CONTRACT BETWEEN

COUNTY OF ORANGE

AND

CALIFORNIA PHYSICIAN SERVICES
DBA BLUE SHIELD OF CALIFORNIA

FOR

Claims Administration for the Self-Insured Preferred Provider Organization (PPO) Health Plans

CONTRACT

THIS AGREEMENT to provide Claims Administration for the Self-Insured Preferred Provider Organization (PPO) Health Plans, (hereinafter referred to as "Contract"), is effective January 1, 2020 by and between the County of Orange, a political subdivision of the State of California, (hereinafter referred to as "County") and California Physician Services, dba Blue Shield of California, with a place of business at 50 Beale Street, San Francisco, CA 94105, (hereinafter referred to as "Contractor"), which are sometimes individually referred to as "Party" or collectively as "Parties".

RECITALS

WHERAS, Contractor responded to a Request for Proposal ("RFP") for the provision to provide Claims Administration for the Self-Insured Preferred Provider Organization (PPO) Health Plans as defined herein; and

WHERAS, the Contractor responded and represents that its proposed services shall meet or exceed the requirements and specifications of the RFP; and

WHEREAS, the County's Board of Supervisors has authorized the Purchasing Agent or authorized Deputy Purchasing Agent to enter into this Contract with Contractor to provide Claims Administration for the Self-Insured Preferred Provider Organization (PPO) Health Plans;

NOW, THEREFORE, the Parties mutually agree as follows:

ARTICLES

1. **Scope of Work:** This Contract, including any Attachments and Exhibits, specifies the contractual terms and conditions by which the County will procure services for Claims Administration for the Self-Insured Preferred Provider Organization (PPO) Health Plans from Contractor as further detailed in the Scope of Work, identified and incorporated herein by this reference as Attachment A.

2. **Compensation/Payment:** The Contractor agrees to accept the compensation as set forth in Attachment B, Compensation/Payment, identified and incorporated herein by this reference, as full remuneration for (a) performing all Services and furnishing all staffing and materials required, (b) any reasonably unforeseen difficulties which may arise or be encountered in the performance of the Services until acceptance, (c) risks connected with the Services, and (d) performance by the Contractor of all its duties and obligations required herein.

3. **Term of Contract:** The ~~initial term of this~~ Contract shall commence ~~is for three (3) years, effective on the date execution is completed by the Parties or on or about~~ January 1, 2020, and shall continue in effect through December 31, 2023, ~~whichever date is later in time, and continuing for three (3) years from that date, unless earlier terminated by the County.~~ The Contract Term may be renewed for one (1) ~~two (2)~~ additional consecutive one (1) year terms, upon the mutual written agreement of the Parties. Renewal of the Contract may require approval by the County Board of Supervisors. Permitted renewals of the Contract provided in this paragraph 3 shall not result in any change in any other term, condition or provisions of this Contract.

4. **Entire Agreement:** This Contract, including its Attachment A through Attachment I and Exhibit 1 through Exhibit 4, as they now exist or may hereafter be changed, modified, or amended, and which are attached hereto and incorporated herein by this reference, constitutes the entire Contract between the Parties with

respect to the matters herein. There are no restrictions, promises, warranties or undertakings other than those set forth or referred to herein. No exceptions, alternatives, substitutes, understandings, agreements or revisions, whether oral or written, are valid or binding on the County unless authorized by the County in writing. Electronic acceptance of any additional terms, conditions or supplemental contracts by any County employee or agent, including but not limited to installers of software, shall not be valid or binding on the County unless accepted in writing by the County's Purchasing Agent or his authorized designee. In the event of a conflict between or among the Contract documents, the order of precedence shall be the provisions of the main body of this Contract (i.e., those provisions set forth in the recitals and articles), and then the attachments and then the exhibits.

5. **Amendments:** No alteration or variation of the terms of this Contract shall be valid unless made in writing and signed by the Parties; no oral understanding or agreement not incorporated herein shall be binding on either of the Parties; and no exceptions, alternatives, substitutes or revisions are valid or binding on the County unless authorized by the County in writing.

6. **Governing Law and Venue:** This Contract has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California, without reference to conflict of laws provisions. In the event of any legal action to enforce or interpret this Contract, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the Parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394. Furthermore, the Parties specifically agree to waive any and all rights to request that an action be transferred for trial to another venue.

7. **Contingency of Funds:** Contractor acknowledges that funding or portions of funding for this Contract may be contingent upon state budget approval; receipt of funds from, and/or obligation of funds by, the state of California to County; and inclusion of sufficient funding for the services hereunder in the budget approved by County's Board of Supervisors for each fiscal year covered by this Contract. If such approval, funding or appropriations are not forthcoming, or are otherwise limited, County may immediately terminate or modify this Contract without penalty.

8. **Taxes: :** The Contract provided does not contemplate any taxes, fees, other charges or offsets by any state or federal government which may, in the future, be assessed against Contractor on the basis of the benefit payments made on County's behalf under this Contract. In the event Contractor becomes liable for paying any such taxes, fees, other charges or offsets, on the County's behalf, including amounts assessed against Contractor under federal regulation, 42 CFR 411.24 (Medicare Secondary Payer), the County agrees to reimburse Contractor for the amount of tax, fee, charge or offset attributable to the benefits paid on the County's behalf. This obligation will survive termination of this Contract. Unless otherwise provided herein or by law, price quoted does not include California state sales or use tax.

9. **Delivery:** Time of delivery of services is of the essence in this Contract. County reserves the right to refuse any services and to cancel all or any part of the services that do not conform to the prescribed Scope of Work.

10. **Independent Contractor:** Contractor shall be considered an independent contractor and neither Contractor, its employees, nor anyone working under Contractor shall be considered an agent or an employee of County. Neither Contractor, its employees nor anyone working under Contractor, shall qualify for workers' compensation or other fringe benefits of any kind through County.

11. **Assignment or Sub-contracting:** The terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators and assigns of the Parties. Furthermore, neither the performance of this Contract nor any portion thereof may be assigned or sub-contracted by Contractor without the express written consent of County Program Manager, as identified below. Any attempt by

Contractor to assign or sub-contract the performance or any portion thereof of this Contract without the express written consent of County Program Manager shall be invalid and shall constitute a breach of this Contract. Irrespective of any assignment of subcontracting with respect to any portion of this Contract, Contractor shall remain fully responsible and liable for the performance of all services required herein. Notwithstanding the preceding provisions of this paragraph, (i) services to be performed for County under this Contract may be performed by personnel of Contractor or of any other entity that is controlling, controlled by, or under common control with, Contractor and (ii) Contractor may assign this Contract and all rights, duties and obligations hereunder to any other entity that is controlling, controlled by, or under common control with the Contractor that succeeds to the business of Contractor providing the services under this Contract. Notwithstanding this paragraph or any other terms or provisions set forth in this Contract or its attachments, none of the work done for the County, its employees, agents, directors, elected officials or their dependents as relates participant interaction may be performed outside the United States of America, with the exception of core Account Team Members as named in Staffing Plan, Attachment C, or otherwise approved by County, on an as needed basis. In no case may participant specific data be sent to locations outside the United States of America. To the extent that non-core account team members, special project teams and the like are required to do work for the County outside the United States of America, data will not include participant data that will allow for personal identification either as a standalone data element or in combination, for example, social security number, date of birth, personal health information, and home addresses. In instances where previously identified core Account Team Members are required to access participant specific data, as approved by the County, on an as needed basis while outside the United States of America, data will be accessed and viewed only, and will not be stored, changed, or updated in any fashion.

12. **Non-Discrimination:** In the performance of this Contract, Contractor agrees that it will comply with the requirements of California state and federal anti-discrimination laws and regulations, including but not limited to Section 1735 of the California Labor Code and not engage nor permit any sub-contractors to engage in discrimination in employment of persons because of the race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, marital status, or sex of such persons. Contractor acknowledges that a violation of this provision shall subject Contractor to all the penalties imposed for a violation of anti-discrimination laws or regulations including but not limited to Section 1741 of the California Labor Code.

13. **Performance:** Contractor shall warrant all work under this Contract, taking necessary steps and precautions to perform the work to County's satisfaction. Contractor shall be responsible for the professional quality, technical assurance, timely completion and coordination of all documentation and other services performed by the Contractor under this Contract. Contractor shall perform all work diligently, carefully, and in a good and workman-like manner; shall furnish all labor, supervision, machinery, equipment, materials, and supplies necessary therefore; shall at its sole expense obtain and maintain all permits and licenses required by public authorities, including those of County required in its governmental capacity, in connection with performance of the services; and, if permitted to sub-contract, shall be fully responsible for all work performed by sub-contractors.

14. **Errors and Omissions:** All reports, files and other documents prepared and submitted by Contractor shall be complete and shall be carefully checked by the professional(s) identified by Contractor as Account Manager and key personnel attached hereto, prior to submission to the County. Contractor agrees that County review is discretionary and Contractor shall not assume that the County will discover errors and/or omissions. If the County discovers any errors or omissions prior to approving Contractor's reports, files and other written documents, the reports, files or documents will be returned to Contractor for correction. Should the County or others discover errors or omissions in the reports, files or other written documents submitted by Contractor after County approval thereof, County approval of Contractor's reports, files or documents shall not be used as a defense by Contractor in any action between the County and Contractor, and the reports, files or documents will be returned to Contractor for correction at no charge to County.

15. **Patent/Copyright Materials/Proprietary Infringement:** Unless otherwise expressly provided in this Contract, Contractor shall be solely responsible for clearing the right to use any patented or copyrighted materials in the performance of this Contract. Contractor warrants that any software as modified through services provided hereunder will not infringe upon or violate any patent, proprietary right or trade secret right of any third party. Contractor agrees that, in accordance with the more specific requirement contained in paragraph 17 below, it shall indemnify, defend and hold County and County Indemnitees harmless from any and all such claims and be responsible for payment of all costs, damages, penalties and expenses related to or arising from such claim(s), including, but not limited to, attorney's fees, costs and expenses.

16. **Compliance with Laws:** Contractor represents and warrants that services to be provided under this Contract shall fully comply, at Contractor's expense, with all standards, laws, statutes, restrictions, ordinances, requirements, and regulations (collectively "laws"), including, but not limited to those issued by County in its governmental capacity and all other laws applicable to the services at the time services are provided to and accepted by County. Contractor acknowledges that County is relying on Contractor to ensure such compliance, and pursuant to the requirements of paragraph 17 below, Contractor agrees that it shall defend, indemnify and hold County and County INDEMNITEES harmless from all liability, damages, costs and expenses arising from or related to a violation of such laws.

17. **Indemnification:** Contractor agrees to indemnify, defend with counsel approved in writing by County, and hold County, its elected and appointed officials, officers, employees, agents and those special districts and agencies which County's Board of Supervisors acts as the governing Board ("County Indemnitees") harmless from any claims, demands or liability of any kind or nature, including but not limited to personal injury or property damage, arising from or related to the services, products or other performance provided by Contractor pursuant to this Contract. If judgment is entered against Contractor and County by a court of competent jurisdiction because of the concurrent active negligence of County or County Indemnitees, Contractor and County agree that liability will be apportioned as determined by the court. Neither Party shall request a jury apportionment.

