plan Participants participating in the Pharmacy Advisor program, Aetna may revise pricing for the program.
 - (ii) Customer agrees to implement all the current conditions in Pharmacy Advisor Counseling: Asthma/COPD, Breast Cancer, Depression, Diabetes, Cardiovascular conditions, and Osteoporosis.
 - (iii) The above pricing reflects the current program and future program expansions may require an additional fee.

² Drug Savings Review Additional Terms:

Aetna guarantees that the gross Customer savings realized from DSR Program over the first Clinical Program Year shall be 200% of the DSR Program fees paid by Customer during the first Clinical Program Year. For the subsequent Clinical Program Years, Aetna guarantees that the gross Customer savings realized from DSR Program shall be 300% of the DSR Program fees paid by Customer during subsequent Clinical Program Years. "Clinical Program Year" means the twelve (12) month period commencing on the start date of the Drug Savings Review Program and each full consecutive twelve (12) month period thereafter that the Drug Savings Review program is provided. In the event Aetna fails to meet the targeted savings, Customer shall be credited for any guaranteed savings short-fall following the end of the applicable Clinical Program Year, up to the amount of fees paid by Customer for the Drug Savings Review Program during the Clinical Program Year. Reconciliation will occur during the quarter after the conclusion of Clinical Program Year.

Aetna may revise the performance guarantee at time of reconciliation in a manner designed to account for membership shifts of 20% or more during the Clinical Program Year. The performance guarantee offered for the Drug Savings Review Program is conditioned on (1) Customer maintaining a monthly average of at least 1,500 Members throughout the Clinical Program Year and (2) Customer participating in the Drug Savings Review Program for the entire Clinical Program Year.

³ Caremark Cost Saver™ : The pricing in the Pharmacy Service and Fee Schedule assumes the use of the Caremark Cost Saver™ program, under which Aetna may compare the price available under the Aetna contracted network with the price available through a non-Aetna contracted network if available for that pharmacy. If the price is lower through a non-Aetna contracted network (including an administrative fee paid to the third-party that contracts the network), the Claim will be processed through that network. These Claims are included in the reconciliation of all financial guarantees. In these instances, the prescription through retail may be less than the same Drug, dosage form, and dose through mail on the same day of adjudication.

⁴ Reviews through the Specialty Guideline Management and Specialty Preferred Drug Plan Design programs will be charged this per review fee.

***DEFINITIONS:**

PMPM = Per Member Per Month

PEPM = Per Employee Per Month

**if retiree membership is over 15%, referral needed to review for custom pricing.

**AETNA PHARMACY PROGRAM SUMMARY – THIRD-PARTY SERVICES**

The services outlined below are provided by third party providers.

Optional Third-Party Services	Fee
PrudentRx Copay Optimization • The PrudentRx offering minimizes the impact of manufacturer copay cards, targeting all Specialty Drugs, including highly utilized classes such as hepatitis C, autoimmune, oncology and multiple sclerosis, to drive maximum value for Customers while providing Members with \$0 out-of-pocket costs. • Customers contract directly with PrudentRx for this service. • Program costs are a percentage of shared savings billed monthly by PrudentRx. Aetna does not charge any fees to Customer to support the PrudentRx Copay Optimization services.	Quoted by Prudent Rx upon request

Pharmacy Service and Fee Schedule to the Master Services Agreement

**Effective January 01, 2026
Miami Dade County Government**



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Pharmacy Discounts & Fees

Management or administration of prescription drug benefits selected by the Customer will be performed by CaremarkPCS Health, L.L.C. and/or its affiliates (CVS Caremark), each of which is an affiliated, licensed pharmacy benefit manager.

Pricing Arrangement	Pass Through at Retail
Network	Aetna National with Extended Day Supply (Retail 90) Network
Employees	28,618

RETAIL 30					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Brand Discount	AWP - 20.50%	AWP - 20.60%	AWP - 20.70%	AWP - 20.80%	AWP - 20.90%
Generic Discount	AWP - 87.00%	AWP - 87.20%	AWP - 87.40%	AWP - 87.60%	AWP - 87.80%
Dispensing Fee	\$0.60 per Script	\$0.60 per Script	\$0.60 per Script	\$0.60 per Script	\$0.60 per Script

RETAIL 90					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Brand Discount	AWP - 20.50%	AWP - 20.60%	AWP - 20.70%	AWP - 20.80%	AWP - 20.90%
Generic Discount	AWP - 87.75%	AWP - 87.95%	AWP - 88.15%	AWP - 88.35%	AWP - 88.55%
Dispensing Fee	\$0.45 per Script	\$0.45 per Script	\$0.45 per Script	\$0.45 per Script	\$0.45 per Script

MAIL ORDER PHARMACY					
Mail Benefit Type	Mail Order Pharmacy				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Brand Discount	AWP - 20.00%	AWP - 20.10%	AWP - 20.20%	AWP - 20.30%	AWP - 20.40%
Generic Discount	AWP - 92.00%	AWP - 92.20%	AWP - 92.40%	AWP - 92.60%	AWP - 92.80%
Dispensing Fee	\$0.00 per Script	\$0.00 per Script	\$0.00 per Script	\$0.00 per Script	\$0.00 per Script

SPECIALTY PHARMACY					
Network	Specialty Regional Network				
Product List	Aetna Specialty Product List				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Discount	AWP - 22.75%	AWP - 22.85%	AWP - 22.95%	AWP - 23.05%	AWP - 23.15%

GENERIC DISPENSING RATE (GDR) GUARANTEE					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Retail GDR	85.00%	85.25%	85.50%	85.50%	85.50%
Mail GDR	86.25%	86.50%	86.75%	86.75%	86.75%
Annual Maximum	\$750,000	\$750,000	\$750,000	\$750,000	\$750,000

ADMINISTRATIVE FEES					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Admin Fee	\$2.00 PEPM	\$2.00 PEPM	\$2.00 PEPM	\$2.00 PEPM	\$2.00 PEPM

Third Party Vendor Fees					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
NACo Fee	\$0.50 Per Script	\$0.50 Per Script	\$0.50 Per Script	\$0.50 Per Script	\$0.50 Per Script

CLINICAL PROGRAM FEES*					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Vaccine Program Management Fee	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM	\$0.05 PMPM

*Clinical Program Fees may be billed on a substantially equivalent PEPM Basis

ALLOWANCES					
	01/01/2026	01/01/2027	01/01/2028	01/01/2029	01/01/2030
Implementation Allowance	\$5.00 PMPY	N/A	N/A	N/A	N/A
General Allowance	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY	\$3.00 PMPY
Audit Allowance	\$80,000	N/A	N/A	N/A	N/A

Rebates

REBATES					
Formulary	Aetna Standard Formulary				
Plan Design	3 Tier Qualifying* (In Force Today)				
Rebate Terms	Customer will receive the following minimum rebate guarantees:				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029*	01/01/2030*
Retail	Greater of 100% or \$432.58 Per Brand Script	Greater of 100% or \$464.43 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script
Retail 90	Greater of 100% or \$938.65 Per Brand Script	Greater of 100% or \$991.86 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script
Mail Order	Greater of 100% or \$749.13 Per Brand Script	Greater of 100% or \$785.94 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script
Specialty	Greater of 100% or \$3,400.26 Per Brand Script	Greater of 100% or \$3,633.72 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script

*Pricing for 1/1/2029 and 1/1/2030 will be evaluated at a later time, in advance of the 1/1/2029 and 1/1/2030 renewal dates.

REBATES					
Formulary	Aetna Standard Formulary				
Plan Design	3 Tier Non-Qualifying* (In Force Today)				
Rebate Terms	Customer will receive the following minimum rebate guarantees:				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029*	01/01/2030*
Retail	Greater of 100% or \$432.58 Per Brand Script	Greater of 100% or \$464.43 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script
Retail 90	Greater of 100% or \$938.65 Per Brand Script	Greater of 100% or \$991.86 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script
Mail Order	Greater of 100% or \$749.13 Per Brand Script	Greater of 100% or \$785.94 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script
Specialty	Greater of 100% or \$3,400.26 Per Brand Script	Greater of 100% or \$3,633.72 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script

*Pricing for 1/1/2029 and 1/1/2030 will be evaluated at a later time, in advance of the 1/1/2029 and 1/1/2030 renewal dates.

REBATES					
Formulary	Aetna Standard Formulary				
Plan Design	2 Tier* (In Force Today)				
Rebate Terms	Customer will receive the following minimum rebate guarantees:				
	01/01/2026	01/01/2027	01/01/2028	01/01/2029*	01/01/2030*
Retail	Greater of 100% or \$432.58 Per Brand Script	Greater of 100% or \$464.43 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script	Greater of 100% or \$493.37 Per Brand Script
Retail 90	Greater of 100% or \$938.65 Per Brand Script	Greater of 100% or \$991.86 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script	Greater of 100% or \$1,037.49 Per Brand Script
Mail Order	Greater of 100% or \$749.13 Per Brand Script	Greater of 100% or \$785.94 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script	Greater of 100% or \$821.15 Per Brand Script
Specialty	Greater of 100% or \$3,400.26 Per Brand Script	Greater of 100% or \$3,633.72 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script	Greater of 100% or \$3,822.50 Per Brand Script

*Pricing for 1/1/2029 and 1/1/2030 will be evaluated at a later time, in advance of the 1/1/2029 and 1/1/2030 renewal dates.

Capitalized terms in the pricing charts above are not intended to reflect defined terms except where specifically noted in the Prescription Drug Services Schedule.

Standard core as well as additional and third-party service options are described in the Aetna Pharmacy Program Summary incorporated herein by reference.

In the event of any inconsistencies between the terms and conditions set forth in this Pharmacy Service and Fee Schedule and the terms and conditions set forth in the Prescription Drug Services Schedule, the term and conditions of this Pharmacy Service and Fee Schedule shall prevail.

Terms & Conditions

The pricing and services set forth herein are subject to the following Terms & Conditions:

- To the extent the pricing and services outlined in this document is part of a proposal to the Customer, the pricing set forth herein is valid for 90 days from the date of such offer.
- This pricing has an effective date of January 1, 2026. In order for Aetna to implement the pricing as set forth above by the effective date, a notification of award must be given 90 days prior to effective date.
- Our proposal assumes that Aetna administers both the medical and pharmacy benefits for Customer on an integrated basis. If Customer elects to use a different vendor to provide medical benefits, then Aetna reserves the right to adjust the pricing contained in this proposal.
- The pricing and services contained herein are limited to prescription drugs dispensed by a Participating Pharmacy to Plan Participants.
- Participating Pharmacy shall give the Plan Participant the benefit of the lesser of (i) the Participating Pharmacy's Usual and Customary Charge, (ii) MAC (where applicable) or (iii) discounted AWP cost. Participating Pharmacy shall collect and retain from the Plan Participant at the time of dispensing the lesser of (i) the Cost Share; (ii) the Participating Pharmacy's Usual and Customary Charge, (iii) MAC (where applicable) or (iv) discounted AWP cost.
- MAC Pricing applies at Mail Order.
- Cost Share will be calculated on the basis of the rates charged to the Customer by Aetna for Covered Services, except for fixed copays or where required by law to be otherwise.
- Discounts and Dispensing Fees contained in this Service and Fee Schedule are guaranteed on an annual basis, subject to the following conditions:
 - Pricing guarantees are measured and reconciled as four separate channels with the channels defined as retail network, mail pharmacy, specialty pharmacy, and rebates.
 - Discount and Dispensing Fee guarantees shall be reconciled and reported to Customer within ninety (90) days following the guarantee period.
 - Discount guarantees are calculated on ingredient cost prior to the application of Plan Participant Cost Share and include zero balance due claims.
 - The following types of Prescription Drug claims are excluded from the Discount and Dispensing Fee guarantees contained herein:
 - Compound Prescription claims
 - Direct Plan Participant reimbursement / out-of-network claims
 - Coordination of Benefits (COB) or secondary payor claims
 - In-house pharmacy claims
 - Vaccines (including for COVID) and other COVID testing-related claims
 - 340B claims
 - Retail pricing guarantees include claims that reflect the Usual & Customary Retail Price.
 - Single Source Generic Drugs are included in the Generic Discount guarantees.