18. **Insurance Provisions:** Prior to the provision of services under this Contract, the Contractor agrees to purchase all required insurance at Contractor's expense, including all endorsements required herein, necessary to satisfy the County that the insurance provisions of this Contract have been complied with. Contractor agrees to keep such insurance coverage, Certificates of Insurance, and endorsements on deposit with the County during the entire Term of this Contract. In addition, all subcontractors performing work on behalf of Contractor pursuant to this Contract shall obtain insurance subject to the same terms and conditions as set forth herein for Contractor.

    Contractor shall ensure that all subcontractors performing work on behalf of Contractor pursuant to this Contract shall carry appropriate lines of insurance and limits for their work. Contractor shall not allow subcontractors to work if subcontractors have an inappropriate level of coverage required by the Contractor. It is the obligation of Contractor to provide notice of the insurance requirements to every subcontractor and to receive proof of insurance prior to allowing any subcontractor to begin work. Such proof of insurance must be maintained by Contractor through the entirety of this Contract for inspection by County representative(s) at any reasonable time. Contractor is responsible for work performed by Contractor's subcontractors.

    All self-insured retentions (SIRs) shall be clearly stated on the Certificate of Insurance. Any self-insured retention (SIR) in an amount in excess of Fifty Thousand Dollars ($50,000) shall specifically be approved by the County's Risk Manager, or designee, upon review of Contractor's current audited financial report. If Contractor's SIR is approved, Contractor, in addition to, and without limitation of, any other indemnity provision(s) in this Contract, agrees to all of the following:

1) In addition to the duty to indemnify and hold the County harmless against any and all liability, claim, demand or suit resulting from Contractor's, its agents, employee's or subcontractor's performance of this Contract, Contractor shall defend the County at its sole cost and expense with counsel approved by Board of Supervisors against same; and
2) Contractor's duty to defend, as stated above, shall be absolute and irrespective of any duty to indemnify or hold harmless; and
3) The provisions of California Civil Code Section 2860 shall apply to any and all actions to which the duty to defend stated above applies, and the Contractor's SIR provision shall be interpreted as though the Contractor was an insurer and the County was the insured.

If the Contractor fails to maintain insurance acceptable to the County for the full Term of this Contract, the County may terminate this Contract.

Qualified Insurer
The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com**). It is preferred, but not mandatory, that the insurer be licensed to do business in the State of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by the Contractor shall provide the minimum limits and coverage as set forth below:

Coverage	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence
Professional Liability Insurance	$10,000,000 per claims made
Employee Dishonesty (Client Coverage)	$3,000,000 per occurrence
Network Security & Privacy Liability	$5,000,000 per claims made

The Employee Dishonesty insurance must provide coverage for the following: employee dishonesty; forgery or alternation; computer and credit/debit/charge card fraud; funds transfer fraud; money order and counterfeit currency; and client or third party coverage in the amount of at least $3,000,000 each coverage part. Coverage to include expenses incurred to establish the amount of the covered loss and all employees are to be considered insureds.

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (ISO) form CG 00 01, or a substitute form providing liability coverage at least as broad.

The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 0012, CA 00 20, or a substitute form providing coverage at least as broad.

Required Endorsements
The Commercial General Liability policy shall contain the following endorsements, which shall accompany the Certificate of insurance:

1) An Additional Insured endorsement using ISO form CG 20 26 04 13 or a form at least as broad naming the County of Orange, its elected and appointed officials, officers, agents and employees as Additional Insureds, or provide blanket coverage, which will state AS REQUIRED BY WRITTEN CONTRACT.

2) A primary non-contributing endorsement using ISO CG 20 01 04 13, or a form at least as broad-evidencing that the Contractor's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Network Security and Privacy Liability policy shall contain the following endorsements which shall accompany the Certificate of Insurance:

1) An Additional Insured endorsement naming the ***County of Orange, its elected and appointed officials, officers, agents and employees*** as Additional Insureds for its vicarious liability.

2) A primary and non-contributing endorsement evidencing that the Contractor's insurance is primary and any insurance or self-insurance maintained by the County of Orange shall be excess and non-contributing.

The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees or provide blanket coverage, which will state "As Required by Written Contract".

All insurance policies required by this Contract shall waive all rights of subrogation against the County of Orange, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

The County of Orange shall be the loss payee on the Employee Dishonesty coverage. A Loss Payee endorsement evidencing that the County of Orange is a Loss Payee shall accompany the Certificate of Insurance.

Contractor shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Contract, upon which the County may suspend or terminate this Contract.

If Contractor's Professional Liability and Network Securities and Privacy Liability policy is a "Claims-Made" policy, Contractor shall agree to maintain coverage for two (2) years following completion of the Contract.

The Commercial General Liability policy shall contain a severability of interests' clause also known as a "separation of insureds" clause (standard in the ISO CG 0001 policy).

Insurance certificates should be forwarded to the agency/department address listed on the solicitation.

If the contractor fails to provide the insurance certificates and endorsements within seven (7) days of notification by CEO/Purchasing or the agency/department purchasing division, award may be made to the next qualified vendor.

County expressly retains the right to require Contractor to increase or decrease insurance of any of the above insurance types throughout the Term of this Contract. Any increase or decrease in insurance will be as deemed by County of Orange Risk Manager as appropriate to adequately protect County.

County shall notify Contractor in writing of changes in the insurance requirements. If Contractor does not deposit copies of acceptable Certificates of Insurance and endorsements with County incorporating such changes within thirty (30) days of receipt of such notice, this Contract may be in breach without further notice to Contractor, and County shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit Contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this Contract, nor act in any way to reduce the policy coverage and limits available from the insurer.

19. **Emergency/Declared Disaster Requirements:** In the event of an emergency or if Orange County is declared a disaster area by the County, state or federal government, this Contract may be subjected to unusual usage. The Contractor shall service the County during such an emergency or declared disaster under the same terms and conditions that apply during non-emergency/disaster conditions. The pricing quoted by the Contractor shall apply to serving the County's needs regardless of the circumstances. If the Contractor is unable to supply the goods/services under the terms of the Contract, then the Contractor shall provide proof of such disruption and a copy of the invoice for the goods/services from the Contractor's supplier(s). Additional profit margin as a result of supplying goods/services during an emergency or a declared disaster shall not be permitted. In the event of an emergency or declared disaster, emergency purchase order numbers will be assigned. All applicable invoices from the Contractor shall show both the emergency purchase order number and the Contract number.

    The California State Assembly passed AB 2941 in 2018 and it went into effect as of January 1, 2019. This bill requires health plans to take certain actions to provide displaced or potentially displaced enrollees with access to medically necessary health care services if a state of emergency is declared by the Governor for a California county. Contractor recently completed an effort to be in compliance with this legislation. Contractor will continue to post actions taken to respond to an emergency which affects enrollees on its website (blueshieldca.com).

    Contractor's obligations under this provision are subject to the limitations set forth in Article 35 – Force Majeure of this model contract. In other words, if an emergency or disaster is a force majeure event for Contractor as defined under Article 35, Contractor would be excused from compliance with the requirements under Article 19.

20. **Confidentiality:** Contractor agrees to maintain the confidentiality of all County and County-related records and information pursuant to all statutory laws relating to privacy and confidentiality that currently exist or exist at any time during the Term of this Contract. All such records and information shall be considered confidential and kept confidential by Contractor and Contractor's staff, agents and employees.

    County and Contractor agree that information identified by either party as confidential or trade secret due

to its proprietary nature, and any confidential medical information shall be held in trust and confidence by the other, except as otherwise required by law, and shall be used only for the purposes contemplated under this Agreement. Contractor understands and agrees that the County is subject to state and federal laws regarding the release of public records and that records and information provided by the Contractor may be subject to those laws.

21. **Contractor Personnel:** Contractor warrants that all Contractor personnel engaged in the performance of work under this Contract shall possess sufficient experience and/or education and the required licenses set forth herein in good standing to perform the services requested by the County. In the event County is dissatisfied with the performance of any Contractor personnel, County will provide notice to Contractor. Contractor agrees to promptly investigate the matter and to work diligently with County toward a satisfactory resolution, including, as reasonably necessary, removal and replacement of Contractor personnel. If after 60 calendar days from the date the County provides notification to the Contractor, the Contractor is unable to resolve the issues, the County's program manager retains its right to request the removal of personnel and Contractor will comply within three business days or a time frame agreeable to the County. The Parties agree to work cooperatively in the resolution of all such matters.

22. **Contractor's Account Manager and Key Personnel**: Contractor shall appoint an Account Manager to direct the Contractor's efforts in fulfilling Contractor's obligations under this Contract. This Account Manager shall be subject to approval by the County and shall not be changed without the written consent of the County's Program Manager, which consent shall not be unreasonably withheld.

    The Contractor's Account Manager and key personnel shall be assigned to this project for the duration of this Contract and shall diligently pursue all work and services to meet the project time lines. Key personnel are those individuals who report directly to the Contractor's Account Manager.

23. **Program Manager:** The County shall appoint a Program Manager to act as liaison between the County and the Contractor during the Term of this Contract. The County's Program Manager shall coordinate the activities of the County staff assigned to work with the Contractor. In the event County's program manager is dissatisfied with the performance of Contractor's Principal Consultant, County will provide notice to Contractor. Contractor agrees to promptly investigate the matter and to work diligently with County toward a satisfactory resolution, including, as reasonably necessary, removal and replacement of Contractor's Principal Consultant. The County's program manager shall review and approve the appointment of the replacement for the Contractor's Principal Consultant, which approval shall not be unreasonably withheld. If after 60 calendar days from the date the County provides notification to the Contractor, the Contractor is unable to resolve the issues, the County's program manager retains its right to request the removal of personnel and Contractor will comply within three business days or a time frame agreeable to the County. The Parties agree to work cooperatively in the resolution of all such matters.

24. **Reports/Meetings:** The Contractor shall develop reports and any other relevant documents necessary to complete the services and requirements as set forth in this Contract. The County's Program Manager and the Contractor's Account Manager will meet on reasonable notice to discuss the Contractor's performance and progress under this Contract. If requested, the Contractor's Account Manager and other project personnel shall attend all meetings. The Contractor shall provide such information that is requested by the County for the purpose of monitoring progress under this Contract. Contractor shall provide reasonable travel arrangements, i.e., transportation and lodging, at Contractor's expense for up to two (2) County staff to travel annually to Contractor's locations for business purposes, as agreed upon by the Parties.

25. **Ownership of Documents:** The County has permanent ownership of all directly connected and derivative materials produced under this Contract by the Contractor. All documents, reports and other incidental or derivative work or materials furnished hereunder shall become and remain the sole properties of the County and may be used by the County as it may require without additional cost to the County. None of the

documents, reports and other incidental or derivative work or furnished materials shall be used by the Contractor without the express written consent of the County.

Contractor's agreement to Article 25 is contingent upon any limitations imposed on Contractor under its licensing agreement with the Blue Cross Blue Shield Association. Furthermore, Article 25 does not create ownership rights for the County nor any obligations for Contractor that would violate this licensing agreement between Contractor and the Association.

26. **Title to Data:** All materials, documents, data or information obtained from the County data files or any County medium furnished to the Contractor in the performance of this Contract will at all times remain the property of the County. Such data or information may not be used or copied for direct or indirect use by the Contractor after completion or termination of this Contract without the express written consent of the County. All materials, documents, data or information, including copies, must be returned to the County at the end of this Contract.