- Only Specialty Products dispensed by a Specialty Pharmacy are included in the Specialty Pharmacy Discount guarantee listed above. Specialty Products dispensed by Participating Retail Pharmacies are not included in any Discount guarantee listed above.
 - Aetna has assumed 0.00% in-house pharmacy utilization. Aetna reserves the right to re-evaluate the proposed pricing if the actual in-house pharmacy utilization varies from this assumption.
 - Pricing and terms in this proposal assume the Customer has elected the Aetna Standard formulary and the Choose Generics program. In addition, for Miami's Dade County's collective bargained populations, the elected Aetna Standard formulary also includes claims-initiated prior use exemption (PUE) or grandfathering of existing utilizers, as well as member-initiated PUE for new utilizers added to the specific plan(s) after 1/1/2026. Both PUEs will apply until the CBA is renegotiated.
 - The proposed formulary includes certain preferred Brand Drugs where the Tier 1 cost share shall be assessed to Members.
 - Specialty Regional Network means that Plan Participants are required to use participating Specialty Pharmacies (no fills at retail allowed), with the exception of the HIV class which is not required to be dispensed at CVS Specialty Pharmacies.
 - Non-Specialty Claims dispensed by a CVS Specialty Pharmacy will adjudicate as a Retail Non-Specialty Claim.
 - The Overall Effective Discount (OED) offer is conditioned on Plan Participants exclusively using the Aetna Specialty Regional Network comprised of only CVS Specialty Pharmacies with the exception of the HIV class and Customer implementing and maintaining a generics first plan design for specialty. The Aetna Specialty Regional Network option may not be available to Plan Participants in certain states. If Aetna Specialty Performance Network is no longer available in certain states, then Customer must select an alternate Specialty Pharmacy network option made available by Aetna. Aetna may equitably adjust the financial terms in this Agreement to account for the impact of any such network change. The rates quoted herein apply to Specialty Products dispensed from CVS Specialty Mail Order Pharmacies, including through the Specialty Connect process. Aetna may amend the individual Specialty Product Discounts to manage the financial guarantee. The financial guarantee is measured and reconciled annually across all Specialty Products dispensed by CVS Specialty pharmacy, including through the Specialty Connect process, with the exception of the following exclusions (in addition to the Discount and Dispensing Fee exclusions). Note: New to market and existing Biosimilars are included in the discount guarantees.
 - New to Market Specialty Products
 - Limited and exclusive distribution drugs
- For the items noted here, the following quoted rates shall apply.
- New to Market Specialty Products: AWP -16.00%;
 - New to Market Limited and exclusive distribution drugs: AWP -15.00%

MAC: Certain dosage forms and strengths may not be included on the MAC List and shall be priced at the specialty default rate.

In the event retail leakage increases by a percentage change of 10%, or more, from the effective date of the agreement, Aetna reserves the right to amend pricing.

- Our financial offer does not assume any adoption of the Transform Diabetes Program. If customer offers a Diabetes Management program, either by Aetna or another vendor, the proposed rebates will need to be re-evaluated.
- Rebate guarantees will exclude the claims noted below; however, any Rebate collected by Aetna for such claims will be passed through to the Customer in accordance with the Rebate terms described herein.
- Rebate guarantees may be subject to:
 - The adoption of Specialty Guideline Management (SGM) program
 - Plan performance that is materially the same as the baseline data provided by Customer and relied upon by Aetna, including information regarding enrollment and utilization of pharmacy services.
- The above rebate guarantees exclude:
 - Any other Claim identified as having received 340B program wholesale pricing
 - Compound Drug Claims
 - Paper or Member Submitted Claims
 - Coordination of Benefits (COB) or secondary payor Claims
 - Vaccine and vaccine administration Claims
 - COVID treatment Claims
 - Claims approved by Formulary Exception
- Rebate guarantees assume Advanced Control Specialty Formulary.
- Specialty rebate guarantees apply to Specialty Product claims at all channels.
- Brand drug claims in the HIV therapeutic category are included in the retail rebate guarantees.
- To receive the rebate guarantees noted:
 - Two-tier qualifying plan designs - will consist of an open plan design, with the first tier comprised of Generic Drugs and the second tier comprised of Brand Drugs. There are no requirements for a minimum Cost Share differential between these tiers. The plan design may need to implement formulary interventions recommended by Aetna.
 - Three-tier non-qualifying plan designs – maintain a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs.
 - Three-tier qualifying plan designs – maintains a first tier comprised of Generic Drugs, a second tier comprised of preferred Brand Drugs, and a third tier comprised of non-preferred Brand Drugs. The plan design maintains at least a \$15.00 co-payment differential between preferred and

non-preferred Brand Drugs, at least a \$15.00 differential in the minimum co-payment for coinsurance, or a differential of coinsurance 1.5 times or 50 percentage points between the preferred and non-preferred Brand Drugs (for example, if preferred brand coinsurance was 20%, non-preferred brand would need to be 30% to qualify).

- Rebate guarantees are measured individually by component and reconciled in the aggregate on an annual basis within 12 months following the end of the Plan year; a surplus in one or more component Rebate guarantees may be used to offset shortages in other component Rebate guarantees.
- The GDR guarantees are based upon plan design, membership, and demographics as represented by Customer, and changes to these aspects may materially affect Aetna's ability to meet the GDR guarantees. In the event of a change to the Plan design, or the Plan's demographics, both parties agree to work in good faith to determine if the GDR guarantees should be adjusted to account for such change, whether higher or lower, depending on the actual impact of such change. An example of this would be situations where generically available medications are excluded from the benefit, such as OTC equivalent strengths. If a brand does not lose patent protection when expected due to unforeseen circumstances, including but not limited to litigation, the parties acknowledge and agree an adjustment may need to be made to the GDR guarantees. The GDR guarantees will be measured and reconciled in the aggregate. The following are excluded from the GDR guarantees calculation: Specialty Drugs, Compound claims, Direct Plan Participant reimbursement / out-of-network claims, COB claims, DAW 1, 2, and 7, and Vaccines. Any potential amount owed will be determined based on the following formula: (Average Amount Paid per Brand claim - Average Amount Paid per Generic claim) multiplied by (GDR guarantee - GDR measured) multiplied by total claims. Penalties for a shortfall on the GDR guarantees will be paid on a dollar-for-dollar basis, with a maximum annual payment cap of \$750,000.00.
- The Aetna Extended Day Supply Network provides the flexible option of a nationwide network of retail pharmacies that can fill up to a 90 days' supply of medications. Aetna's Retail-90 Network pricing is applicable for non-specialty claims equal to or greater than an 84 days' supply filled by a participating Aetna Retail-90 Network pharmacy.

Market Check

On an annual basis, in the second quarter of each Contract Year, and at Customer's reasonable request, Aetna and Customer or a mutually agreed upon third party with a signed non-disclosure agreement may review the financial terms of Customer compared to financial offering presented to similar employers in the marketplace as deemed appropriate. The parties agree for the purpose of this market check that Aetna or Customer's representative will compare, among other things, the following factors to determine whether Customer is entitled to such revised pricing terms: (i) the aggregate pricing terms of such applicable customers of comparable size, inclusive of the program savings, the retail pricing for brand and generic drugs, pricing for specialty drugs, administrative fees, rebates and guarantees; (ii) the services provided by Aetna to such customers; and (iii) the plan design of such customers, which may

include plan formulary, brand/generic utilization information and mail and retail utilization information, available to Aetna. Customer, or its representative, shall provide Aetna with a report to substantiate its findings. Should the comparison demonstrate that the current market conditions would yield a savings of 2% or more in net costs (i.e. gross costs net of administration fees and rebate guarantees), then the parties will discuss in good faith a revision to the current pricing terms and other applicable contract provisions. If Customer and Aetna agree to any revisions to the financial terms as a result of this review (i) the agreement shall be amended and (ii) shall be effective January of the contract year following agreement on such revisions, provided that the parties agree on final pricing not less than 120 days prior to the first day of the contract year as to which the revisions are to apply.

Allowances

Allowances which are based on the information available to Aetna during this process will be available as of the Effective Date of the Pharmacy Services and Fee Schedule. Aetna will pay related expenses directly to a third-party vendor once the Customer sends the invoice(s) outlining the expenses incurred to Aetna. Invoices must be submitted before the end of each Plan year otherwise the Customer forfeits the funds. Any unused allowance monies at the end of each Plan year will be forfeited. It is the intention of the parties that, for purposes of the Federal Anti-Kickback Statute, this credit shall constitute and shall be treated as discounts against the price of drugs within the meaning of 42 U.S.C. §1320a-7b(b)(3)(A). The parties acknowledge and agree that the allowances provided by Aetna are commercially reasonable and necessary services related to this Agreement, including without limitation, implementation, audit, communication and/or external data file/feeds, and represent fair market value for the services provided.

Implementation Allowance

Aetna shall provide the Customer with an Implementation Allowance of up to \$5.00 per member per year. The Customer can use this allowance to pay for reasonable implementation and enrollment services incurred during the first Plan year.

Audit Allowance

Aetna is including an audit allowance of up to \$80,000.00 on a 1st year only basis. The Customer can use this allowance to pay for the costs associated with an audit performed to review claim transactions for the purpose of assessing the accuracy of the benefit determination.

General Allowance

Aetna is including a general allowance up to \$3.00 per enrolled member per year on an Annual basis. The Customer can use this allowance to pay for implementation, audit or communication related expenses along with external data files or feeds.

Third Party Vendor Fees

Pharmacy pricing includes \$0.50 per script in ongoing third party Service and Audit fees payable monthly to the NACo.

Additional Disclosures

The Customer acknowledges that the Discounts and Dispensing Fees contained in this Agreement reflect a Transparent or Pass Through pricing arrangement at Retail. Transparent or Pass Through Pricing means the amount charged to the Customer and Plan Participants for network claims shall equal the amount paid to Participating Retail Pharmacy. Maintenance Choice claims dispensed at CVS/pharmacy, if applicable, are exempt from the Transparent Pricing requirements under this Agreement. The amount billed to the Customer will be equal to the amount paid to the participating pharmacies.

The financial provisions in this Agreement are based upon Claims data and membership information provided by Customer (or Customer's authorized representative) during the pricing request process, which shall serve as the baseline. Aetna reserves the right to make an equitable adjustment to modify or amend the financial provisions set forth herein in a manner designed to account for the impact of specific triggering events identified below ("Equitable Adjustment").

1. Greater than 15% change in total membership or Claims volume as compared to the baseline
2. Customer-initiated change to the Benefit Plan Design, or Formulary alignment. To the extent applicable, Aetna will notify Customer in advance of any proposed Equitable Adjustment
3. Product offering decisions by drug manufacturers that result in a reduction of rebates, including the introduction of a lower cost alternative product which may replace an existing rebateable brand product; an unexpected launch of an interchangeable version of a brand product; or a branded product converted to OTC status, recalled or withdrawn from the market; or a material reduction in the Wholesale Acquisition Cost (WAC); or
4. Other events triggering an Equitable Adjustment as detailed below:
 - Legal and/or regulatory changes specific to customers which negatively affects the economic value of the Agreement to a party or the parties under the Agreement, for example restrictions on preferred or limited network arrangements; policy changes impacting drug manufacturers which negatively affect the economic value of the Agreement including the ability to provide or maintain discounts or Rebates; and/or
 - An inability to access, or changes to, industry pricing information (e.g. AWP) required to support the current economic structure of the Agreement.

If one or more of such triggering events occurs, Aetna may initiate a review to determine if an Equitable Adjustment to any of the financial provisions is warranted as a direct result of the triggering event(s). Aetna will conduct an analysis based upon Customer-specific Claims, utilization, and membership data demonstrating how the triggering event(s) result in the proposed Equitable Adjustment. Any such Equitable Adjustment based upon events #1 or #2 described above shall be effective on the first day that the triggering event occurred. Any such Equitable Adjustment based upon events #3 or #4 described above shall be effective 30 days after notification to Customer. Aetna will provide

documentation of the reason for the proposed Equitable Adjustment in addition to a summary analysis demonstrating that the Equitable Adjustment is solely related to the impact of the specific triggering event. Aetna will disclose necessary facts and data to an independent auditor for validation.

Aetna reserves the right to modify its products, services, and fees, and to recoup any costs, taxes, fees, or assessments, in response to legislation, regulation or requests of government authorities. Any taxes or fees (assessments) applied to self-funded benefit Plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the Customer. The pharmacy pricing contained herein does not include any such Customer liability.