27. **Audits/Inspections:** Contractor agrees to permit the County's Auditor-Controller or the Auditor-Controller's authorized representative (including auditors from a private auditing firm hired by the County) access during normal working hours to all books, accounts, records, reports, files, financial records, supporting documentation, and other papers or property of Contractor for the purpose of auditing or inspecting any aspect of performance under this Contract. The inspection and/or audit will be confined to those matters connected with the performance of the Contract. The County will provide reasonable notice of such an audit or inspection.

    The County reserves the right to audit and verify the Contractor's records before final payment is made.

    Contractor agrees to maintain such records for possible audit for a minimum of three years after final payment, unless a longer period of records retention is stipulated under this Contract or by law. Contractor agrees to allow interviews of any employees or others who might reasonably have information related to such records. Further, Contractor agrees to include a similar right to the County to audit records and interview staff of any sub-contractor related to performance of this Contract.

    Should the Contractor cease to exist as a legal entity, the Contractor's records pertaining to this Contract shall be forwarded to the County's Program Manager.

28. **Publication:** No copies of schedules, written documents, and computer based data, photographs, maps or graphs, resulting from performance or prepared in connection with this Contract, are to be released by Contractor and/or anyone acting under the supervision of Contractor to any person, partnership, company, corporation, or agency, without prior written approval by the County, except as necessary for the performance of the services of this Contract. All press releases, including graphic display information to be published in newspapers, magazines, etc., are to be administered only by the County unless otherwise agreed to by both Parties.

29. **Conflict of Interest:** The Contractor shall exercise reasonable care and diligence to prevent any actions or conditions that could result in a conflict with the best interests of the County. This obligation shall apply to the Contractor; the Contractor's employees, agents, and subcontractors associated with accomplishing work and services hereunder. The Contractor's efforts shall include, but not be limited to establishing precautions to prevent its employees, agents and subcontractors from providing or offering gifts, entertainment, payments, loans or other considerations which could be deemed to influence or appear to influence County staff or elected officers from acting in the best interests of the County.

30. **Termination:** In addition to any other remedies or rights it may have by law, and subject to section 32 hereof, County has the right to terminate this Contract without penalty immediately with cause or after 30

days' written notice without cause, unless otherwise specified. Cause shall be defined as any breach of this Contract or any misrepresentation or fraud on the part of the Contractor. Exercise by County of its right to terminate the Contract shall relieve County of all further obligations. In addition to any other remedies or rights it may have by law and as set forth in this Contract, Contractor has the right to terminate this Contract without penalty after 365 days written notice without cause, unless otherwise specified. The County shall have the right to terminate Contractor's services under the following conditions and timeframes:

a) Upon the firm committing a material breach of the terms of the Contract with the County subject to the notice and right to cure described in Section 34.

b) Immediately for violation of any fiduciary duty or if the Contractor commits a fraud or criminal act in providing the agreed upon services.

c) Thirty days after the County provides Contractor with written notice, if the Contractor sells all of their assets or transfers control of management or operations to any third party.

d) Upon appropriate notice if there has been a filing of a petition for voluntary or involuntary bankruptcy or dissolution involving Contractor and/or thirty days after the County provides Contractor with written notice, if under Title 11 of the United States Code, the firm becomes subject to any voluntary or involuntary insolvency, cession or similar proceedings or the Contractor has made an assignment for the benefit of creditors.

e) Thirty days after the County provides the Contractor with written notice, if the County determines there has been a significant decline in the firm's financial condition.

f) Thirty days after a termination from your provider panel, hospital network and/or medical group(s) that ranks in the top 20 in claims volumes or participant utilization

In the event Contractor attempts to terminate this Contract or otherwise ceases delivery of the services provided in Attachment A – Scope of Work, without complying with the Termination provisions herein, Contractor agrees to pay the County as damages the sum of: (1) the County's (including County consultants and advisors) costs and expenses in procuring a new contractor to perform the services, (2) the additional fees, expenses and other compensation paid to the new contractor in excess of what would have been paid to Contractor had Contractor fully performed the services under this Contract and (3) any and all other costs, expenses, damages or liabilities of the County resulting from Contractor's improper termination of this Contract of the failure to perform Contract services.

If the County fails to fund the account at County Bank after ten (10) business days from the receipt of notice of deficiencies, Contractor may terminate this Agreement upon five (5) business days written notice, to be provided after the ten days receipt of notice of deficiencies, for failure to provide sufficient funds for claim payments as required under this agreement unless the County adequately funds the account before the end of five business days.

31. **PPO Network Changes**: (1) Contractor may provide the County with periodic updates regarding the hospitals and medical for which contract renewals are being negotiated subject to a notice of termination from the provider and, (2) Contractor will provide County with as much advance notice of the termination of any such provider contractor as reasonable possible and no less notice than within (1) one business day of the date any such provider contract is actually terminated. For provider ranking in the top 20 in claims volume or participant utilization, Contractor will provide written notice at no cost to the County to those participants that utilized these providers within the last six months.

32. **Breach of Contract:** The failure of the Contractor to comply with any of the terms, provisions, covenants or conditions of this Contract shall constitute a material breach of this Contract. In such event the County will, and in addition to any other remedies available at law, in equity, or otherwise specified in this Contract, afford the Contractor written notice of the breach and fifteen (15) calendar days or such shorter time that may be specified in this Contract within which to cure the breach. If the breach is not cured within fifteen (15) calendar days, the County may choose to:

    a. Terminate this Contract, without penalty to the County; or
    b. Discontinue payment to the Contractor for and during the period in which the Contractor is in breach, and offset against any monies billed by the Contractor but yet unpaid by the County any such discontinued payments; any discontinued payments shall subsequently become due if, and to the extent that, Contractor cures the breach.

    For the avoidance of doubt, in no case shall the County be relieved of its obligation to fund benefit claims in accordance with the terms of Attachment I.

33. **Disputes:** The Parties shall deal in good faith and attempt to resolve potential disputes informally. If a dispute concerning a question of fact arising under the terms of this Contract is not disposed of in a reasonable period of time by the Contractor's Account Manager and the County's Program Manager, such matter shall be brought to the attention of the Purchasing Agent by way of the following process:

    a. The Contractor shall submit to the Deputy Purchasing Agent a written demand for a final decision regarding the disposition of any dispute between the Parties arising under, related to, or involving this Contract, unless the County, on its own initiative, has already rendered such a final decision.
    b. The Contractor's written demand shall be fully supported by factual information, and, if such demand involves a cost adjustment to this Contract, the Contractor shall include with the demand a written statement signed by a senior official indicating that the demand is made in good faith, that the supporting data are accurate and complete, and that the amount requested accurately reflects the amount for which the Contractor believes the County is liable.
    c. Pending the final resolution of any dispute arising under, related to, or involving this Contract, the Contractor agrees to diligently proceed with the performance of his Contract, including the provision of services. The Contractor's failure to diligently proceed shall be considered a material breach of this Contract.

    Any final decision of the County shall be expressly identified as such, shall be in writing, and shall be signed by the County's Purchasing Agent or his designee. If the County fails to render a decision within 90 days after receipt of the Contractor's demand, it shall be deemed a final decision adverse to the Contractor's contentions.

34. **Orderly Termination**: Upon termination or other expiration of this Contract, each Party shall promptly return to the other Party all papers, materials, and other properties of the other held by each for purposes of this Contract. In addition, each Party will assist the other Party in orderly termination of this Contract and the transfer of all aspects, tangible and intangible, as may be necessary for the orderly, non-disruptive business continuation of each Party.

    At the end of the term of this Contract or in the event of termination of this Contract by either party, the Contractor agrees to provide County with a computer history tape (in a form and format reasonable acceptable to the County) with information necessary to transfer the records of each member's history of Claims within thirty (30) days of the effective date of the termination of this Contract. County may request copies of individual files necessary to reconstruct individual histories on specified members for up to five

(5) years after termination of this Contract.

At the end of the term of this Contract or in the event of termination of the Contract by either Party the Parties each agree to cooperate with and timely respond to requests from the other Party for records, information or other reasonable requests for assistance relating to matters that occurred while the contract was in effect. Such cooperation shall include providing reasonable access to records and information and assistance in responding to inquiries and litigation.

35. **Force Majeure:** Contractor shall not be in breach of this Contract and assessed with liquidated damages or unsatisfactory performance penalties during any delay beyond the time named for the performance of this Contract caused by any act of God, war, civil disorder, employment strike or other cause beyond its reasonable control, provided Contractor gives written notice of the cause of the delay to the County within 36 hours of the start of the delay and Contractor avails himself of any available remedies.

36. **Consent to Breach Not Waiver:** No term or provision of this Contract shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. Any consent by any Party to, or waiver of, a breach by the other, whether express or implied, shall not constitute consent to, waiver of, or excuse for any other different or subsequent breach.

37. **Remedies Not Exclusive:** The remedies for breach set forth in this Contract are cumulative as to one another and as to any other provided by law, rather than exclusive; and the expression of certain remedies in this Contract does not preclude resort by either Party to any other remedies provided by law.

38. **Notices:** Any and all notices, requests demands and other communications contemplated, called for, permitted, or required to be given herein shall be in writing with a copy provided to the assigned Deputy Purchasing Agent (DPA), except through the course of the County's Program Manager and Contractor's Account Manager routine exchange of information and cooperation during the terms of the work and services. Any written communications shall be deemed to have been duly given upon actual in-person delivery, if delivery is by direct hand, or upon delivery on the actual day of receipt or no greater than four (4) calendar days after being mailed by US certified or registered mail, return receipt requested, postage prepaid, whichever occurs first. The date of mailing shall count as the first day. All communications shall be addressed to the appropriate Party at the address stated herein or such other address as the Parties hereto may designate by written notice from time to time in the manner aforesaid.

County:	Program Manager, Lauren Pierson Human Resource Services/Employee Benefits 333 W. Santa Ana Blvd., 1st Floor, Room 137 Santa Ana, CA 92701
Cc:	Human Resource Services/Employee Benefits Attn: Diana Banzet, Deputy Purchasing Agent 333 W. Santa Ana Blvd., 1st Floor, Room 137 Santa Ana, CA 92701
Contractor:	California Physician Services dba Blue Shield of California 50 Beale Street San Francisco, CA 94150

39. **County of Orange Child Support Enforcement Certification Requirements:** Contractor is required to comply with the child support enforcement requirements of the County. Failure of the Contractor to comply with all federal, state, and local reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall

constitute a material breach of the Contract. Failure to cure such breach within 60 calendar days of notice from the County shall constitute grounds for termination of this Contract. Within ten days of the effective date to this Agreement, Contractor shall provide the County with a certification that Contractor is in compliance with all applicable federal and state reporting requirements regarding Contractor's employees.

40. **EDD INDEPENDENT CONTRACTOR REPORTING REQUIREMENTS:** Effective January 1, 2001, the County of Orange is required to file in accordance with subdivision (a) of Section 6041A of the Internal Revenue Code for services received from a "service provider" to whom the County pays $600 or more or with whom the County enters into a contract for $600 or more within a single calendar year. The purpose of this reporting requirement is to increase child support collection by helping to locate parents who are delinquent in their child support obligations.

    The term "service provider" is defined in California Unemployment Insurance Code Section 1088.8, subparagraph B.2 as "an individual who is not an employee of the service recipient for California purposes and who received compensation or executes a contract for services performed for that service recipient within or without the state." The term is further defined by the California Employment Development Department to refer specifically to independent Contractors. An independent Contractor is defined as "an individual who is not an employee of the government entity for California purposes and who receives compensation or executes a contract for services performed for that government entity either in or outside of California."

    The reporting requirement does not apply to corporations, general partnerships, limited liability partnerships, and limited liability companies. The Contractor is representing themselves as a corporation and the reporting requirement would not be applicable.

    Additional information on this reporting requirement can be found at the California Employment Development Department web site located at http://www.edd.ca.gov/Employer_Services.htm.

41. **Change Of Ownership/Name, Litigation Status, Conflicts with County Interests:** Contractor agrees that if there is a change or transfer in ownership of Contractor's business prior to completion of this Contract, and the County agrees to an assignment of the Contract, the new owners shall be required under the terms of sale or other instruments of transfer to assume Contractor's duties and obligations contained in this Contract and complete them to the satisfaction of the County.

    County reserves the right to immediately terminate the Contract in the event the County determines that the assignee is not qualified or is otherwise unacceptable to the County for the provision of services under the Contract.

    In addition, Contractor has the duty to notify the County in writing of any change in the Contractor's status with respect to name changes that do not require an assignment of the Contract. The Contractor is also obligated to notify the County in writing if the Contractor becomes a party to any litigation against the County, or a party to litigation that may reasonably affect the Contractor's performance under the Contract, as well as any potential conflicts of interest between Contractor and County that may arise prior to or during the period of Contract performance. While Contractor will be required to provide this information without prompting from the County any time there is a change in Contractor's name, conflict of interest or litigation status, Contractor must also provide an update to the County of its status in these areas whenever requested by the County.

    The Contractor shall exercise reasonable care and diligence to prevent any actions or conditions that could result in a conflict with County interests. In addition to the Contractor, this obligation shall apply to the Contractor's employees, agents, and subcontractors associated with the provision of goods and services provided under this Contract. The Contractor's efforts shall include, but not be limited to establishing rules

and procedures preventing its employees, agents, and subcontractors from providing or offering gifts, entertainment, payments, loans or other considerations which could be deemed to influence or appear to influence County staff or elected officers in the performance of their duties.

42. **Precedence:** The Contract documents herein consist of this Contract and its attachments. In the event of a conflict between or among the Contract documents, the order of precedence shall be the provisions of the main body of this Contract, i.e., those provisions set forth in the articles of this Contract, and then the attachments and exhibits.

43. **Headings:** The various headings and numbers herein, the grouping of provisions of this Contract into separate clauses and paragraphs, and the organization hereof are for the purpose of convenience only and shall not limit or otherwise affect the meaning hereof.

44. **Severability:** If any term, covenant, condition or provision of this Contract is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired or invalidated thereby.

45. **Calendar Days:** Any reference to the word "day" or "days" herein shall mean calendar day or calendar days, respectively, unless otherwise expressly provided.

46. **Attorney Fees:** In any action or proceeding to enforce or interpret any provision of this Contract, or where any provision hereof is validly asserted as a defense, each Party shall bear its own attorney's fees, costs and expenses.

47. **Interpretation:** This Contract has been negotiated at arm's length and between persons sophisticated and knowledgeable in the matters dealt with in this Contract. In addition, each Party has been represented by experienced and knowledgeable independent legal counsel of their own choosing, or has knowingly declined to seek such counsel despite being encouraged and given the opportunity to do so. Each Party further acknowledges that they have not been influenced to any extent whatsoever in executing this Contract by any other Party hereto or by any person representing them, or both. Accordingly, any rule of law (including California Civil Code Section 1654) or legal decision that would require interpretation of any ambiguities in this Contract against the Party that has drafted it is not applicable and is waived. The provisions of this Contract shall be interpreted in a reasonable manner to affect the purpose of the Parties and this Contract.

48. **Authority:** The Parties to this Contract represent and warrant that this Contract has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

49. **Survival:** Notwithstanding any provision to the contrary herein, the provisions of paragraphs 14, 15, 16, 17, 18, and 20 shall survive the termination of this Contract.

50. **Health Insurance Portability and Accountability Act (HIPAA):** Contractor understands and agrees that the disclosure of PHI by a health care component of a covered entity is subject to the HIPAA Privacy Rule, Contractor understands and agrees that it is a Business Associate of County for the purposes of the HIPAA Privacy Rule. Therefore, the provisions set forth in Attachment H hereto shall be operative and control the Business Associate relationship of the parties. Nothing in Attachment H shall be considered a waiver of the limitation on subcontracting as set forth in this Contract.

51. **Civil Rights:** Contractor attests that services provided shall be in accordance with the provisions of Title VI and Title VII of the Civil Rights Act of 1964, as amended, Section 504 of the Rehabilitation Act of

1973, as amended; the Age Discrimination Act of 1975 as amended; Title II of the Americans with Disabilities Act of 1990, and other applicable State and federal laws and regulations prohibiting discrimination on the basis of race, color, national origin, ethnic group identification, age, religion, marital status, sex or disability.

52. **Lobbying**: On the best information and belief, Contractor certifies no federal appropriated funds have been paid or will be paid by, or on behalf of, the Contractor to any person influencing or attempting to influence an officer or employee of Congress; or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative contract.

53. **Debarment**: Contractor shall certify that neither Contractor nor its principles are presently debarred, proposed for debarment, declared ineligible or voluntarily excluded from participation in the transaction by any Federal department or agency. Where Contractor as the recipient of federal funds, in unable to certify to any of the statements in the certification, Contractor must include an explanation with the bid/proposal. Debarment pending debarment, declared ineligibility or voluntary exclusion from participation by any Federal department of agency may result in the bid/proposal being deemed non-responsible.

54. **Employee Eligibility Verification:** The Contractor warrants that it fully complies with all Federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Contract meet the citizenship or alien status requirement set forth in Federal statutes and regulations. The Contractor shall obtain, from all employees performing work hereunder, all verification and other documentation of employment eligibility status required by Federal or State statutes and regulations including, but not limited to, the Immigration Reform and Control Act of 1986, 8 U.S.C. §1324 et seq., as they currently exist and as they may be hereafter amended. The Contractor shall retain all such documentation for all covered employees for the period prescribed by the law. The Contractor shall indemnify, defend with counsel approved in writing by County, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against the Contractor or the County or both in connection with any alleged violation of any Federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Contract.

55. **Bills and Liens:** Contractor shall pay promptly all indebtedness for labor, materials, and equipment used in performance of the work. Contractor shall not permit any lien or charge to attach to the work or the premises, but if any does so attach, Contractor shall promptly procure its release and, in accordance with the requirements of paragraph 18 above, indemnify, defend, and hold County harmless and be responsible for payment of all costs, damages, penalties and expenses related to or arising from or related thereto.

56. **Changes:** Contractor shall make no changes in the work or perform any additional work without County's specific written approval.

57. **Terms and Conditions:** Contractor acknowledges that it has read and agrees to all terms and conditions included in this Contract.

58. **Incorporation:** This Contract and its Attachments A through I and Exhibits 1 through 4 are attached hereto and incorporated herein by this reference and made a part of this Contract.

CONTRACT SIGNTURE PAGE TO FOLLOW

CONTRACT SIGNATURE PAGE

IN WITNESS WHEREOF, The Parties hereto have executed this Contract on the dates shown opposite their respective signatures below.

CONTRACTOR*:

Print Name	Title
Signature	Date
Print Name	Title
Signature	Date

**If the contracting party is a corporation, two (2) signatures are required: one (1) signature by the Chairman of the Board, the President or any Vice President; and one (1) signature by the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer. The signature of one person alone is sufficient to bind a corporation, as long as he or she holds corporate offices in each of the two categories described above. For County purposes, proof of such dual office holding will be satisfied by having the individual sign the instrument twice, each time indicating his or her office that qualifies under the above described provision.*

In the alternative, a single corporate signature is acceptable when accompanied by a corporate resolution demonstrating the legal authority of the signature to bind the company.

****

COUNTY of ORANGE
A political subdivision of the State of California

Print Name	Title
Signature	Date

Approved by the Board of Supervisors on: _____

APPROVED AS TO FORM:

_____
Deputy, Office of County Counsel
Orange County, California

ATTACHMENT A

Scope of Work

I. Definitions: For purposes of this Contract, including all Attachments and Exhibits, the parties agree to the following definitions:

1. *"The Board*" The Board of Supervisors for the County of Orange is the legislative and policy making body of the County and is responsible for the review and approval of all service agreements and/or contracts with the County.

2. *"Employee Benefits Division*" A Division of Human Resource Services of the County responsible for the design, implementation and on-going administration of the County's various employee benefit plans and programs.

3. *"Human Resource Services (HRS)*" The County's HRS is comprised of various divisions and sections that provide a wide array of personnel and employee services to County departments and agencies. The HRS Director reports directly to the County Executive Officer (CEO).

4. *"TPA*" Third Party Administrator(s) for the County's self-insured PPO health plans.

5. *"Benefits Center"* shall be defined as the County's Benefits Center for employees and retirees, which provides full Benefits administration such as benefits eligibility and enrollment, currently provided through Secova.

6. *"Claim"* shall be defined as one or more documents related to accident, illness or treatment that are submitted for reimbursement under the Plan and received together in batch plus any additional documents received at a later time in support of the original submission.

7. *"Claimant"* are certain County employees, retirees, and their dependents who are Participants under the Plan.

8. *"Claim Form*" includes, but is not limited to a County Claim form, HCFA 1500 (Physician Bill) or a UB 82 (Hospital Bill) or information in writing from Claimant or Provider that is sufficient to accurately process a Claim, including diagnosis, the services rendered, the date the services were rendered, the charge for each service, billing address, phone number, Provider's name and signature of licensed medical Provider who provided the services.

9. "*Coinsurance*" or "*Copayment*" shall mean a percentage of cost or dollar amount that a Participant is responsible for paying for a service, supply or medication based on the County's Plan Design Document, and includes, but is not limited to coinsurance, copayment and deductible.

10. *"County Bank"* means the bank selected by County.

11. *"Covered Person" or "Participant"* shall mean any eligible covered person under the Plan, including dependents of the covered employee or retiree.

12. "*Explanation of Benefit*" (EOB) is a periodic summary Statement of Plan and Participant paid amounts sent to Participants.

13. *"IVR"* is Interactive Voice Response and shall mean any automated voice response system utilized by Contractor for incoming calls from plan participants.

14. *"Net Proceeds of Subrogation"* is the amount recovered on account of the enforcement by Contractor or its subcontractors of the Subrogation provision of the medical plans less the costs of such recovery retained by the Contractor and/or paid by the Contractor to third persons.

15. *"Plan"* means the self-funded PPO Health Plans established by County for certain employees, retirees, and dependents, consisting of the Wellwise Choice Health Plan, Sharewell Choice Health Plan, Wellwise Retiree Health Plan, and Sharewell Retiree Health Plan.

16. *Pharmacy Benefits Manager or "PBM"* shall be defined as the County's pharmacy benefit manager for the prescription drug coverage provided by the Sharewell Choice, Sharewell Retiree, Wellwise Choice and Wellwise Retiree health plans. The County's PBM services are currently provided by OptumRx, Inc.