Rebate Payment Terms

Rebates will be distributed on a quarterly basis by claim wire credit.

Rebate collections are paid quarterly one hundred and twenty (120) days after the quarter ends. Rebates are calculated and paid in accordance with the terms and conditions of this Agreement. Earned Rebates are distributed in March, June, September and December each contract year.

Rebates are paid on Prescription Drugs dispensed by Participating Pharmacies and covered under Customer's Plan. Rebates are not available for Claims arising from Participating Pharmacies dispensing Prescription Drugs subject to either their (i) own manufacturer Rebate contracts or (ii) participation in the 340B Drug Pricing Program codified as Section 340B of the Public Health Service Act or other Federal government pharmaceutical purchasing program. The Customer shall adopt the formulary indicated in the rebates section of this Service and Fee Schedule in order to be eligible to receive Rebates.

When remitting and reconciling minimum Rebate guarantees, Aetna may add "Rebate Credit" value to the total Rebates remitted to Customer for each respective Rebate component (e.g., Retail, Mail, Retail 90, and Specialty). "Rebate Credits" shall consist of (i) the differential between the Wholesale Acquisition Cost (WAC) of a lower net cost Brand Drug, including but not limited to a Biosimilar, ("Low Cost Brand") Claim processed, and the WAC of the reference Brand Drug, subject to the below cap; and/or (ii) the value of WAC reductions for rebateable products that have experienced a material WAC decrease and material rebate reduction, measured as the differential between the Baseline WAC of the product and the WAC of the product when the Claim is processed, subject to the below cap. The "Baseline WAC" will be the WAC of the product prior to a reduction in WAC or, as applicable, for Low Cost Brands, the Baseline WAC will be the WAC of the reference Brand Drug at the time of Claim processing.

Rebate Credit will be capped in two ways: First, the WAC of the reference Brand Drug will be capped at a pre-determined WAC inflation rate communicated at time the eligible product is added to the list of products eligible for the Rebate Credit. Second, in no way will the Rebate Credit exceed the Baseline Rebate less the earned Rebates on either the Low Cost Brand or the rebateable product that has experienced a WAC decrease. "Baseline Rebate" is calculated as follows: in the year the price reduction occurred, Baseline Rebate will be the Rebate available for coverage of the product prior to the WAC

reduction or, as applicable, for Low Cost Brands the Baseline Rebate will be the Rebate available for coverage of the reference Brand Drug on the date of Claim processing. For a product experiencing a WAC reduction in subsequent years, the Baseline Rebate will increase over the prior year Baseline Rebate at the average WAC inflation rate of the GPI subclass (GPI-6) of the impacted product. Aetna shall perform all Rebate Credit calculations at a Claim level based on the unit quantity attached to the Claim, and shall map Low Cost Brand NDCs to the NDCs of reference Brand Drugs with the most equivalent attributes (e.g., strength, package size).

The following products will be eligible for the Rebate Credit: (1) Any Biosimilar product processed where Humira or Stelara are the reference Brand Drug; (2) any Insulin product (GPI-4 2710) that experienced a WAC decrease; and (3) any other products as mutually agreed in writing by Customer and Aetna.

Aetna will provide 60 days' advance notice of product(s) that qualify(ies) for Rebate Credits and will be added to the list of products eligible for the Rebate Credit. Customer may otherwise elect a minimum Rebate guarantee adjustment. Aetna shall provide reporting, upon Customer request, demonstrating the net-cost impact in the therapeutic category(ies) of the product(s) eligible for the Rebate Credit and the proposed adjustment to the minimum Rebate guarantee. A Covered Drug Claim will only be eligible for the Rebate Credit if a minimum Rebate guarantee adjustment has not already been made by Aetna.

Customer's authorized auditor may validate the application of the Rebate Credit value as part of the Customer Rebate Audit set forth in [Section __ of] the Agreement. If Rebate Credits are applied based on manufacturer contracts that are not included within auditor's sample selection, Aetna will make available all additional manufacturer contracts that are necessary to validate and reconcile Aetna's Rebate Credit adjustment. For each additional manufacturer contract provided to validate the Rebate Credit, auditor's review will be limited to only the product impacting the Rebate Credit calculation. With respect to Low Cost Brands, Aetna shall not apply Rebate Credit unless the differential between the Low Cost Brand WAC and the reference Brand WAC is at least twenty-five percent (25%). With respect to rebateable products experiencing a reduction in WAC, Aetna shall not apply Rebate Credit unless the actual drop in WAC is at least twenty-five percent (25%). If Customer disagrees with Aetna in its decision that a change is necessary, Customer may terminate the Agreement without being assessed any penalties (e.g., loss of Rebates earned but not yet paid).

Additional 340B reconciliation and true-up may occur post annual minimum Rebate guarantee reconciliation.

If this Agreement is terminated by Aetna for the Customer's failure to meet our obligations to fund benefits or pay administrative fees (medical or pharmacy) under the Agreement, Aetna shall be entitled to deduct deferred administrative fees or other plan expenses from any future rebate payments due to the Customer following the termination date.

Formulary Management

Aetna offers several versions of formulary options for Customer to consider and adopt as Customer's Formulary. The formulary options made available to Customer will be determined and communicated by

Aetna prior to the implementation date. Customer agrees and acknowledges that it is adopting the Formulary as a matter of its plan design and that Aetna has granted Customer the right to use one of our Formulary options during the term of the Agreement solely in connection with the Plan, and to distribute or make the Formulary available to Plan Participants. As such, Customer acknowledges and agrees that it has sole discretion and authority to accept or reject the Formulary that will be used in connection with the Plan. Customer further understands and agrees that from time to time Aetna may propose modifications to the drugs and supplies included on the Formulary as a result of factors, including but not limited to, market conditions, clinical information, cost, rebates and other factors. Customer also acknowledges and agrees that the Formulary options provided to it by Aetna is the business confidential information of Aetna and is subject to the requirements set forth in the Agreement.

For Miami-Dade County we have agreed, on an exception basis, to only allow a one time of year formulary change. However, in the event of a material market event (i.e introduction of new biosimilars), we reserve the right to update the formulary outside of this once a year exception. Aetna will provide notification in the event of a significant market event.

Other Payments

The term Rebates as defined in the Prescription Drug Services Schedule includes any manufacturer administrative fees that may be paid by pharmaceutical manufacturers to cover the costs related to the reporting and administration of the pharmaceutical manufacturer agreements. Such manufacturer administrative fees are shared with Customer hereunder.

Aetna may also receive other payments from drug manufacturers and other organizations that are not Rebates. These payments are generally for one of two purposes: (i) to compensate Aetna for bona fide services it performs, such as the analysis or provision of aggregated data or (ii) to reimburse Aetna for the cost of various educational and other related programs, such as programs to educate physicians and members about clinical guidelines, disease management and other effective therapies. These payments are not considered Rebates and are not included in Rebate sharing arrangements with Customers.

Aetna may also receive network transmission fees from our network pharmacies for services we provide for them. These amounts are not considered Rebates and are not shared with Customers. These amounts are also not considered part of the calculation of claims expense for purposes of Discount Guarantees, if applicable.

Customer agrees that the amounts described above are not compensation for services provided under this Agreement by either Aetna or CVS Caremark and instead are received by Aetna in connection with network contracting, provider education and other activities Aetna conducts across our book of business. Customer further agrees that the amounts described above belong exclusively to Aetna or its affiliate, CVS Caremark, and Customer has no right to, or legal interest in, any portion of the aforesaid amounts received by Aetna or CVS Caremark.

Rebates for Specialty Products that are administered and paid through the Plan Participant's medical benefit rather than the Plan Participant's pharmacy benefit will be retained by Aetna as compensation for Aetna's efforts in administering the preferred Specialty Products program. Payments or rebates from drug manufacturers that compensate Aetna for the cost of developing and administering value-based rebate contracting arrangements when drug therapies underperform thereunder also will be retained by Aetna.

Early Termination

In the event of an Early Termination, the pharmacy guarantees described hereunder, if any, shall be considered null and void for the Plan year and, therefore, not subject to reconciliation.

In addition, in the event Customer terminates the Agreement prior to the expiration of the initial term for any reason other than for Aetna's material breach, Customer shall refund, prior to the termination date, to Aetna all allowances described herein and received by Customer for the unfulfilled term on a prorated basis

Aetna's remedies as described immediately above are liquidated damages and shall not be characterized as a penalty (collectively, the "Early Termination Fee"). Unless otherwise agreed in writing by the parties, such Early Termination Fee will be due and paid in full within sixty (60) days after the termination effective date.

Late Payment Charges

If the Customer fails to provide funds on a timely basis to cover benefit payments and/or fails to pay service fees on a timely basis as required in the Agreement, Aetna will assess a late payment charge. The current charges are outlined below:

- i. Late funds to cover benefit payments (e.g., late wire transfers): 12.0% annual rate
- ii. Late payments of Service Fees: 12.0%, annual rate

In addition, Aetna will make a charge to recover our costs of collection including reasonable attorney's fees. We will notify the Customer of any changes in late payment interest rates. The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay.

Pharmacy Audit Rights and Limitations

Customer is entitled to one annual Rebate audit, subject to the audit terms and conditions outlined in the Prescription Drug Services Schedule.

Customer is entitled to an annual electronic claim audit subject to standard pharmacy benefit audit practices and audit terms and conditions outlined in the Prescription Drug Services Schedule.

Pharmacy audits shall be conducted at the Customer's own expense unless otherwise agreed to between the Customer and Aetna.



Aetna Pharmacy Program summary – Core Services

Unless otherwise specified, the services outlined below are available at no additional cost for our Customers and Members.

PBM Services	
<i>Included in Core Services</i>	
PBM Benefit Administration	Member Services
• Maintenance Choice • Aetna Standard Preventive Drug List (HDHP) • Aetna Standard Preventive Drug List (ACA) • Integrated retail, mail and specialty claims with medical benefit claims in real-time • Benefit Automation • Loading Client Benefit Plan • RxSavingsPlus Savings Program • Generic Substitution/DAW Penalties	• Member Services Call Center – Available 24/7 • Real-Time Benefits • Aetna Health Mobile App and Internet Tools • Price-A-Drug Tool available at aetna.com or through our mobile app, Aetna Health
Member Communication Materials	Customer Services
• Initial Implementation benefits communication materials, printed and online support • Member specific e-mail communications • Aetna Integrated Pre- and Post-enrollment materials • Clinical program member letters, including transition letters for formulary changes/updates • Informational brochures for using the CVS Caremark Mail Service Pharmacy, including order forms • Member-specific formulary and plan design • Aetna Health website and app brochures	• Claim funding and banking arrangements integrated with your Aetna medical plan • Consultative services • Education materials on key healthcare topics • Implementation support including eligibility loading and ongoing additions/deletions • Regulatory and compliance support by specific line of business • Meetings to discuss program performance • Account Management • Client Authorized Override • Member Satisfaction Surveys • Post Rejection Communications (PRC) • Proactive Retail Refill Notice
Claims Processing Services	Mail Service Pharmacy
• Online, Point-of-Service (POS) claims adjudication with real-time integration with medical claims	• Use of CVS Caremark Mail Service Pharmacies • Information System Infrastructure & Maintenance • Profile/order form and return envelope • Member counseling labels – drug specific • First time fill prescription processing
Online Customer Access	
• Online Services (on-site eligibility maintenance and prior authorization overrides-viewing member claims history)	

- Website Access allowing customized dashboard creating for members--keep



AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Analytics and Reporting	
Included in Core Services	
Analytic Support	Analytic Support cont.
• Aetna Report Rx self-service reporting tool suite for up to 10 Customer users • RxNavigator Self-Service Reporting Tool Suite • E Tool Access (Self Service for Rx Insight Reports)	• Claim detail reporting combined with medical reporting through the new reporting tool, ART
• Account Team Supported Reporting • Clinical Program Opportunity Analysis	• Quarterly clinical and financial reports based on aggregate customer utilization

Formulary	
Included in Core Services	
Standard Formulary Administration	Standard Formulary Administration cont.
• Formulary maintenance	• Rebate administration
• Formulary exclusions lists	• Point of Sale (POS) Rebates Type 3
• Hyperinflation management	• Compound Management