17. *"Plan Administrator"* is the County Human Resource Services Director or his or her designee.

18. *"Plan Benefit Account*" means the Contractor Bank account establish for payment of County Plan(s) for health care benefits and from which Provider payment checks are issued by the Contractor.

19. *"Preferred Provider Organization" or "PPO"* means the Network of preferred providers offered by Contractor.

20. *"Provider"* means a hospital, physician, or other medical care provider, who, through contract with Contractor or with a physician hospital organization, individual physician association, or other provider network or organization with whom Contractor has contracted, has agreed to be a member of Contractor's PPO network.

21. *"Provider Agreement"* means Contractor's agreement with a hospital, physician, or other medical care provider or with a physician hospital organization, individual physician association, or other provider network or organization, whereby Providers have agreed to be members of Contractor's PPO network.

22. *"Subrogation"* means the right to recover payments made to person covered under the Plan or a health care provider because of an injury to that person caused by a third party's wrongful act or negligence and which person or health care provider later recovers or is entitled to recover from the third party or the third party's insurer.

23. *"Utilization and Case Management"* means the services provided by Contractor as described in this Attachment A.

24. *"Working Days"* are all calendar days except Saturday, Sunday, and legal holidays, as recognized by the Plan Administrator and Contractor.

II. Scope of Services for the County of Orange Self-Insured PPO Health Plans

Objectives

The Contractor shall perform the required services of this Attachment A – Scope of Work to accomplish the following objectives:

1. Ensure that claims are processed in compliance with Plan provisions in an expeditious manner.
2. Ensure that claims are processed in compliance with Preferred Provider negotiated rates (where applicable) and utilization review decisions in accordance with program requirements to maximize the cost management savings of these programs.
3. Ensure that Plan Participants receive high quality customer service and access to information relative to understanding and utilizing their Plan benefits.

III. County Responsibilities

County shall:

1. Promptly pay the County's self-funded claim liability under this Contract as approved claims are presented by Contractor.

2. In addition to Plan documents, which Contractor acknowledges that it has received and reviewed, furnish the Contractor with a detailed written description of Plan coverage.

3. Furnish the Contractor with information from which the Contractor can determine Claimant eligibility under the Plan.

4. Authorize Contractor to enter into Provider Agreements and amendments thereto, on behalf of the County, which Provider Agreements may, among other provisions, specify fee amounts which shall be accepted by Providers as payment in full for health care services provided to Covered Persons under the Plans.

5. Be bound by all terms and conditions of Provider Agreements, which apply to Contractor and its network only if required under State or Federal Law. (For example, California Health and Safety Code section 1375.7(d)(1), California Business and Professions Code section 511.3and California Insurance Code section 10178.4). The County must receive advance written notice from Contractor of Provider Agreements containing terms and conditions that materially deviate from Contractor's standard Provider Agreement.

6. Sufficiently fund the Plan Benefit Account to meet the County's obligation to pay Providers based on the payment amount specified in the applicable Provider Agreement and to allow Contractor to process Claim payments in accordance with the terms of the Contract.

IV. Contractor Responsibilities

A. Facilities and Staffing

Contractor shall:

1. Maintain adequate staff in Claims offices for the effective administration of the Plan Claims processing and payments. The staffing shall include a Designated Team to be dedicated to the County account. The Designated Team will be supplemented as needed to meet the performance requirements of the Contract. For purposes of the Contract, "Designated Team" means staff in the claims and customer service area, trained on the unique provisions of the County Plans and whose primary and priority job function is the servicing of the County claims and Participants in order to meet the performance requirements of the Contract. The Designated Team will be maintained so that 75% of the staff has 2 or more years of relevant experience.

   Contractor agrees to staff the Designated Team at a level sufficient to routinely have:
   a. 95% of Plan claims processed through a combination of auto-adjudication and/or the Designated Team; and,
   b. 85% of customer service calls handled through the Designated Team.

2. Notify the County program manager within 30 calendar days prior when possible, of any Designated Team long term staffing level changes, but no later than 14 calendar days after the change(s).

3. Provide a dedicated toll free number routed to the County's Designated (dedicated) customer service team for County Participants; a voice response system with a user-friendly menu and alternative language options (or access to language translation services); system availability 24 hours a day/7 days a week/365 days a year (excluding scheduled downtime); and a dedicated Post Office Box for submission of County claims, as part of the base administrative fees with no additional cost to the County.

4. Maintain Customer Service hours for the Plans from at least 6:00 a.m. to 8:00 p.m. (Pacific Time) Monday through Friday except for the following holidays; New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. For purposes of the Contract, dedicated customer service team is defined as a unit specifically trained on the unique provisions of the County Plans. County calls shall be routed to and processed exclusively by this unit.

5. Ensure that Participants with limited English proficiency and those who are deaf or hearing impaired have access to communication services that enable participants to utilize the phone lines.

6. Provide access to a 24 Hour Telephone Advice Nurse. Telephone Advice Nurse shall encourage utilization of PPO providers whenever possible.

7. Conduct prepayment audits of new claim team members ensuring that 100% of new claim team member's work is audited for 30 days after training.

8. Withhold the addition of other new accounts serviced by the County's account team until September 1, 2020, to facilitate successful implementation of the County account.

9. Should Contractor be merged with, acquired by or acquire another entity during the Contract Term; Contractor shall pay for all of the County's transition costs if there is a need to migrate the County plans, including but not limited to reimbursement of County programming and communications costs and pre and post implementation audit costs if a change in claims processing and/or eligibility systems occurs.

B. Claims Processing

Contractor shall:

1. Supervise and administer the payment of Claims in accordance with the Plan Documents and act as the representative of the County with regard to Claims administration and review. Services provided by Contractor shall cover Claimants' benefits provided in the State of California as well as outside the State of California.

2. Coordinate and administer Claims in cooperation with contractor(s) selected by County for services of the Sharewell and Wellwise Plans' Prescription Drug Card and Mail Order Program.

3. In accordance with the requirements set forth in Attachment G, adjudicate Plan Claims in an expeditious and courteous manner, responding to each Claim with a benefit determination within 30 calendar days of receipt of the Claim. Provide Plan Participants with an explanation of benefits for each and every adjudicated claim, including Claims which are ineligible. The explanation of benefits shall include the reason for ineligibility and shall include all of the content required to be included in such notices pursuant to the applicable requirements set forth in the Patient Protection and Affordable Care Act, and the regulations issued thereunder, with regards to denied claims and appeals for denied claims.

4. Out of Network Claims: For the Plans: Except when the allowance derived from an existing negotiated letter of agreement, as noted in Paragraph 25 below, is less than URC, (i) process out of network claims from providers using allowances as follows: (A) for professional claims (i.e., non-facility claims), utilize a URC amount equal to the 90th percentile of recorded charges for each procedure or service in a specific

geographic area and, (B) for facility claims, except for ambulatory surgery center and dialysis center claims, utilize a URC amount equal to the 90th percentile of recorded charges for each procedure or service in a specific geographic area; (ii) process facility claims for out of network ambulatory surgery centers and dialysis centers located in California in accordance with the County plan documents; and (iii) process all out of network claims provided by radiologists, anesthesiologists, pathologists, and emergency room Physicians at network facility at the in-network benefit level.

5. Provide Claims information services to Plan Participants including a dedicated Benefits Specialist to research and resolve, to the satisfaction of the County, benefits and/or Claims inquiries and complaints submitted by the Participants. Claims Service Representative should have the ability to gather and analyze data, create a historical picture, including a timeline of Claim activity for individual Participants, and develop appropriate correspondence for complicated Claim issues that are appealed to the County in accordance with the requirements set forth in Attachment G.

6. Take reasonable and effective precautions to prevent payment of invalid, duplicate and fraudulent Claims with respect to the Plans.

7. Coordinate benefit payments with other group insurance plans and Medicare in which employees, retirees or dependents may be enrolled to protect against duplication of benefits or excessive payment of Claims. Coordination of payment with Medicare shall be done via Contractor's direct crossover with Medicare claims information and shall not require the submission of a Medicare EOB from Plan Participants.

8. Maintain accepted professional practices for the control and efficient payment of Claims.

9. Verify the eligibility of all Claimants for benefits under the County's group Plans from eligibility information provided by the Benefits Center.

10. Compute and pay Claims for group hospital and medical benefits from funds provided by the County in accordance with the Plan documents established and/or amended by the County.

11. Provide bank reconciliation services and produce checks and/or electronic fund transfers for Claims and indicate that Contractor administers the Plan. Any interest earned on County funds remains with the County.

12. Notify the Benefits Center and the County in writing through the Claims Service Representative when during the course of claims payment or benefits verification Contractor is notified, or should have known, a retiree or dependent eligible for Medicare is not enrolled in Medicare or has assigned their Medicare benefits to another health plan.

13. Notify the Benefits Center of deceased Covered Persons when Contractor receives notification of such death via telephone call with Customer Service or Utilization Management or via claim submission.

14. Pursue and enforce Subrogation under the Plans when, in Contractor's judgment, there is recovery potential. The Contractor or its subcontractors will make final settlement decisions, which, in Contractor's judgment, are reasonable based on the circumstances of the accident or injury and the available recovery sources. Contractor shall have the authority to reduce the amount of a lien and Order to Pay against a third party for paid claims paid under the following conditions:

    a. The attorney for the claimant shall request in writing a reduction for the lien indicating the potential settlement and percentage of attorney's fees;

    b. The percentage of reduction of the lien shall not exceed the percentage of settlement represented by the attorney's direct fees;

c. The reduction shall not exceed $20,000; and

d. The Claims paid by the Contractor and the amount represented by the lien are verified and a record of the reduction is available for audit.

15. Report status of subrogation cases quarterly to County.

16. Comply with the County's rules and procedures in the processing of large Claim payments (currently required for Claim payments of $100,000 or more), withholding such check or electronic fund transfer until approved by the County.

17. Maintain proper controls to avoid overpayments with respect to the Plans. If Coordination of Benefits (COB) is noted on a claim, Contractor shall mail a COB questionnaire to Participant's for whom there is no COB information on file. Such claim will not be processed until such time as the COB questionnaire is properly completed and returned to Contractor. Contractor will update COB systems upon receipt.

18. Provide to each Participant an Explanation of Benefits (EOB) for Claims processed for the member or eligible enrolled dependent(s). The explanation shall include at a minimum, a listing of billed charges, the charges as adjusted under a Preferred Provider Agreement, charges not eligible, charges paid, deductible applied, calculation of rate paid, listing of payees and amounts and the amount to be paid by the Participant, including the amount of any balance billing liability. At County's request, Contractor will customize EOBs for County's specific requirements and will include the County's logo and County specific website.

19. Provide, upon request, information on Claims to assist the County in resolving problems of Participants with Claims, providing information for retirement actions and to assist in preparing litigation.

20. Perform internal audit of Claims for accurate and correct application of medical benefits, for all checks or electronic fund transfers in excess of $10,000.

21. Provide an effective, on-going review of randomly selected claims as delineated in the performance guarantees.

22. Provide for adjustment in the event a Claimant has been paid less than the amount provided by the Plan, and for collection of overpayment in the event the Claimant has been paid more than the amount provided by the Plan. The method of collection for overpayments must be approved by the County.