Clinical Programs and Utilization Management Edits	
Included in Core Services	
Clinical Solutions	Clinical Solutions cont.
• Diabetic Meter Program • Standard Utilization Management edits, including quantity limits and step therapy • Pharmacy Advisor Support – Automatic refill and renewal programs	• Dose Optimization • Core Medication Management: Closing Gaps in Medication Therapy • Retrospective Safety Review • Point of Sale (POS) Drug Safety Alerts
• Pharmacy Advisor Support – Adherence to Drug Therapy	• Member and Physician clinical education
• Smart Edit overrides	• Global safety edits
• Opioid safety edits	• Compound drugs management
• Maximum pay edits	• Select OTC Coverage
• Mail Order DAW Solution	



AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Specialty	
Included in Core Services	
Specialty Clinical Solutions	Specialty Support cont.
- Specialty Starter Fill AccordantCare Specialty - Proactively supports and empowers Members with rare conditions to manage their whole condition, not just adherence to their medication (beyond traditional specialty pharmacy care). Members identified by Aetna Specialty dispense for nine (9) specialty conditions. Available to Customers who use the Aetna Specialty Performance Network.	- Specialty Expedite - Specialty Connect - Digital - Secure Messaging - First time fill prescription processing - Specialty CareTeam - Patient Assistance Program
Specialty Benefit Administration	Specialty Pharmacy
Specialty Guideline Management (SGM) – criteria development and maintenance	- Use of the CVS Specialty Pharmacy network with full integration of retail, mail and specialty claims - Information System Infrastructure & Maintenance
- Specialty Copay Card Plan Designs - Standard Specialty Product List	- Member Onboarding - Member counseling label – drug specific
Exclusive Specialty Grace Fill Member Letter (Under Member Communication Materials)	- Supply Management Optimization (SMO) (Exclusive and Preferred Specialty Customers) - Specialty Connect - Digital Secure Messaging - Specialty Expedite - Specialty CareTeam

Digital	
Included in Core Services	
Standard Digital Services	Standard Digital Services cont.
Open enrollment links	Single Sign on (SSO)
Aetna.com configurations	Integrated medical and pharmacy websites



AETNA PHARMACY PROGRAM SUMMARY – CORE SERVICES

Mandatory Fees

The services outlined below are associated with meeting federal, state, and local regulatory compliance requirements

Regulatory Programs	Member Threshold, if any	Fee	Basis
State Regulatory Impact Assessment ¹		\$0.30	Per Retail Claim Only
Retail Network Pharmacy Third Party Appeal		Pass through Fees Per Review	

¹Applies to claims in select states with relevant regulatory requirements. The current list of states includes AL, AR, AZ, CO, DE, FL, GA, IA, LA, MD, MI, ND, NM, OK, SD, MS, NJ, TN, VA, TX, WA, WV, WY and is subject to change


AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Custom Formulary	Fee	
Custom Formulary and Maintenance , including services such as: • Custom UM Criteria • Custom Exclusion Lists • Custom Preventive Lists • Hyperinflation Management • Compound Management • Net Cost Analysis and Consultation	\$100,000	
Enhanced Safety, Adherence and Gaps in Care Programs	Fee	Basis*
Pharmacy Advisor Counseling at CVS Pharmacy ¹	\$0.25**	PMPM
Pharmacy Advisor Counseling All Channels ¹	\$0.60**	PMPM
Pharmacy Advisor Counseling Retail All Channels ¹	\$0.60**	PMPM
Integrated Fraud and Safety Solutions	\$0.06	PMPM
Drug Savings Review (DSR) (2:1 ROI over 1 year) ²	\$0.30	PMPM
Precertification	Fee	Basis
Clinical and Non-Clinical Review		
• Precertification	\$45.00	Per review
• Formulary Exceptions	\$45.00	Per review
• Wegovy Cardiovascular	\$45.00	Per review
Specialty Precertification	Fee	Basis
Specialty Guideline Management (SGM) Precertification	\$45.00	Per review
Initial Reviews & Appeals	Fee	Basis

Initial Clinical and Non-Clinical Reviews, including Prior Authorization and Exceptions ⁴	\$45.00	Per review
Appeals		
• First Level Appeals	\$100.00	Per review
• Second Level Appeals	\$500.00	Per review
• Urgent Appeals (Combination of 1st & 2nd Level Appeals)	\$600.00	Per review
• External Review	\$500.00	Per review
Vendor Transition Files	Fee	Basis
Termination files for all open mail service and specialty pharmacy refill files (one test and two production files)	\$5,200	As listed
Specialty User Report (SUR) – specialty pharmacy file	\$1,500	Per file
Refill Transfers upon termination	\$4,500	Per file
Precertification history	\$3,500	Per file
Accumulator files	\$1,000	Per file
Historical claims data	\$1,000	Per file
Additional Services	Fee	Basis
Custom programming (includes customer-specific data file formats, reporting, or IT systems work)	\$150	Per Hour
Standard on-going claim files to third-parties (includes Universal Pharmacy Claim File)	\$500	\$500 for initial set up and \$500 per file for ongoing frequencies.
Optional pre-transition Open Refill Transfer	\$1,500	Per file
Audit Claim Files for data over 24 months old	\$5,000	Per file
Open enrollment site: applicable link changes not included	\$150	Per hour

Prior Authorization Microsite	\$150	Per hour
Prescription Drug Data collection - annual reporting	\$0.02	PMPY
Aetna Report Rx Self-Service Reporting Tool License over 10 Customer users	\$1,500	Per License
Caremark Cost Saver™ 3	\$0.00	Optional
Vaccine Program Management Fee	\$0.05	PMPM
Manual Claim Administration Fee	\$1.50	Per claim
Shipping and Handling of Temperature Sensitive Products	\$22.00	Per Non-Specialty Mail Rx Temperature Sensitive



AETNA PHARMACY PROGRAM SUMMARY – ADDITIONAL SERVICES

Additional Specialty Programs	Fee	Basis
Custom Specialty Network - When Accreditation Support is Required		Quoted Upon Request

Charges for services not identified above and/or changes in financial terms resulting from a change in the scope of services shall be quoted upon request.

Pricing noted above for programs not implemented within twelve (12) months from the time of pricing negotiations is subject to change.

NOTES:

¹ Pharmacy Advisor Counseling Additional Terms:

- (a) Customer may terminate the Pharmacy Advisor Counseling program by providing Aetna at least 60-days prior written notice.
- (b) The pricing described above for Pharmacy Advisor Counseling program is based on the following conditions:
 - (i) In the event Customer desires to include additional lines of business, implement a portion of the Plan Participants, or reduces the Plan Participants participating in the Pharmacy Advisor program, Aetna may revise pricing for the program.
 - (ii) Customer agrees to implement all the current conditions in Pharmacy Advisor Counseling: Asthma/COPD, Breast Cancer, Depression, Diabetes, Cardiovascular conditions, and Osteoporosis.
 - (iii) The above pricing reflects the current program and future program expansions may require an additional fee.

² Drug Savings Review Additional Terms:

Aetna guarantees that the gross Customer savings realized from DSR Program over the first Clinical Program Year shall be 200% of the DSR Program fees paid by Customer during the first Clinical Program Year. For the subsequent Clinical Program Years, Aetna guarantees that the gross Customer savings realized from DSR Program shall be 300% of the DSR Program fees paid by Customer during subsequent Clinical Program Years. "Clinical Program Year" means the twelve (12) month period commencing on the start date of the Drug Savings Review Program and each full consecutive twelve (12) month period thereafter that the Drug Savings Review program is provided. In the event Aetna fails to meet the targeted savings, Customer shall be credited for any guaranteed savings short-fall following the end of the applicable Clinical Program Year, up to the amount of fees paid by Customer for the Drug Savings Review Program during the Clinical Program Year. Reconciliation will occur during the quarter after the conclusion of Clinical Program Year.

Aetna may revise the performance guarantee at time of reconciliation in a manner designed to account for membership shifts of 20% or more during the Clinical Program Year. The performance guarantee offered for the Drug Savings Review Program is conditioned on (1) Customer maintaining a monthly average of at least 1,500 Members throughout the Clinical Program Year and (2) Customer participating in the Drug Savings Review Program for the entire Clinical Program Year.

³ Caremark Cost Saver™ : The pricing in the Pharmacy Service and Fee Schedule assumes the use of the Caremark Cost Saver™ program, under which Aetna may compare the price available under the Aetna contracted network with the price available through a non-Aetna contracted network if available for that pharmacy. If the price is lower through a non-Aetna contracted network (including an administrative fee paid to the third-party that contracts the network), the Claim will be processed through that network. These Claims are included in the reconciliation of all financial guarantees. In these instances, the prescription through retail may be less than the same Drug, dosage form, and dose through mail on the same day of adjudication.

⁴ Reviews through the Specialty Guideline Management and Specialty Preferred Drug Plan Design programs will be charged this per review fee.

***DEFINITIONS:**

PMPM = Per Member Per Month

PEPM = Per Employee Per Month

**if retiree membership is over 15%, referral needed to review for custom pricing.

**AETNA PHARMACY PROGRAM SUMMARY – THIRD-PARTY SERVICES**

The services outlined below are provided by third party providers.

Optional Third-Party Services	Fee
PrudentRx Copay Optimization • The PrudentRx offering minimizes the impact of manufacturer copay cards, targeting all Specialty Drugs, including highly utilized classes such as hepatitis C, autoimmune, oncology and multiple sclerosis, to drive maximum value for Customers while providing Members with \$0 out-of-pocket costs. • Customers contract directly with PrudentRx for this service. • Program costs are a percentage of shared savings billed monthly by PrudentRx. Aetna does not charge any fees to Customer to support the PrudentRx Copay Optimization services.	Quoted by Prudent Rx upon request

Aetna Gene Therapy Product Proposal

Date Issued:

Firm Quote

7/8/25

Plan Sponsor Number (if assigned)

0

Plan Sponsor Name

Miami Dade County Government

STOP LOSS QUOTE SPECIFICATIONS

Renewal Date:	01/01/26
Policy Period Length (months):	12
Individual Stop Loss Level:	250,000
Contract Type:	12/18
Number of Employees Covered Under Stop Loss:	28,682
Number of Single Covered Under Stop Loss:	17,553
Number of Family Covered Under Stop Loss:	11,129

Medical Coverage	Aetna
Rx Coverage	Aetna
Producer Compensation:	0%

FINANCIAL INFORMATION

Stop Loss Premium:	\$1,247,198
Premium (PEPM) Composite Billing Rate:	\$3.62
PMPM Composite Illustrative Rate	\$2.06

COVERED DRUGS**Drug**

Luxturna
 Zolgensma
 Zynteglo
 Skysona
 Roctavian
 Hemgenix
 Elevidys
 Lyfgenia
 Casgevy
 Lenmeldy (fka Libmeldy, Atidarsagene autotemcel, OTL200)
 Exa-cel - exagamglogene autotemcel
 Beqvez (Fidanacogene elaparovvec)
 Kebilidi (fka Upstaza, AAVhAADC)
 Kresladi/RPL201
 Giroctocogene fitelparovvec
 Zolgensma
 AT132
 UX111(fka ABO-102)
 RPL102
 pariglasgene breccaparovvec
 RGX121
 avalotcogene ontaparovvec
 RPA501
 ST920/ isaralgagene civaparovvec
 botaretigene sparoparovvec
 laruparetigene zosaparovvec
 sonpiretigene isteparovvec
 OCU400

Approved & Pipeline**Brief Diagnosis***

Bi-allelic RPE65 mutation-associated retinal dystrophy
 SMA Type1
 Beta-thalassemia non-β0/β0 & β0/β0 genotype
 CALD - Cerebral adrenoleukodystrophy
 Hemophilia A
 Hemophilia B
 DMD
 SCD/Beta-thal
 SCD/Beta-thal
 metachromatic leukodystrophy (MLD)
 Beta-thalassemia
 Hemophilia B
 Aromatic L-amino acid decarboxylase deficiency
 leukocyte adhesion deficiency type 1 (LAD-1)
 Hemophilia A
 SMA Type2
 X-linked myotubular myopathy
 Sanfilippo syndrome type A
 Fanconi Anemia
 Glycogen storage
 Hunter Syndrome
 OTC deficiency
 Danon disease
 Fabry Disease
 X-linked retinitis pigmentosa
 X-linked retinitis pigmentosa
 retinitis pigmentosa
 retinitis pigmentosa

*Coverage is limited to specific condition, age, and gene expression as included in Aetna CPB after FDA Approval

Gene Therapy Product Proposal - Caveats

This is a final, firm proposal. Additional details may be required to validate the information received. You must accept this proposal within 30 calendar days from the date of its delivery to you. If you fail to do so, Aetna reserves the right to request updated underwriting data, which may result in revised rates and/or terms being offered. This final, firm proposal assumes you have identified, through the claim data or completed Disclosure, all known claimants who have received or are actively progressing through a gene therapy treatment, from initiating the application process to receiving an FDA-approved gene replacement therapy drug. Such known claimants are not included under the 'no lasering' feature for gene replacement therapy drugs.