23. At the County's request, assist in managing the prescription drug payments to include:

    a. Verify eligibility for Prescription benefits under the plan during normal working hours.

    b. Pay any eligible prescription claims in cooperation with the formulary of the County's contracted Pharmacy Benefits Manager for urgent/emergent and out-of-network prescriptions for the Wellwise and Sharewell.

    c. Assist the Pharmacy Benefits Manager to prevent Claims paid under the Pharmacy Network from also being paid by Contractor through the Plans.

    d. Support near real time (NRT) interface for prescription claims data for out-of-pocket cost accumulators (deductibles and out-of-pocket maximums) for the Sharewell plans**.**

24. Conduct, at the written request of the County, hospital audits to ensure accurate billing of charges to be covered under the Plans.

25. For medical claims, actively seek provider discounts for claims from non-network providers as follows: (1) utilize previously negotiated letters of agreement from non-network facilities for claims of $5,000 or more in billed charges, and, (2) seek ad hoc discounts from other non-network facilities for claims of $5,000 or more in billed charges. Report status of negotiations and savings quarterly to County.

26. Distribute, upon request, informational material furnished by the County with the Explanation of Benefits.

27. Administer annual Wellwise Retiree Non-Smoker Incentive during the 2nd quarter of 2020, and the 2nd quarter of each subsequent contract year, if requested by the County as follows:

    Retiree Non-Smoker Incentive per the Wellwise Retiree Plan Documents

    a. Determine all subscribers who were enrolled in the Wellwise Retiree plan at any time during the plan year (no pro-rating required).

    b. Create a file of subscribers who are eligible for the Wellwise Retiree Non-Smoker Incentive.

    c. Utilize file of eligible Wellwise Retiree Non-Smoker Incentive subscribers to create notifications to claim Incentive payment.

    d. Mail notifications to eligible subscribers.

    e. Review and process claims for Incentive payments as they are returned by subscribers.

    f. Wellwise Retiree Non-Smoker Incentive payments shall be made via check issued by Contractor directly to retirees. The Contractor will responsible for providing a detail file and report itemizing the Wellwise Retiree Non-Smoker Incentive payments and invoicing the County for reimbursement. Incentive will be paid following the end of the Plan Year. The final year Incentive will be paid as part of run out service.

28. Provide individual Usual Reasonable and Customary amounts, on request, to the County or its designee when needed to process internal County appeals to reimburse out of pocket expenses for Superior Court Judges not covered by the County's Plans.

29. Print and pay the cost of all necessary Plan Claim forms, including Plan benefit account checks.

30. Process and flag claims potentially involve third party liability sending appropriate claims to the third party to pursue recovery. Review all claims data to identify and to pursue potential third party liability claims.

31. In accordance with the requirements set forth in Attachment G, comply with the federal Patient Protection and Affordable Care Act appeal requirements for non-grandfathered Plan participants, as specified in the applicable Plan Document. For participants in retiree Plans, review and process all Participant and provider appeals, grievances and complaints in the same manner as the non-grandfathered Plans, as specified in the Plan Documents. For all Plans, in accordance with the requirements set forth in Attachment G, provide external reviews of denied claims performed by Contractor's rotating Independent Review Organizations. Maintain a log of all County appeals that includes, at a minimum, the Participant's name and ID number, the nature of the appeal, grievance or complaint, the date the appeal, grievance or complaint was received, and the date Contractor's review of the appeal, grievance or complaint was completed and communicated to the Participant.

32. Review claims for medical necessity when appropriate, utilizing Contractor's internal written guidelines to identify candidates for review, and to conduct such a review in a consistent manner for similar claims.

Such reviews should be conducted by a clinician with the appropriate background, training and expertise to evaluate questions of medical necessity.

33. Continue the administration of claims incurred prior to the effective ending date of this Contract for a period of twelve months after the termination date (Run-Out Claims) including but not limited to claims processing, claims reporting, bank reconciliation reports, claim appeals, subrogation, etc.

34. Coordinate with previous administrator to process final run-in claims from 2019 and prior not processed by December 31, 2020.

35. Conduct plan testing of all non-standard benefit provisions, as defined by the County and Contractor, for the County's Plans in conjunction with any significant claims processing software upgrade or system/plan maintenance to identify the impact, if any, the upgrade or maintenance had on the accuracy of claims processing, and report results to the County. Plan testing must occur prior to claims processing resuming under the new or modified system. Significant is defined as any upgrade or maintenance item that would be anticipated to impact County non-standard provisions. Non-standard provisions will be mutually identified during the implementation process. All other upgrades or maintenance would be reviewed by Contractor during regular monthly performance audits.

36. Contractor will provide Telehealth consultation services for primary care services. Telehealth consultations for primary care services will provide confidential consultation using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. to 9 p.m. by secure online video, 7 days a week (subject to change). Telehealth Physicians can provide diagnosis and treatment for urgent and routine non-emergency medical conditions and can also issue prescriptions for certain medications. Telehealth consultation services are optional to the Covered Persons and are not intended to replace services from a Covered Person's Physician but are a supplemental service to assist Covered Persons when their Physician is not available and they need quick access to a Physician. Telehealth consultation services are not available for specialist services or mental health and Substance Use Disorder Services. Before Telehealth services can be accessed, the Covered Person must enter their medical history on the Telehealth service organization's website or mobile app, or via the Telehealth service organization's call center prior to a consultation. The Telehealth consultation fee is considered a network benefit subject to network deductibles and coinsurance. If medications are prescribed, applicable co-insurance and other requirements of the Prescription Drug Card Program contained in the Plan Document apply. The County at its sole discretion may add or delete Telehealth services based on an analysis of service results, cost effectiveness, and risk as needed.

C. Customer Service

Contractor shall:

1. Provide a dedicated Customer Service team to quote benefits, provide Claim status information, assist in the filing of appeals, and related Claims processing issues.

2. Provide, upon request by Plan Participants, Claim forms for those without Internet Access.

3. Provide on Contractor's web site access to custom County web page containing links to PPO provider directories, eligibility and Plan benefit information, claim status, the ability to request replacement ID cards and email a Customer Service Representative.

4. Attend County Open Enrollment meetings and annual Health Fair to provide health education information and to assist employees and Participants with Plan inquiries or customer service issues.

5. Make its best efforts to sponsor four (4) employee lunch-time wellness seminars each year and work with designated County staff to determine scheduling and topics.

6. Provide on-line verification of eligibility to health care providers on Contractors' website.

D. Utilization Review / Case Management

The Utilization Review program described herein is designed to help determine if certain health care services may be recommended for certification as medically necessary under the terms of the Plans. Contractor will use the results of the Utilization Review program to assist in making Claims decisions under the Plans. The Utilization Review program is not intended to be a substitute for actual Claims decisions. The decision or determination to obtain or deliver any health care service is always made only by the patient (and his or her parent or guardian, if appropriate) and/or his or her health care provider. Final Claim decisions will continue to be governed by the terms and conditions of this Contract and the Plan.

Contractor shall:

1. Be responsible for the provision of medical Utilization Review (UR) services. Medical Utilization Review services shall include at a minimum Hospital Pre-admission Review, Concurrent Review, Retrospective Review, maternity management, Mental Health and Chemical Dependency Review, and Case Management.

    a. Pre-admission Review involves review of medical necessity and/or appropriateness of proposed hospitalizations and Outpatient Surgery Review.

    b. Concurrent Review involves the monitoring of the medical necessity and/or appropriateness of an ongoing hospital stay and discharge planning.

    c. Retrospective Review involves review of medical necessity and/or appropriateness of a hospital stay after the stay has been completed.

    d. Case Management is a comprehensive service that provides assistance in the design of medically necessary treatment plans, including, without limitation, discharge planning and referrals to home health care and hospice care, with the consent of the patient and the patient's treating physician, for persons facing catastrophic illness or injury.

    e. Maternity management is a service designed to promote healthy pregnancies through early prenatal care, education, early identification of high risk factors and, if necessary, early Case Management.

    f. Mental Health and Chemical Dependency Review involves Pre-admission Review and Concurrent Review of the medical necessity and/or appropriateness of all proposed hospitalizations for mental health or chemical dependency treatment.

2. Identify Case Management cases promptly upon notification of a hospital admission, or based upon other catastrophic condition indicators identified by claims data, pharmacy data, customer service referrals, referrals from practitioners, etc.

3. Send a review letter to the Participant to verify the Utilization Review decision on the proposed treatment plan, need for hospital admission or both. This letter is to be sent within one Working Day of the Utilization Review decision.

4. Coordinate efforts with the County's Employee Assistance Program (EAP) to refer Participants to PPO Providers when seeking treatment.

5. Provide minimum UR/Case Management/Discharge Planning office hours from 8:00 a.m. to 5:00 p.m., Monday-Friday (PST).

6. Provide a toll-free telephone number and live telephone Nurse line, 24 hours a day, and 7 days a week.

7. Provide the County with Utilization Review reports similar to those listed below. Reports shall be issued once each calendar quarter. The final quarterly report shall include information applicable to the full calendar year.

   a. Executive Summary

   b. Quarterly UR Report

   c. Major Diagnostic Category (MDC) at Policy Level

   d. MDC by Relationship
   e. Claims by Age Group

8. Prepare and provide Utilization Review communication material and/or presentations for County Participants.

9. Refer to the County for consideration and final decision, certain Utilization Review recommendations or decisions based upon procedures mutually agreed upon in writing by the Parties.

10. Identify outlier hospitals and physician organizations through Contractor's Care Coordination Model to reduce preventable admissions.

11. Refer Participants considering treatment from non-network providers to PPO providers as appropriate.

E. Disease Management

Contractor shall:

1. Interface with the County's Pharmacy Benefit Manager to obtain prescription Claims data in order to conduct pharmacy utilization analysis.

2. Accept referrals into the disease management program from physicians and Participants, as appropriate.

3. Identify Participants with chronic illnesses and offer available programs and services to assist in the management of these conditions. At a minimum, include programs for heart failure, chronic obstructive pulmonary disease, coronary artery disease, diabetes, asthma and musculoskeletal conditions.

4. Provide detailed procedures denoting how potential program participants are identified and the data utilized, how outreach is conducted, how enrollment is tracked against goals and benchmarks, how return on investment is calculated as well as how participants can disenroll in programs.

5. Provide quarterly reports of disease management utilization and program impacts. Program impacts will include:

   a. **Patient Activation Measure (PAM).** This tool is used to assess a member's underlying knowledge, skills, and confidence integral to managing his or her own health and care. Contractor will report the percentage of engaged members with an increased activation level, who therefore developed strong self-management skills and resilience. This is an annual book of business metric.

b. **Consumer Health Activations Index (CHAI).** Contractor will report on the percent of engaged members with increased CHAI, which measures physical and mental health activation. This is an annual book of business metric.

c. **Pain Self Efficacy Questionnaire (PSEQ).** Contractor will report the percent of engaged members with improved scores on the PSEQ, which is associated with clinically-significant outcomes for those with chronic paid. This is an annual book of business metric.

d. **Consumer Health Index (CHI).** Contractor will report the percent of engaged members in behavioral health condition management with improved self-efficacy as measured by the CHI. This is an annual book of business metric.