This is an Individual Stop Loss (ISL) proposal for gene replacement therapy drug reimbursement.

Gene replacement therapies use genetic engineering to replace or repair mutated genes, effectively treating a patient's medical condition. This Individual Stop Loss coverage specifically applies to the gene replacement therapy drugs approved by the U.S. Food and Drug Administration to treat specific disease, age, and gene expressions via one-time gene replacement treatments – or curative treatments – for previously untreatable, often fatal, conditions. There is no coverage for any other medical costs associated with the gene replacement therapy treatment, the underlying medical condition, or other claims paid by the plan.

The gene replacement therapy drugs covered are listed on the Financial Exhibit.

- When the gene replacement therapy drug is administered by one of Aetna's 'Gene-Based, Cellular, and other Innovative Therapies' (GCIT) network providers, Aetna will reimburse you for the cost of the gene replacement therapy drug exceeding the ISL amount shown on the Financial Exhibit.

- When the gene replacement therapy drug is not administered by one of Aetna's 'Gene-Based, Cellular, and other Innovative Therapies' (GCIT) network providers, Aetna will consider the eligible claim expense for the gene replacement therapy drug up to 100% of the Wholesale Acquisition Cost (WAC) and reimburse you for that amount less the ISL amount shown on the Financial Exhibit. You are responsible for any amount exceeding the WAC.

- Aetna will provide this coverage without lasering potential high risk members, ie: those members who have a high probability of receiving gene replacement therapy to treat a specific disease, age, and gene expression. A gene replacement therapy drug is excluded from this feature if a member is known to have received or be actively progressing through gene replacement therapy treatment at the time a final, firm Stop Loss proposal is delivered. A member is considered actively progressing through a gene replacement therapy treatment beginning with a member initiating the application process through receiving an FDA-approved gene replacement therapy drug.

This proposal assumes the group's primary location is situated in the state of Florida and the group meets Aetna's requirements to be situated in this state.

This proposal assumes the Stop Loss policy period is effective 01/01/2026 through 12/31/2026.

Stop Loss coverage is not provided for dates of service prior to the policy's initial effective date.

This proposal includes 6 months of run-out coverage. Eligible claim expenses that accumulate towards the ISL amount as a result of the run-out period will not accumulate toward the subsequent year's ISL amount.

Stop Loss coverage is provided for claims paid on covered persons enrolled in accordance with the eligibility provisions of the underlying medical plan.

Pre- and post-age 65 retirees, and their dependents, have been included in this quotation. Eligible retirees and their dependents age 65 years and older will be treated as Medicare primary and the Insured's plan as secondary.

This proposal assumes the group is a legitimate business and is financially sound.

When multiple divisions are included in the proposal, there must be common ownership among all participating divisions for this quote to remain valid.

This proposal assumes a group size of 28682 employees/covered units 50480 covered persons, and 61.2% of employees covered in the Single tier.

The premium rates indicated in this proposal do not include broker commissions.

We reserve the right to revise premium rates as of the date of any change to the underlying assumptions that impacts the risk assumed for the insurance we are providing under the policy, or if the change affects the initial underlying assumptions made, as of the effective date of coverage. Changes include, but are not limited to:

- Any change of +/- 15% in employees/covered units
 - Any change to the plan document(s) that will change the risk assumed under this policy
 - Any change to the policy
 - Any change in federal or state law or regulation that impacts the policy or the coverage provided
 - Any change impacting the risk we have assumed, including but not limited to: age, gender, geography, incorrect or incomplete information provided in Disclosure statements, etc., that we determine impacts the nature of the risk by more than 15%
 - Any change in claims administrator, provider network or cost containment vendor, provided we have consented to the change in writing
 - Any change in the claims administrator's claim payment system or payment practices that causes a variation of +/- 5% versus the most recent 12 month average of claims processing time
- New units, subsidiaries, etc., will be underwritten. Claim reports may be requested. If this information is not provided, we reserve the right to require a completed and signed Disclosure [and may apply AAW/DNC rules]on the acquired group.

This proposal assumes the claims administrator for the underlying self-insured medical plans is also Aetna.

The Stop Loss policy period must agree with the self-funded plan's contract period, both of which must end on the next renewal date.

If you purchase Aetna's Stop Loss coverage, you will receive your application for insurance electronically. You will access it via a link delivered by email and endorse it using electronic signature capabilities. You will also receive your policy electronically. This process requires a web browser which supports the HTTPS protocol, HTML, and cookies. You will also need to view PDF documents using software such as Adobe Reader or similar. You have the right to request that these transactions occur by regular mail using paper copies, which would require you to physically sign your application and mail it back to us. Please contact your broker and/or your Aetna Account Representative to make this request.

Stop Loss policies and applications/schedules of insurance are updated annually upon renewal. Please contact your broker and/or your Aetna Account Representative for a copy of the Stop Loss policy.

Aetna Gene Therapy Product Proposal

Date Issued:

Firm Quote

7/8/25

Plan Sponsor Number (if assigned)

0

Plan Sponsor Name

Miami Dade County Government

STOP LOSS QUOTE SPECIFICATIONS

Renewal Date: 01/01/26

Policy Period Length (months): 12

Individual Stop Loss Level: 250,000

Contract Type: 12/18

Number of Employees Covered Under Stop Loss: 28,682

Number of Single Covered Under Stop Loss: 17,553

Number of Family Covered Under Stop Loss: 11,129

Medical Coverage Aetna

Rx Coverage Aetna

Producer Compensation: 0%

FINANCIAL INFORMATION

Stop Loss Premium: \$1,109,565

Premium (PEPM) Composite Billing Rate: \$3.22

PMPM Composite Illustrative Rate \$1.83

COVERED DRUGS**Drug**

Luxturna

Zolgensma

Zynteglo

Skysona

Roctavian

Hemgenix

Elevidys

Lyfgenia

Casgevy

Lenmeldy (fka Libmeldy, Atidarsagene autotemcel, OTL200)

Beqvez (Fidanacogene elaparovvec)

Kebilidi (fka Upstaza, AAVhAADC)

Approved Only**Brief Diagnosis***

Bi-allelic RPE65 mutation-associated retinal dystrophy

SMA Type1

Beta-thalassemia non- β^0/β^0 & β^0/β^0 genotype

CALD - Cerebral adrenoleukodystrophy

Hemophilia A

Hemophilia B

DMD

SCD/Beta-thal

SCD/Beta-thal

metachromatic leukodystrophy (MLD)

Hemophilia B

Aromatic L-amino acid decarboxylase deficiency

*Coverage is limited to specific condition, age, and gene expression as included in Aetna CPB after FDA Approval

Gene Therapy Product Proposal - Caveats

This is a final, firm proposal. Additional details may be required to validate the information received. You must accept this proposal within 30 calendar days from the date of its delivery to you. If you fail to do so, Aetna reserves the right to request updated underwriting data, which may result in revised rates and/or terms being offered. This final, firm proposal assumes you have identified, through the claim data or completed Disclosure, all known claimants who have received or are actively progressing through a gene therapy treatment, from initiating the application process to receiving an FDA-approved gene replacement therapy drug. Such known claimants are not included under the 'no lasering' feature for gene replacement therapy drugs.

This is an Individual Stop Loss (ISL) proposal for gene replacement therapy drug reimbursement.

Gene replacement therapies use genetic engineering to replace or repair mutated genes, effectively treating a patient's medical condition. This Individual Stop Loss coverage specifically applies to the gene replacement therapy drugs approved by the U.S. Food and Drug Administration to treat specific disease, age, and gene expressions via one-time gene replacement treatments – or curative treatments – for previously untreatable, often fatal, conditions. There is no coverage for any other medical costs associated with the gene replacement therapy treatment, the underlying medical condition, or other claims paid by the plan.

The gene replacement therapy drugs covered are listed on the Financial Exhibit.

- When the gene replacement therapy drug is administered by one of Aetna's 'Gene-Based, Cellular, and other Innovative Therapies' (GCIT) network providers, Aetna will reimburse you for the cost of the gene replacement therapy drug exceeding the ISL amount shown on the Financial Exhibit.

- When the gene replacement therapy drug is not administered by one of Aetna's 'Gene-Based, Cellular, and other Innovative Therapies' (GCIT) network providers, Aetna will consider the eligible claim expense for the gene replacement therapy drug up to 100% of the Wholesale Acquisition Cost (WAC) and reimburse you for that amount less the ISL amount shown on the Financial Exhibit. You are responsible for any amount exceeding the WAC.

- Aetna will provide this coverage without lasering potential high risk members, ie: those members who have a high probability of receiving gene replacement therapy to treat a specific disease, age, and gene expression. A gene replacement therapy drug is excluded from this feature if a member is known to have received or be actively progressing through gene replacement therapy treatment at the time a final, firm Stop Loss proposal is delivered. A member is considered actively progressing through a gene replacement therapy treatment beginning with a member initiating the application process through receiving an FDA-approved gene replacement therapy drug.

This proposal assumes the group's primary location is situated in the state of Florida and the group meets Aetna's requirements to be situated in this state.

This proposal assumes the Stop Loss policy period is effective 01/01/2026 through 12/31/2026.

Stop Loss coverage is not provided for dates of service prior to the policy's initial effective date.

This proposal includes 6 months of run-out coverage. Eligible claim expenses that accumulate towards the ISL amount as a result of the run-out period will not accumulate toward the subsequent year's ISL amount.

Stop Loss coverage is provided for claims paid on covered persons enrolled in accordance with the eligibility provisions of the underlying medical plan.

Pre- and post-age 65 retirees, and their dependents, have been included in this quotation. Eligible retirees and their dependents age 65 years and older will be treated as Medicare primary and the Insured's plan as secondary.

This proposal assumes the group is a legitimate business and is financially sound.

When multiple divisions are included in the proposal, there must be common ownership among all participating divisions for this quote to remain valid.

This proposal assumes a group size of 28682 employees/covered units 50480 covered persons, and 61.2% of employees covered in the Single tier.

The premium rates indicated in this proposal do not include broker commissions.

We reserve the right to revise premium rates as of the date of any change to the underlying assumptions that impacts the risk assumed for the insurance we are providing under the policy, or if the change affects the initial underlying assumptions made, as of the effective date of coverage. Changes include, but are not limited to:

- Any change of +/- 15% in employees/covered units
 - Any change to the plan document(s) that will change the risk assumed under this policy
 - Any change to the policy
 - Any change in federal or state law or regulation that impacts the policy or the coverage provided
 - Any change impacting the risk we have assumed, including but not limited to: age, gender, geography, incorrect or incomplete information provided in Disclosure statements, etc., that we determine impacts the nature of the risk by more than 15%
 - Any change in claims administrator, provider network or cost containment vendor, provided we have consented to the change in writing
 - Any change in the claims administrator's claim payment system or payment practices that causes a variation of +/- 5% versus the most recent 12 month average of claims processing time
- New units, subsidiaries, etc., will be underwritten. Claim reports may be requested. If this information is not provided, we reserve the right to require a completed and signed Disclosure [and may apply AAW/DNC rules]on the acquired group.

This proposal assumes the claims administrator for the underlying self-insured medical plans is also Aetna.

The Stop Loss policy period must agree with the self-funded plan's contract period, both of which must end on the next renewal date.

If you purchase Aetna's Stop Loss coverage, you will receive your application for insurance electronically. You will access it via a link delivered by email and endorse it using electronic signature capabilities. You will also receive your policy electronically. This process requires a web browser which supports the HTTPS protocol, HTML, and cookies. You will also need to view PDF documents using software such as Adobe Reader or similar. You have the right to request that these transactions occur by regular mail using paper copies, which would require you to physically sign your application and mail it back to us. Please contact your broker and/or your Aetna Account Representative to make this request.