Contractor will also report on the following outcomes based on annual book of business metrics:

- The percent of engaged members who improved their ability to manage their health condition
- The percent of engaged members who improved their overall health.
- The percent of engaged members who improved their ability to communicate with their physician.
- The percent of engaged members who improved their ability to carry out physical activities.
- The percent of engaged members whose mental health improved or remained stable.
- The percent of engaged members who reported an improvements their ability to focus on achieving their goals, despite their health condition.
- The percent reduction in inpatient admissions for members with heart disease.
- The percent of overall satisfaction with the program.

6. Accept data from prior Contractor for purposes of identification of potential program participants.

F. Preferred Provider Network

Contractor shall:

1. Make its PPO network of Providers available to Participants in the Plans. Contractor shall require Providers to accept the Contractor's reimbursement amount as payment in full less any patient responsibility (e.g. deductibles and coinsurance) for covered services rendered by Providers to Participants under County's Plans. Contractor's negotiated rate will result in health Plan discounts.

2. Notify the County within 60 days prior to the termination of the following: (1) any network hospital in Southern California, (2) any medical group or medical provider utilized by more than 100 County participants in a 12-month period and (3) any lab or diagnostic provider utilized by more than 100 County participants in a 12-month period.

3. Provide and maintain its PPO network information on Contractor's website.

4. Provide appropriate referrals to the website, or provide assistance in locating a PPO provider upon request by a Participant.

5. Provide the County with management reports similar to those listed below on utilization of the PPO programs: (Such reports shall be based on data available to the Contractor). Reports shall be presented quarterly.

    a. Health Experience Report / Executive Summary

    b. Hospital Utilization by Diagnostic Category

    c. Provider Report by PPO Indicator and Type

    d. County-specific care coordination fees for value-based care providers

    e. Quality metrics and outcomes under value-based arrangements for attributed members

    f. The reports described shall be provided electronically and hard copy

6. Assist the County in interpreting the reports and shall make recommendations for improving cost-effective utilization of health care for Participants.

G. Eligibility Administration

The Benefits Center on behalf of the County will determine participant eligibility and provide Contractor with eligibility records. Contractor will be entitled to rely on the eligibility information the County provides and will not maintain or independently verify any portion of the Plan eligibility records. The Benefits Center, on behalf of the County, will provide Contractor with changes in enrollment as soon as practical in the month in which a change in eligibility occurs, but generally no later than sixty (60) calendar days after the effective date of change. Changes in eligibility will be effective on the first of the month, whenever possible. Eligibility information will include new Plan Participants and effective dates of coverage, changes in types or levels of coverage for existing Plan Participants and effective dates of termination of coverage.

As Plan Administrator, the County will be responsible for billing and compliance with other administrative requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272 ("COBRA"), as amended, and will include qualified beneficiaries eligible to participate under the Plan pursuant to COBRA in the eligibility information provided to Contractor.

Contractor shall:

1. Accept and load eligibility information weekly, within 48 hours of receipt from the Benefits Center. Contractor shall accept eligibility electronically in the County's current ANSI 834 formatted file and future formats as required by Federal laws and regulations. Provide industry standard file discrepancy reports within 48 hours of receipt of the weekly eligibility file and work with the Benefit Center to research and resolve file discrepancies in a timely manner.

2. Contractor shall notify County or its designee, if the eligibility file is not received by the due date identified on the file schedule provided by the County' Benefit Center.

3. Contractor shall notify County or its designee prior to the eligibility update application, of any material errors or coding problems on the eligibility file that exceeds agreed upon thresholds.

4. Provide weekly electronic eligibility information to the County's Prescription Benefits Manager for Participants and dependents in the Sharewell and Wellwise PPO Plans. Contractor shall reconcile Participant counts and review file discrepancy reports from the PBM within 48 hours and resolve discrepancies in a timely manner.

5. Provide urgent verification of coverage and/or eligibility updates within one (1) business day as directed by the Benefits Center when needed to provide access to care in between eligibility file transmissions. Provide necessary information to the PBM within one (1) business day to allow eligibility update of their system, if applicable.

6. Reconcile enrollment and administrative fee of Plan Participants with the Benefits Center records monthly. Correct information to match the County enrollment information and maintain appropriate Claims payment history.

7. Develop, print, and mail Plan identification cards within seven (7) working days of eligibility updates.

H. Banking

Contractor shall:

1. Establish and maintain Account with or agreed to between Contractor and County to fund all claim costs in accordance with the Funding and Banking Arrangement attached hereto as Attachment I.

2. Contractor's Bank must be members of the state or local ACH for debits to be processed process the ACH debits according to National Automated Clearing House Association (NACHA) rules and regulations.

3. Furnish bank account activity and check and EFT registers, including reconciliation of account on a monthly basis, in a format acceptable to the County.

4. Issue forms and payment of assessments for New York Health Care Reform Act of 1996 and Massachusetts Uncompensated Care Trust Fund.

5. Issue annual 1099 forms to providers using Contractor's Tax ID and reconcile any discrepancies with the 1099s directly with the Internal Revenue Services, if necessary.

6. Provide a report of all uncleared checks and the amounts as of June 30th of each year, within five business days after June 30th.

7. California state law usually does not require escheatment of unclaimed participant monies for local government plans. Contractor agrees to only escheat unclaimed monies to the State if legally required and approved by the County.

8. Contractor will provide County with notice of funding deficiencies, if the County fails to fund account at County Bank as required in Attachment I. If the County does not fund the account within forty-eight (48) hours after notification of deficiency, excluding weekends and County holidays, Contractor may cease claims administration and issuance of benefit checks until appropriate funding is provided. If the deficiencies are corrected, Contractor will commence claims administration and issuance of benefits checks.

I. Management Information Reports

Contractor shall:

1. Prepare and submit to the County not later than the 20th day of each month a Medical Paid Claims analysis by the enrollment categories including, but not limited to:

a. Employees and Dependents by Plan

b. Retirees and Dependents by Plan

c. Retirees with no Medicare, Spouse with Medicare by Plan

d. Retirees with Medicare, Spouse with Medicare by Plan

e. Retirees with Medicare, Spouse with no Medicare by Plan

f. Total Retirees and Dependents all Plans

g. Total Employees and Dependents, all Plans

h. Total all categories, all Plans combined

County will provide designation of enrollment in the reporting groups for the Claims reporting. Account structure may be modified during the 2020 implementation process or during the term of this Contract, as needed.

2. Prepare and submit a variety of Management Reports to be agreed upon by the Contractor and the County, which may include, but are not limited to the types of reports listed below and may include breakdown between active and retiree:

a. Executive Summary

b. Monthly Claims Lag Analysis by Plan

c. Monthly Pended Claims by Plan

d. Standardized Large Claim Report, Claims Exceeding $100,000

e. PPO Savings Report

f. Large Case Management Report

g. Third Party Lien Report

h. Accounts Receivable Reports (monthly aging and analysis)

i. Utilization Reports by Provider, Diagnosis, Categories of illnesses or injuries, Major services

j. Year-end Employee/Retiree and Dependent Claims Report (Required)

k. Turn Around Time

l. Customer Service Performance Reports

m. Quality Review Reports

n. Subrogation Activity and Recovery Reports

3. Prepare and submit additional specific reports to be agreed upon by the Contractor and County, which may include but not be limited to the types of reports listed below and may include breakdown between active and retiree:

    a. Value based care attribution

    b. Value based care fees paid on a monthly basis

    c. Quality results/outcomes for value based care providers

    d. Annual report on quality results and outcomes compared to Contractor's standards

    e. Annual reconciliation of value based care fees paid to providers, fees collected from the County, and any reimbursements due back to the County

4. County will provide designation of enrollment in the reporting groups for the Claims reporting.

5. Contractor shall provide all reports, either through on-line access and/or electronic format, within 20 days following the close of the applicable reporting period.

6. Contractor shall work with the County to customize a monthly reporting package that meets the needs of the County. Final Standard Reporting Package shall be mutually finalized in writing no later than June 30, 2020.

7. For purposes of Ad-Hoc/Custom reporting, including obtaining information or custom formatting or analysis requiring specific programming, Contractor shall provide report programming at no additional cost.

8. Contractor shall provide the on-line reporting capabilities of a data warehouse system, which provides a comprehensive set of reports profiling the County's membership, incorporating comparative data, including network averages and external benchmarks and utilization statistics for medical plans.

9. Contractor shall provide a reporting download feature.

10. At County's request, interface with the County's PBM to obtain prescription Claims data for analysis and reporting purposes. County will hold PBM responsible to provide Contractor with prescription claims data. At County's request, Contractor shall provide monthly medical claims data to the County's PBM.

11. Provide monthly the number of members enrolled in the plans with benefits provided by the PBM. Reconcile any difference in enrollment counts with the PBM, if necessary.

J. Contract Administration and Account Management

Contractor shall:

1. Meet with the County on a biweekly basis from January 1, 2020 through June 30, 2020, and on a monthly basis thereafter, to discuss current issues, new procedures, etc. Contractor attendees shall include: Claims Manager, Claims Supervisor, Customer Service Manager, Customer Service Supervisor, Ombudsman/Claims Service Representative, and Account Manager.

2. Provide the County with a custom Administrative Manual consisting of policies and procedures used by Contractor to administer the Plans. Update the Administrative Manual and provide updates to County within thirty (30) days of any changes in policies and/or procedures.

3. Act as the Plan's Fiduciary in all matters related to Claims Administration (including appeals and external reviews) under the scope of this Contract, as specified in Attachment G. However, after a Plan Participant has completed the first level appeal process offered by Contractor, the Participant may submit additional second level appeals as specified in the applicable Plan Documents.

4. Contractor shall:

   a. Provide an account management team that is experienced in services similar to County's, trained in the County's plan issues, accessible to the County geographically and with sufficient capacity and authority to respond to the County's issues in a timely manner.

   b. Provide an Account Manager as primary point-of-contact for day-to-day communications with the County and have an Account Assistant Manager and back-up plan when the primary person is unavailable.

   c. Provide an escalation process to assist in matters that are unable to be resolved at the account team level.

   d. Allow the County administration 30 days advance notice, where possible, of any planned change in the primary account manager. Some changes may be beyond Contractor's control (i.e. illness or life changing events).

   e. Provide the County administration the right to interview and agree to the intended replacement of the primary account manager. The County shall provide written or verbal approval of all proposed replacements.

   f. Provide access to an electronic tracking and resolution log of the County issues.

   g. Provide documentation of a process for prompt issue resolution in the event of a failure to perform a required service.

   h. Attend monthly teleconferences and in person quarterly and annual program reviews on site as requested at the County benefits office to review Plan benefit performance, clinical issue, new therapeutic options, programs, financial results and servicing of County's account.

   i. Members of the Account Management Team shall respond to all account inquiries from the County staff within one (1) business day.

   j. The assigned Account Management team shall review the County's Plan Documents for accuracy and document any changes that occur each year as part of the base administrative fees and at no additional charge to the County.

K. Records Retention and Audit

Notwithstanding any provision to the contrary in this Contract, Contractor Shall:

1. Store and maintain Claims records safely for a minimum of five (5) years beyond the end of the calendar year in which Claim is made, or a longer period of time, as required by law, and necessary in the case of litigated Claims.

2. Assist County with information necessary to perform periodic audits of fiscal procedures and Claims processing and respond to all audit recommendations as requested by the County.