Stop Loss policies and applications/schedules of insurance are updated annually upon renewal. Please contact your broker and/or your Aetna Account Representative for a copy of the Stop Loss policy.



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FULL COBRA ADMINISTRATIVE SERVICES MIAMI-DADE COUNTY GOVERNMENT – SCOPE OF SERVICES

EXHIBIT A

Benefits Outsource, Inc. (BOI) seamless COBRA Administrative services provide a dedicated account representative, an easy, more efficient system to input, monitor and track eligibility, as well as flexible reporting, making a simplified solution to overall COBRA administration.

Administrative services include but are not limited to; access to web-based system, generation of notices, mailings, election and termination processing, monthly billings, premium collections and accountability, detailed monthly reporting and customer service.

Initial Setup:

1. Onboarding/Client Setup - Enter plan specs provided by client into system for line of benefit (i.e. medical, dental, vision, FSA)
 - a. Coordinate requirements for file set-up and transmission of participant data.
2. Receive client data via secure channel (SFTP or Encrypted Email) in various formats.
3. Integrate participant data into Web-system.
4. Receive and send qualified beneficiary data via SFTP, in Excel or CSV format)
5. Integrate qualified beneficiary data into Web-system
6. Generate letters and forms for election; revise as deemed necessary.
7. Provide access to web-based COBRA system for staff to enter COBRA enrollment information and continuants to view information and/or optionally make payments.

Ongoing Administration:

1. Receive client data from carrier(s) via secure channel (SFTP or encrypted email)
2. Annually enter current plan specs into system for respective line of benefit (i.e. medical, dental, vision)
3. Prepare COBRA availability notice for QB
4. Prepare General Notice for New Hires (where applicable)
5. Mail all notices and bill enrolled COBRA continuants monthly
6. Track COBRA election timelines
7. Record and process COBRA elections
8. Notify the client and carrier(s) of COBRA eligibility (enrollment, updates, terminations)
 - a. Via Point of Contact (POC)
 - b. Via Direct Access to respective carrier portal
 - c. Via EDI file feed
8. Provide payment methods via ACH, checks, money order and credit card
9. Collect COBRA premiums and record, accordingly
10. Reconcile premium discrepancy with carrier
11. Send follow-up letter to COBRA continuant regarding premium underpayment, late payment, NSF
12. Send to COBRA continuant reminder notice due to:
 - Failure to make regular payment timely
 - Formal terminations of continuant's coverage; nonpayment, per request by continuant, and upon exhaustion of COBRA period (18, 29 or 36 months)
13. Provide Secondary event notification when applicable
14. Prepare Conversion notice 180 and 60 days prior to attainment of COBRA continuation

15. coverage expiration.
16. Update rates annually at point of renewal, where applicable
17. Assist client with annual Open Enrollments
18. Provide ongoing access, support and training to system for both client & participants
19. Provide QBs and COBRA continuants with a toll-free contact number for convenience
20. Local presence for members to visit, make payment and to discuss their account(s).

Monthly Reporting:

1. Provide monthly Disbursement and Enrollment Details Report with COBRA Continuants to include the following: Name, masked SSN, coverage level, paid through date, monthly premium, unpaid premium, short payment, retroactive premium, termination.
2. Adhoc reports are available upon request



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FULL COBRA ADMINISTRATIVE SERVICES
MIAMI-DADE COUNTY GOVERNMENT **FEE SCHEDULE**

EXHIBIT B

The fee schedule below for COBRA Administrative Services includes but are not limited to; annual web-based set-up of plans, generation of notices, mailings, enrollment election and termination processing, billings, monthly premium collection and remittance, detailed monthly reporting and customer service. Our complete COBRA package offers value-added administration and competitive pricing, combined with excellent service.

COBRA FEES: PER BENEFIT ELIGIBLE EMPLOYEE PER MONTH (PEPM) ADMINISTRATIVE SERVICES PRICING (Quoted in accordance with BOI's discounted Graded Scale)			
Plan Years	2026-2028	2029	2030
Implementation Fee	Waived	Waived	Waived
Annual Recurring Fee	Waived	Waived	Waived
COBRA Administrative Services Fee	\$.92	\$.92	\$.92

Rates include administrative costs related to COBRA administrative services as outlined in EXHIBIT A, Scope of Services.

Venipuncture Service: On-site Event or Patient Service Center	
A minimum of 30 participants is necessary for the pricing below. Requests submitted require an 8-12 week lead time from date that the Service Request is signed by the plan sponsor. Any changes or cancellations once the implementation work begins will incur a fee. All Online My Guide Reports noted are digital/online only. Printed, paper versions are available as a buy-up.	
Venipuncture Services	On-Site/PSC per participant
Fasting Lipid/Glucose Panel: TC, HDL, calc. LDL, Trig, ratio(calc TC/HDL), glucose, measured Ht/Wt, calculated BMI and/or Waist Circumference, BP, Online My Guide Report, MET S Insights	\$53.00
Non-Fasting Lipid/Glucose Panel: TC, HDL, ratio (TC/HDL), (glucose or HgbA1c), measured Ht/Wt calc BMI and/or waist circumference, BP, Online My Guide Report	\$53.00
Full Comprehensive: %Saturation, Albumin, Albumin/Globulin Ratio, Alkaline Phosphatase, ALT, AST, Bilirubin, Direct, Bilirubin, Total, BUN/Creatinine Ratio, Calcium, Cardio CRP, Chloride, Creatinine, EGFR (Estimated Glomerular Filtration Rate) EGFR African American ,Ferritin, GGT, Globulin, Iron Binding Capacity (TIBC), Iron, Total, Potassium, Protein, Total, Sodium, T-4, Free, TSH, 3rd Generation, with reflex, Urea Nitrogen (BUN), TC, HDL, calc. LDL, Trig, ratio(calc TC/HDL), glucose, measured Ht/Wt, calculated BMI and/or Waist Circumference, BP, Online My Guide Report	\$100.00
Comprehensive Metabolic Panel with eGFR Glucose, Albumin, Alkaline Phosphatase, Aspartate Transaminase, Bilirubin Total, Calcium, Carbon Dioxide, Chloride, Creatinine, Globulin, Potassium, Protein Total, Sodium, Urea Nitrogen (bun), BUN Creatine Ratio, eGFR, ALT, AST Choose one of the following options: Fasting Lipid/Glucose Panel: TC, HDL, calc. LDL, Trig, ratio(calc TC/HDL), glucose, measured Ht/Wt, calculated BMI and/or Waist Circumference, BP, Online My Guide Online My Guide Report OR Non-Fasting Lipid/Glucose Panel: TC, HDL, ratio (TC/HDL), (glucose or HgbA1c), measured Ht/Wt calc BMI and/or waist circumference, BP, Online My Guide Report	\$76.00

Venipuncture Additional Test Options	
These are add-ons that are venipuncture only.	
Additional Test Options (Venipuncture Only)	Add-On to panel: Per participant
Blood Glucose	\$6.00
Complete blood count (CBC)	\$8.40
Cotinine (Nicotine Metabolite)	\$15.60
C-Reactive Protein	\$10.80
Creatinine egfr	\$7.20
Hemoglobin Hgb A1C	\$7.20
Liver Profile	\$9.60
Privacy Screens at events (per examiner, per event, per screen - not per participant)	\$42.00
Prostate Specific Antigen (PSA) (males only)	\$12.00
Thyroid Stimulating Hormone (TSH)	\$6.00
Vitamin D	\$10.80

Fingerstick Service: On-Site Event or Patient Service Center	
A minimum of 30 participants is necessary for the pricing below. Requests submitted require an 8-12 week lead time from date that the Service Request is signed by the plan sponsor. Any changes or cancellations once the implementation work begins will incur a fee. All Online My Guide Reports noted are digital/online only. Participant report will be provided at the time of screening. Printed, paper versions are available as a buy-up.	
Fingerstick Services	On-Site/PSC per participant
Healthy Heart Fasting Panel: TC, HDL, LDL, TC/HDL ratio, Glucose, Trig, BP, measured Ht/Wt calculated BMI and/or Waist Circumference, participant and employer aggregate Online My Guide Reports, MET S Insights	\$53.00
Healthy Heart Non-Fasting Panel: TC, HDL, TC/HDL ratio, non-fasting Glucose, BP, measured Ht/Wt calculated BMI, and/or Waist Circumference, Online My Guide Reports	\$53.00

Fingerstick Additional Test Options		
These are add-ons for fingerstick only. Some tests can be ordered as standalone and will be marked.		
Test Option	Standalone	Add-On: Per Participant
Blood Pressure	\$18.00	\$2.40
Body Mass Index (BMI)	\$33.60	<i>Included in primary package</i>
Cotinine (Nicotine metabolite)	N/A	\$18.00
Cotinine Swab	\$44.40	\$13.20
Hemoglobin A1c	N/A	\$18.00
PSA	N/A	\$18.00
TSH	N/A	\$18.00
Screenings on an Hourly Basis: Includes BP, BMI, Body Comp, Measured Ht/Wt, Waist, Hip per staff/per hour onsite set up and tear down (min 4 hrs)	\$114.00	

Quest Activate	
Choose between the \$36.00 or \$51.00 kit. Then add the \$46.80 for the testing. If you have additional testing, it is \$18.00	
Quest Activate self-collection materials without BP Cuff	\$36.00
Quest Activate self-collection materials with BP Cuff	\$51.00
Quest Activate: Lipid Panel (TC, HDL, TC/HDL ratio, LDL, Triglycerides)	\$46.80
Additional Tests (Cotinine, HbA1c, PSA, TSH)	\$18.00

Quest Activate with Tasso* (an improved home blood collection)	
The mailing kit + the testing is the total price of Tasso. If the mailing kit is submitted but materials are not returned, add the Unreturned Materials Fee.	
Tasso Kit Mailing (w/o BP Cuff)	\$28.80
Tasso Unreturned Materials Fee	\$48.00
Tasso Testing	\$134.40

Insure Colorectal Cancer Screening Program	
The total price is the kit + testing per person. Over/under 2,000 is now the same price.	
Insure Kits (aka Materials)	\$24.00
Insure Testing	\$43.20

Misc Services	
Additional event staffing beyond the recommended number is requested - per hour	\$72.00
Administrative staffing is requested - per hour	\$36.00
Cancellation & Postponement**	\$53.00 (per participant)
No Shows***	\$53.00 (per participant)
End of Program Reporting of Attestation Questions/Answers (up to 5 questions)	\$600.00
Fax to Physician per fax sent	\$2.40
Home or office single participant collection (in addition to the participant fee for testing)	\$120.00
MyGuide Paper, Mailed Report	\$5.00
Non-Standard Hours*	
Physician Forms (Per form fee including processed, denied, reprocessed)	\$17.00
Reach Premium Services (all design included - any copies additional cost to print) per program year fee	\$3,000.00

Data Services	
Additional Aggregate Report (per report)	\$240.00
Customize Participant Report Language with My test (Cover letter) (Pass/Fail Report at End of Program)	\$715.00
Data feed to third party in csv format (starts a \$5K or quoted on a hourly basis)	\$4,200.00
Data to third party in custom format (starts a \$5K or quoted on a hourly basis)	\$6,000.00
Remapping of Unique ID's after scheduler has launched and is open	\$4,800.00
Remapping of Unique ID's prior to scheduler opening	\$1,200.00
Report pulled at the end of the program with cotinine results (per report pulled)	\$715.00

* Non-Standard Hours: Outside daily screening hours - Evening 9pm Friday -6am Monday. Daily screening hours 6am to 9pm and includes one hour set up and 30 min tear down. Fee per examiner/per hour

** Cancellation & Postponement: Customer will confirm with the Quest Diagnostics team member at least two (2) weeks prior to each Event ("Projected Participants"). In the event of a customer postponement or cancellation of an Event after the Projected Participants have been finalized, or less than two (2) weeks prior to each Event, the customer shall be responsible for paying the Projected Participants at the fee notated above or the Event Billing Minimum, whichever is greater, for each cancelled/postponed event.

*** No Shows: No shows will be billed at the screening rate for each. Example: a screening rate is \$53 per participant, and the event had 5 no-

MDCG - Labcorp Sample Biometric Screening Pricing

Sample Pricing: Labcorp Fingerstick Biometric Screenings Requires an 6 - 8* week lead time from date that the Service Request Form is signed/submitted Any changes or cancellations within 10-business days prior to event start will incur a fee Service dates confirmed within 48-business hours			
Choose one of the Fingerstick Panels: Note: Fee per participant with minimum of 30 participants. (registered and walk-ins)	Fingerstick Services	Onsite/PSC per participant	Physician Form
	Fasting Lipid/Glucose: Total cholesterol, HDL, LDL, triglycerides, glucose, blood pressure, height, weight, BMI, waist circumference.	\$47.50	\$13.00
	Non-Fasting Lipid/Glucose: Total cholesterol, HDL, glucose, blood pressure, height, weight, BMI, waist circumference.	\$47.50	\$13.00
	<i>Note: Metabolic Syndrome Screening Indicator would be displayed within the dashboard on any fasting panel that included the following: Waist Circumference, Blood Pressure, Triglycerides, Blood Glucose, HDL.</i>		
	Additional test options - must be in addition to Fingerstick screenings	Onsite/PSC Per participant	
	Cotinine	\$20.00	
	HbA1c	\$17.50	
Pixel by Labcorp Biometric Kit	TSH	\$18.75	
	PSA	\$27.50	
	Pixel Home Kit	Per Kit Rate	
	Standard fasting lipid panel (Total cholesterol, LDL, HDL, Triglycerides, Total Cholesterol, HDL, A1c and self-reporting biometrics.	Per Kit Ordered and Returned: \$56.00 Per Kit Ordered and NOT Returned: \$31.00	
Fit by Labcorp Colorectal Kit	A1c and self-reporting biometrics	Per Kit Ordered and Returned: \$56.00 Per Kit Ordered and NOT Returned: \$31.00	
	Home Test Kit mailers	\$2.40 per letter	
	Fit Colorectal Cancer Screening Program	Per Kit Rate	
Physician Form Detail	Fit Kit and self-reported biometrics	\$68.00	
	Home Test Kit mailers	\$2.40 per letter	
Participants have two options for returning the completed forms: 1. Physician Faxes the form or Participants can upload the form through the Labcorp online scheduler (this option must be enabled by the plan sponsor). The participant then receives a confirmation email that the form was successfully received. Physician Form Option - Physician form is to be distributed by the plan sponsor or by using the Labcorp online scheduler and used only in the following circumstances: - Member does not have access to an onsite screening or Labcorp Patient Service Center within a 25-mile driving distance. Labcorp will provide a Geomatch. - If the member had the same tests performed by a physician or lab within (X - X months of the screening date). Timing is determined by the plan sponsor, but time period should not exceed 6 months. - The Physician Form charge (see above for rates) will be applied when the form is returned to Labcorp, deemed to be valid, and the data entry is completed. - This form and process cannot be used to adjust or correct measured results in screening programs.			

**Depending on the plan sponsor and number of EEs, an 8-10+ week lead could be advantageous.*

Sample Pricing: Labcorp Venipuncture Biometric Screenings Requires an 6 -8* week lead time from date that the Intake Service Request Form is signed/submitted Any changes or cancellations within 10-business days prior to event start will incur a fee Service dates confirmed within 48-business hours			
All panels fasting and non-fasting. Choose one of the Metabolic Panels: Note: Fee per participant with minimum of 30 participants. (registered and walk-ins)	Venipuncture Services	Onsite/PSC per participant	Physician Form
	Cardiovascular and Diabetes Screening: Height, Weight, BMI, Waist Circumference, Blood Pressure, Total Cholesterol, HDL, LDL, VLDL, Triglycerides, Glucose. <i>MetS Recommended</i>	\$57.00	\$13.00
	Cardiovascular, Diabetes, Renal, Liver and Electrolyte Screening: Height, Weight, BMI, Waist Circumference, Blood Pressure, Albumin, Alkaline Phosphatase, BUN, Calcium, Creatinine, GGT, Globulin, Glucose, LDH, AST, ALT, Bilirubin, Protein, Uric Acid, Albumin: Globulin Ratio, Chloride, Iron, Phosphorus, Potassium, Sodium, Lipid Panel (Total Cholesterol, Triglycerides, HDL, VLDL, LDL, Chol/HDL Ratio, LDL/HDL Ratio), Bicarbonate CO ₂ , eGFR Non-African American, eGFR African American, BUN: Creatinine Ratio.	\$65.00	\$13.00
	Cardiovascular, Diabetes, Renal and Liver Screening: Height, Weight, BMI, Waist Circumference, Blood Pressure, Uric Acid, BUN, Creatinine, BUN/Creatinine Ratio, Calcium, Total Protein, Albumin, Globulin, A/G Ratio, Total Bilirubin, Alkaline Phosphatase, LDH, SGOT, SGPT, GGT, Lipid Panel (Total Cholesterol, Triglycerides, HDL, VLDL, LDL, Chol/HDL Ratio, LDL/HDL Ratio) <i>NOTE: Please note that this panel does NOT include glucose. If glucose is needed, select glucose as an add-on below.</i>	\$80.00	\$13.00
<i>Note: Metabolic Syndrome Screening Indicator would be displayed within the dashboard on any fasting panel that included the following: Waist Circumference, Blood Pressure, Triglycerides, Blood Glucose, HDL.</i>			
Venipuncture Additional Tests	Additional Test Options - must be in addition to Venipuncture screenings	Onsite/PSC Per participant	
	Glucose	\$12.50	
	HbA1c	\$8.75	
	CBC	\$10.30	
	CBC w/ differentials	\$6.25	
	Cotinine	\$15.00	
	PSA	\$10.00	
	TSH	\$7.50	
	Vitamin D	\$35.00	
	C-Reactive Protein, Cardiac	\$21.25	
	LDH (Lactic Acid Dehydrogenase)	\$12.50	
	Hepatic Function Panel	\$15.00	
	Iron	\$12.50	
	TIBC (Total Iron-binding Capacity)	\$18.75	
	CA-125 (Cancer Antigen (CA)-125)	\$32.50	
	CEA (Carcinoembryonic Antigen)	\$22.50	
	Homocysteine	\$50.00	
	NT-PROBNP	\$118.75	
Physician Form Detail	Participants have two options for returning the completed forms: 1. Physician Faxes the form or Participants can upload the form through the Labcorp online scheduler (this option must be enabled by the plan sponsor). The participant then receives a confirmation email that the form was successfully received. Physician Form Option - Physician form is to be distributed by the plan sponsor or by using the Labcorp online scheduler and used only in the following circumstances: • Member does not have access to an onsite screening or Labcorp Patient Service Center within a 25-mile driving distance. Labcorp will provide a Geomatch. • If the member had the same tests performed by a physician or lab within (X - X months of the screening date). Timing is determined by the plan sponsor, but time period should not exceed 6 months. • The Physician Form charge (see above for rates) will be applied when the form is returned to Labcorp, deemed to be valid, and the data entry is completed. - This form and process cannot be used to adjust or correct measured results in screening programs.		

**Depending on the plan sponsor and number of EEs, an 8-10+ week lead could be advantageous.*

Sample Pricing Labcorp Onsite Flu Vaccine Clinics Requires an 6 - 8* week lead time (can combine with event) Service dates confirmed within 48-business hours		
Additional charges may apply	Price based on	Price
Flu Immunization - Thimerosal Free (T-Free)		\$50.00
Flu Immunization - FluAD (65+)		\$94.00
Onsite Extras (Optional)		
Additional Flu Nurse		\$113.00
Pre-clinic Setup	Per setup for Clinics with 1-4 Screeners	\$187.50
	Per setup for Clinics with 5+ screeners	\$375.00
Administration Fees		
Short Notice Fee: Clinics requested less than six weeks in advance (Vendor will not accommodate less than 4-weeks' notice of a Clinic date)		\$625.00
Cancellation or Rescheduling Fee Cancellation or rescheduling a Clinic less than ten business days prior to a Clinic.	If less than 10-business days; 50% of projected vaccinations and costs associated with rebooking travel, diverting shipments or expired supplies that have been purchased for that Clinic, plus a 10% rebooking fee. <i>No fee for rescheduling/cancellation if greater than 10-days.</i>	
Outside of Hours Surcharge Clinics held outside of normal business hours and Federal Holidays	12% of Clinic costs	

**Depending on the plan sponsor and number of EEs, an 8-10+ week lead could be advantageous when combined with an onsite event*

Fingerstick only
Participants receive results at the time of the event; results also available through the Labcorp Dashboard. Plan Sponsors receive a participant reports and aggregate results.

Venipuncture only
Participants Personal Lab Report via their online portal up to 10-days post event. Plan sponsors receive participation report and aggregate results.

Plan Sponsor Reports	
Results report pulled at the end of a Cotinine program	Included
Plan Sponsor Aggregate Reporting: Produced within two weeks of the final screening event, biometric screening aggregate reports include all screening methods: on-site screenings, vouchers, physician forms, etc.	Included
Cohort Report for First-Year Client (flat fee per report)	\$1,875.00

Sample Pricing Labcorp Event Charges Requires an 6-8* week lead time		
Additional charges may apply	Price based On	Price
Short Notice Fee: Clinics/Events requested less than six weeks in advance (Vendor will not accommodate less than 4-weeks' notice of a Clinic/Event date)		\$625.00
Cancellation or Rescheduling Fee: Cancellation or rescheduling an event less than ten (10) business days prior to the event. Exception: Force Majeure.	50% of projected screenings and any costs associated with rebooking travel, diverting shipments, or expired supplies that have been purchased for that Clinic/Event, plus a 10% rebooking fee.	
Privacy Screens	One screen per each station	Included
No Show/Minimum participant - A. Each Clinic/Event is quoted with a thirty (30) Recipient minimum, per Clinic/Event. In the event a Clinic/Event does not meet the thirty (30) Recipient minimum, Vendor will bill CVS for additional Recipients to meet the minimum. example: minimum is 30 but 25 people attend, client is billed for the 30 at the panel cost. B. CVS will be billed for 90% of the projected minimum per Clinic, or actual participation, or thirty (30) Recipient minimum, whichever is greater. The projected minimum is used by Vendor to calculate the number of staff required for a Clinic. This number must be furnished to Vendor by the CVS or CVS Client, as applicable, by noon EST ten (10) business days prior to all Clinics, excluding Federal Holidays. The rate used to calculate additional screenings to meet the projected minimum will be the lesser of the fasting or non-fasting screening rates for the Clinic.		
Evening and Weekend Charges Clinics/Events held outside of normal business hours and Federal Holidays	12% additional to clinic/event costs	
Pre-event set-up - if setup is required the day prior to the clinic/event	Per setup for Clinics/events with 1-4 Screeners Per setup for Clinics/events with 5+ screeners	\$187.50 \$375.00
Additional Staffing Additional event staffing beyond the recommended number is requested - before	Additional Registration Coordinator Additional Screener(s)	\$75.00 hr. \$112.50 hr.
PCP - Physician Forms	Flat Fee	\$13.00
Administrative Event Staff		Included
Well Review Services	Price based On	Price
WellReview Services - Onsite Health Education (4hr. min) - Extended counseling session with a trained RD Health Coach "Teachable moment(s)" helps participants understand their results and choose next steps		\$156.00 hr.
Cancelling or rescheduling onsite WellReview Services less than 10-business days prior to a clinic	50% of projected fees related to the On-Site WellReview Services and any costs associated with rebooking travel or diverting shipments that have been purchased for such service, plus a 10% rebooking fee.	
Telephonic WellReview Service	priced per person	\$21.00
Cancellation, or Rescheduling of Telephonic Session: Cancelling or rescheduling a Telephonic Session less than twenty-four (24) hours prior to scheduled Session	Per Recipient Session Cancelled or Rescheduled	\$21.00
Missed Telephonic Session	per each missed participant	\$21.00
Customized Health Education Booklet (Optional)	per booklet	\$3.10
Travel Policy: 1. If a Clinic is more than one hundred and twenty (120) miles of city limits of a city with a population of fifty thousand (50,000) or greater, hotel fees may be incurred. Hotels will be booked individually for each individual performing Services at a maximum of one hundred and ten dollars (\$110) per night. 2. Travel costs are included for all Clinic/Event locations within fifty (50) miles of city limits of a city with a population of fifty thousand (50,000) or greater. Any Clinic/Event location that does not meet this criteria is considered a "remote location" and will incur travel fees. A travel quote will be provided upon request. 3. If travel fees include mileage, mileage will be billed at the current Federal Mileage Reimbursement Rate, as provided by the IRS. 4. All travel will be invoiced at cost, plus a ten percent (10%) administrative fee.		

*Depending on the plan sponsor and number of EEs, an 8-10+ week lead could be advantageous.

Sample Onsite Labcorp Data Services		
	Service	Cost
Customized Reporting Fees	Creation of custom report(s)	\$250.00 hr
	Customization requiring additional coding and development	\$310.00 hr

ATTACHMENT 2

HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum ("Addendum") supplements and is made a part of the Agreement by and between the Miami-Dade County, Florida ("County"), and Aetna Life Insurance Company, Business Associate ("Associate").

RECITALS

- A. As part of the Agreement, it is necessary for the County to disclose certain information ("Information") to Associate pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI").
- B. County and Associate intend to protect the privacy and provide for the security of PHI, including but not limited to, PHI, disclosed to Associate pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.
- C. The purpose of this Addendum is to satisfy certain standards and requirements of HIPAA and the HIPAA Regulations, including, but not limited to, Title 45, Sections 164.308(b), 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR"), as the same may be amended from time to time.

In consideration of the mutual promises below and the exchange of information pursuant to the Agreement, the parties agree as follows:

- 1. **Definitions.** Terms used, but not otherwise defined, shall have the same meaning as those terms in 45 CFR Sections 160.103, 164.304 and 164.501.
 - a. "Business Associate" shall have the meaning given to such term under the HIPAA Regulations, including, but not limited to, 45 CFR Section 160.103.
 - b. "Covered Entity" shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 160.103.
 - c. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to 45 CFR Section 1103. [45 CFR Parts 160, 162 and 164]
 - d. "Electronic Protected Health Information" or "ePHI" means any information that is transmitted or maintained in electronic media: (i) that relates to the past, present or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual. and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including, but not limited to 45 CFR Section 160.103. [45 CFR Parts 160, 162 and 164]
 - e. "Electronic Media" shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including but not limited to, 45 CFR Section 160.103.
 - f. "Security incident" shall have the meaning given to such term under HIPAA and the HIPAA Regulations, including but not limited to, 45 CFR Section 164.304.

2. Obligations of Associate.

- a. Permitted Uses and Disclosures. Associate may use and/or disclose PHI received by Associate pursuant to the Agreement ("County's PHI") solely in accordance with the specifications set forth in the Scope of Services, Appendix A. In the event of any conflict between this Addendum and Appendix A, this Addendum shall control. [45 CFR § 164.504(e)(2)(i)]
- b. Nondisclosure. Associate shall not use or further disclose County's PHI other than as permitted or required by law. [45 CFR § 164.504(e)(2)(ii)(A)]
- c. Safeguards. Associate shall use appropriate safeguards to prevent use or disclosure of County's PHI in a manner other than as provided in this Addendum. [45 CFR § 164.504(e)(2)(ii)(B)] Associate shall maintain a comprehensive written information security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Associate's operations and the nature and scope of its activities. Appropriate safeguards used by Associate shall protect the confidentiality, integrity, and availability of the PHI and ePHI that is created, received, maintained, or transmitted on behalf of the County. [45 CFR § 164.314(a)(2)(i)(A)] County has at its sole discretion, the option to audit and inspect, the Associate's safeguards at any time during the life of the Agreement, upon reasonable notice being given to Associate for production of documents and coordination of inspection(s).
- d. Reporting of Disclosures. Associate shall report to the County's Project Manager, any use or disclosure of the County's PHI in a manner other than as provided in this Addendum. [45 CFR § 164.504(e)(2)(ii)(c)] Associate shall report to the County through the County's Project Manager, any security incident of which it becomes aware within forty-eight (48) hours of discovery of the incident. [45 CFR § 164.314(a)(2)(i)(C)]
- e. Associate's Agents. Associate agrees and shall ensure that any agents, including subcontractors, to whom it provides PHI received from (or created or received by Associate on behalf of) the County, agrees in writing to the same restrictions and conditions that apply to Associate with respect to such PHI and that such agents conduct their operations within the United States. Associate agrees and shall ensure that any agents, including subcontractors, to whom it provides ePHI received, created, maintained, or transmitted on behalf of the County, agrees in writing to implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of that ePHI. [45 CFR § 164.314(a)(2)(i)(B)] In no case may Associate's Agents reside and operate outside of the United States.
- f. Documentation of Disclosures. Associate agrees to document disclosures of the County's PHI and information related to such disclosures as would be required for the County to respond to a request by an individual for an accounting of disclosures of PHI. Associate agrees to provide the County or an individual, in a time and manner designated by the County, information collected in accordance with the Agreement, to permit the County to respond to such a request for an accounting. [45 CFR § 164.528]
- g. Availability of Information to County. Associate shall make available to the County such information as the County may require to fulfill the County's obligations to provide access to, provide a copy of, and account for, disclosures of PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Sections 164.524 and 164.528. [45 CFR § 164.504(e)(2)(ii)(E) and (G)]
- h. Amendment of PHI. Associate shall make the County's PHI available to the County as may be required to fulfill the County's obligations to amend PHI pursuant to HIPAA and the HIPAA Regulations, including, but not limited to, 45 CFR Section 164.526 and Associate shall, as directed by the County, incorporate any amendments to the County's PHI into copies of such PHI maintained by Associate, and in the time and manner designated by the County. [45 CFR § 164.504(e)(2)(ii)(F)]
- i. Internal Practices. Associate shall make its internal practices, books and records relating to the use and disclosure of the County's PHI (or PHI created or received by Associate on behalf of the County) available to the County and to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the County or the Secretary for purposes of determining Associate's compliance with HIPAA and the HIPAA Regulations. [45 CFR § 164.504(e)(2)(ii)(H) and 45 CFR Part 64, Subpart C.]

- j. Mitigation. Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the County's PHI by Associate in violation of the requirements of this Addendum.
 - k. Associate's Insurance. Associate agrees to maintain the insurance coverage provided in the Agreement.
 - l. Notification of Breach. Associate shall notify the County within twenty-four (24) hours, and shall provide written notice no later than forty-eight (48) hours of any suspected or actual breach of security, intrusion or unauthorized disclosure of PHI and/or any actual or suspected disclosure of data in violation of any applicable federal or state laws or regulations. Associate shall take (i) prompt corrective action to cure any such deficiencies, and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.
 - m. Expenses. Any and all expenses incurred by Associate in compliance with the terms of this Addendum or in compliance with the HIPAA Regulations shall be borne by Associate.
 - n. No Third-Party Beneficiary. The provisions and covenants set forth in this Agreement are expressly entered into only by and between Associate and the County and are intended only for their benefit. Neither Associate nor the County intends to create or establish any third-party beneficiary status or right (or the equivalent thereof) in any other third party nor shall any other third party have any right to enforce or enjoy any benefit created or established by the provisions and covenants in this Agreement.
3. **Audits, Inspection and Enforcement.** From time to time, after reasonable notice, upon any breach of this Addendum by Associate, the County may inspect the facilities, systems, books and records of Associate to monitor compliance with this Addendum. Associate shall promptly remedy any violation of this Addendum and shall certify the same to the County in writing. The fact that the County inspects, or fails to utilize its right to inspect, Associate's facilities, systems, books, records, and procedures does not relieve Associate of its responsibility to comply with this Addendum, nor does the County's (i) failure to detect or (ii) detection, but failure to notify Associate or require Associate to remedy such breach, constitute acceptance of such practice or a waiver of the County's enforcement rights under this Addendum.
4. **Termination.**
- a. Material Breach. A breach by Associate of any provision of this Addendum, shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement by the County. [45 CFR § 164.504(e)(3) and 45 CFR § 164.314(a)(2)(i)(D)]
 - b. Termination for Cause - Reasonable Steps to Cure Breach. If the County recognizes a pattern of activity or practice of Associate that constitutes a material breach or violation of the Associate's obligations under the provisions of this Addendum and does not terminate the Agreement pursuant to Section 4a, above, the County may provide an opportunity for Associate to end the violation or cure the breach within five (5) days, or other cure period as may be specified in the Agreement. If Associate does not cure the breach or end the violation within the time period provided, the County may immediately terminate the Agreement.
 - c. Judicial or Administrative Proceedings. The County may terminate the Agreement, effective immediately, if (i) Associate is named as a defendant in a criminal or administrative proceeding for a violation of HIPAA, or (ii) a finding or stipulation that Associate has violated any standard or requirement of the HIPAA Regulations (or other security or privacy law) is made in any administrative or civil proceeding.
 - d. Effect of Termination. Upon termination of the Agreement for any reason, Associate shall return or destroy as directed by the County all PHI, including but not limited to ePHI, received from the County (or created or received by Associate on behalf of the County) that Associate still maintains in any form. This provision shall also apply to County PHI that is in the possession of subcontractors or agents of Associate. Associate shall retain no copies of such PHI or, if return or destruction is not feasible, Associate shall provide to the County notification of the conditions that make return or destruction infeasible, and shall continue to extend the protections of this Addendum to such information, and limit further use or disclosure of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 CFR § 164.504(e)(2)(ii)(I)]
5. **Indemnification.** Associate shall indemnify and hold harmless the County and its officers, employees, trustees, agents, and instrumentalities (the indemnified parties) from any and all liability, losses or damages, including attorneys' fees and costs of defense,

which the County or its officers, trustees, employees, agents or instrumentalities may incur as a result of claims, demands, suits, causes of actions or proceedings of any kind or nature arising out of, relating to, or resulting from the performance of this Addendum by Associate or its employees, agents, servants, partners, principals, or subcontractors. Associate shall pay all claims and losses in connection therewith and shall investigate and defend all claims, suits, or actions of any kind or nature in the name of any of the indemnified parties, where applicable, including appellate proceedings, and shall pay all costs, judgments, and attorney's fees which may issue thereon. Associate expressly understands and agrees that any insurance protection required by this Addendum, or otherwise provided by Associate, shall in no way limit the responsibility to indemnify, keep and save harmless and defend the indemnified parties as herein provided. This paragraph shall survive the termination of the Agreement.

6. **Limitation of Liability.** Nothing in this Addendum shall be construed to affect or limit the County's sovereign immunity as set forth in Florida Statutes, Section 768.28.
7. **Amendment.**
 - a. **Amendment to Comply with Law.** The parties acknowledge that state and federal laws relating to the security and privacy of PHI, including electronic data, are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that the County must receive satisfactory written assurance from Associate that Associate will adequately safeguard all PHI that it receives or creates pursuant to this Agreement. Upon the County's request, Associate agrees to promptly enter into an amendment to the Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA Regulations or other applicable laws. The County, in addition to any other remedies including specific performance, may terminate the Agreement upon five [5] days' written notice in the event Associate does not enter into said amendment to the Agreement providing assurances regarding the safeguarding of PHI that the County, in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA Regulations. Notwithstanding Associate's failure to enter into an amendment, Associate shall comply with all provisions of the HIPAA laws.
 - b. **Amendment of Attachment C.** In addition to amendments described in 7a above, Attachment C may otherwise be modified or amended by written mutual agreement of the parties without amendment of the remainder of this Agreement.
8. **Assistance in Litigation or Administrative Proceedings.** Associate shall make itself, and any subcontractors, employees or agents assisting Associate in the performance of its obligations under this Agreement, available to the County at the County's convenience upon reasonable notice, at no cost to the County, to testify as witnesses, for document production, or otherwise, in the event of litigation or administrative proceedings being commenced against the County, its trustees, officers, agents or employees based upon claimed violation of HIPAA, the HIPAA Regulations or other laws relating to security and privacy, except where Associate or its subcontractor, employee or agent is a named adverse party.
9. **Effect on Agreement.** Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the Agreement shall remain in force and effect. In the event of any conflict between this Addendum and Agreement, this Addendum shall control.
10. **Interpretation.** This Addendum and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA Regulations and applicable Florida laws. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA and the HIPAA Regulations.
11. **Jurisdiction.** Any litigation between the parties regarding the terms of this Addendum shall take place in Miami-Dade County, Florida.