3. Be subject to periodic audits of the Claims administration activity performed by Contractor, conducted by the County or its designee. The scope and timing of the audits will be determined prior to the commencement of the audits. Following the filing of the report of findings and after a reasonable period has elapsed to test the implementation of corrections and/or recommended actions; County may elect to conduct follow-up audits.

4. County shall notify Contractor of intent to audit and the time periods in which audit staff will conduct the audit. Notice will be given of intent to audit at a minimum of fifteen (15) days prior to the beginning of the audit. With the notice of intent to audit, County will inform Contractor of the purpose and scope of the audit.

5. Make workspace available and produce all records and materials necessary for the work of the audit staff.

6. Provide, upon the identification of the audit sample by County or its designee, all Claims records and related documentation requested for the audit. If, in the process of the audit, County or its designee needs additional documentation, the same standards for furnishing such documentation shall apply.

7. Provide reasonable travel arrangements, i.e. transportation and lodging at Contractor's expense, for County Auditor-Controller staff or designee for purposes of conducting the audits. Amount not to exceed $5,000 throughout the term of this Contract.

8. County shall be responsible for the cost of audit fees for post-implementation audits, excluding travel, as noted above. The first post-implementation audit shall commence no later than 120 days following the end of the first contract year. Audits will be conducted annually thereafter at the discretion of the County.

9. Provide Recovery Status reports monthly for recovery of all audit errors that resulted in claim overpayments. Contractor shall reimburse the County the full value of all audit error claims overpayment recovery regardless of subrogation fees paid by contractor to subcontractor for recovery services.

10. Initiate correction of all underpayments within five (5) calendar days of identification by either Contractor during normal course of business or by the County through an independent audit.

11. Initiate recovery of all provider overpayments within 14 calendar days of identification of overpayment by either Contractor, during normal course of business, or by the County through an independent audit. For those overpayments that cannot be recovered from providers via deduction from next payment to the provider, Contractor will send follow-up requests at 30-day intervals until overpayment is recovered. Should Contractor elect to utilize the services of an external vendor for overpayment recoveries, any costs (contingency fees) associated with overpayment recovery efforts by the external vendor will be absorbed by Contractor as a cost of doing business. Contractor shall reimburse the County the value of overpayments not recovered due to Contractors failure to initiate recovery as outlined above.

12. Consult with the County prior to initiating overpayment recovery efforts against a plan member, within 14 calendar days of identification of overpayment by either Contractor during normal course of business or by the County through an independent audit.

13. Annually provide County with detailed back-up documentation on a County-selected sampling of Contractor's self-reported Performance Guarantee results for the purposes of County's validation.

14. Annually, provide the County with Contractor's audited SOC 1 – Type 2 report (Service Organization Controls).

L. Implementation and Transition

Contractor shall:

1. Provide a Pre-Enrollment toll free number for Plan Participants to call during the period identified on Attachment D, Implementation Plan/Project Schedule.

2. Conduct new Participant welcome calls to Plan Participants, as requested, during the period identified on Attachment D, Implementation Plan/Project Schedule.

3. Develop, in collaboration with the County, customized medical identification cards for distribution to plan participants.

4. Develop, in collaboration with the County, a dedicated webpage on Contractor's Website to contain County specific plan and claims information and services such as contacting customer service and requesting identification cards.

5. Develop electronic eligibility interfaces necessary to 1) receive eligibility information in the format currently provided by the County's Benefits Center and 2) subsequently send eligibility information to the County's Pharmacy Benefits Manager in the format currently being provided.

6. Update eligibility and mail new Medical identification cards to all Plan Participantswithin 7 days of receipt of the eligibility files.

M. Wellness and Health Management Activities

1. The County has implemented certain wellness and health management activities named OC Healthy Steps. Contractor shall provide to the County Annual Wellness Credit Dollars specified in Attachment B. These Annual Wellness Credit Dollars may be utilized and/or applied to the following. This includes but is not limited to:

    a. Biometric Screening costs of the OC Healthy Steps Wellness Program.

    b. Specified Wellness related activities, not provided by Contractor. The County would be required to get approval for services from Contractor and pay third party before invoicing Contractor for reimbursement.

    c. Contractor will maintain an ongoing tally of Wellness Program Credit, and provide to County designee at determined intervals.

2. Contractor shall provide wellness and lifestyle programs included at no additional cost, which the County may elect to implement.

N. Data and Systems

1. Contractor will not modify any operational or clinical program or process that substantially impacts the services Contractor provides to County during the Term of this Contract without the prior notification and approval of the County.

2. Contractor shall accept electronic data transfer and administer membership information in compliance with HIPAA standards for privacy, security and electronic data interchange.

3. Contractor will adopt and implement written confidentiality policies and procedures in accordance with applicable law to ensure the confidentiality of member information used for any purpose.

4. Contractor will agree to not use or further disclose protected health information (PHI) other than as permitted or required by the Business Associate Agreement or as required by law.

5. The Contractor agrees to:

    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits;

    b. Report to the plan sponsor any security incident (within the meaning of 45 CFR 164.304) of which Contractor becomes aware; and,

    c. Ensure that any Contractor employee or agent, including any subcontractor to whom it provides PHI received from, or created or received by the Contractor agrees to implement reasonable and appropriate safeguards to protect such PHI.

6. Contractor shall notify the County immediately upon identification of system-related problems, programming problems or data transfer problems. The Contractor shall make every effort necessary to correct such problems within 48 hours regardless of the time or date in order to minimize any disruption to participants.

7. Contractor shall maintain a disaster recovery plan that contemplates a natural disaster or national emergency, enabling Contractor to continue to provide core medical services and fill all prescription requests using alternative sites and locations as reasonably necessary and appropriate.

8. Contractor will maintain and update sufficient documentation (such as excel spreadsheets) to support the correct set-up of Contractor's claims processing systems in conformance with the County's Plan design and subsequent Plan changes. System changes resulting from Plan design changes shall be based upon receipt of signed documentation from the client.

O. Other

Contractor shall:

1. Contractor must notify the County within ten (10) days of the account management team being made aware of official court filings and relevant class action suits in regards to pharmacy pricing and utilization. Data required to participate in the class action suit will be provided to the County for up to three (3) years following Contract termination. Such data will be provided to County at no charge for up to one (1) year following Contract Termination. Any data provided thereafter will be provided to the County at Contractor's then current rates. Contractor's involvement will be limited to providing data.

2. Assist legal counsel in the preparation and conduct of any litigated cases or claims and pursuit of actions of fraud or misrepresentation by Participants or Providers of service during the contract term and for a period of two years following termination of the contract.

3. Assist the County in the modification or amendment of the Plan documents to incorporate revisions, additions, or amendments to the Plans as directed by the County.

4. Assist the County in updating Summaries of Benefits and Coverage for active employees and One Page Summaries for retirees and in appropriately communicating any revisions, additions or amendments to the Plan Documents.

5. Implement, at the request of the County, any changes to benefit plan design made during the course of the contract.

6. Provide consultation on benefit design and market trends.

7. Calculate benefit change worth, i.e., impact on claims and administration costs, for proposed Plan design changes. Contractor shall provide this requested modeling analysis within two weeks of the County's request date.

8. Determine expected Claims costs for existing and proposed benefits, including accrual rates.

9. Provide annual calendar year end accounting consisting of the amount of paid Claims at the coverage level and a summary of fees paid.

10. Perform such other services, at the written request of the County, such as special communications, peer review fees, audit of provider records, reprogramming of computer information to accommodate Plan changes or amendments, and other such costs consistent with providing administration of the Plan.

11. At the written request of the County, provide, at no additional cost, access to Contractor's health programs.

12. At the written request of the County, and at no additional cost to the County, produce and distribute standard communication material to participants that shall include, but not be limited to: program announcement letters and brochures, periodic Plan design change and other updates, and mutually agreed upon communications targeted to specific participants and/or groups of participants. Standard communications material will include announcements and participant specific impact letters for network changes, formulary changes, etc.

13. Assist the County in implementing any actions or data/reporting required by the Federal Patient Protection and Affordable Care Act.

14. In performing its services under this Contract, Contractor agrees to act in compliance with health care reform regulations. Each Party shall, in good faith, notify the other Party of any changes required by law that impact services provided under this Contract. Contractor shall provide written notice to County in the event that any such change in law requires additional services for which additional costs will be assessed to County. The Parties agree to enter into a mutually acceptable amendment for such additional services and associated costs. Each Party acknowledges that it shall remain solely responsible for its own compliance with health care reform.

ATTACHMENT B

Compensation/Payment

1. **Compensation**: This is a fixed fee price Contract between the County and Contractor for services as provided in this Contract. The Contractor agrees to accept the specified compensation as set forth in this Contract as full remuneration for performing all services and furnishing all staffing and materials required, for any reasonably unforeseen difficulties which may arise or be encountered in the execution of the services until acceptance, for risks connected with the services, and for performance by the Contractor of all its duties and obligations hereunder. The County shall have no obligation to pay any sum in excess of total Contract amount specified below unless authorized by amendment.

2. **Firm Discount and Pricing Structure:** Contractor agrees that no price increases shall be passed along to the County during the term of this Contract not otherwise specified and provided for within this Contract.

3. **Contractor's Expense:** The Contractor will be responsible for all costs related to photo copying, telephone communications, fax communications, and parking while on County sites during the performance of work and services under this Contract. The County will not provide free parking for any service in the County Civic Center.

4. **Payment Term:** Invoices for Miscellaneous Additional Fees, Retiree Wellwise Incentive Fees, and Runout Fees are to be submitted within 30 days from the date Contractor completes deliverables as defined in the Attachment A-Scope of Work. Contractor shall reference Contract number on invoice. Payment will be net 30 days after receipt, and approval, by County of an invoice in a format acceptable to the County and verified and approved by the agency/department and subject to routine processing requirements.

   Invoices shall cover services not previously invoiced. The Contractor shall reimburse the County for any monies paid to the Contractor for services not provided or when services do not meet the Contract requirements.

   Payment for per employee per month costs for fixed ASO fees identified herein will not be based upon Contractor invoice, but will be issued by the County based on the number of active and retired subscribers as provided by the County to the Contractor on the monthly Claims Administration Fee Report.

   Payment will be made by the last day of each month, representing payment for services provided in the current month, i.e. payment for the month of January will be paid by January 31st.

   Payments made by the County shall not preclude the right of the County from thereafter disputing any items or services involved or billed under this Contract and shall not be construed as acceptance of any part of the services.

5. **Payment – Invoicing Instructions for Miscellaneous Fees, Wellwise Retiree Non-Smoker Incentive, and Other Charges:** The Contractor will provide an invoice on the Contractor's letterhead for services rendered. Each invoice will have a unique invoice number and will include the following information:

   1. Contractor's name and address
   2. Contractor's remittance address, if different from 1 above
   3. Name of County agency/department
   4. Delivery/service address
   5. Contract Number
   6. Date of order
   7. Type of fees/service

8. Sales tax, if applicable
9. Dates of fees/service
10. Brief description of fees/service
11. Contractor's Federal I.D. Number

The County's Program Manager, or designee, is responsible for approval of invoices and subsequent submittal of invoices to the County Auditor-Controller for processing of payment. The responsibility for providing an acceptable invoice to the County for payment rests with the Contractor. Incomplete or incorrect invoices are not acceptable and will be returned to the Contractor for correction.

Invoices and support documentation are to be forwarded to:

Program Manager, Lauren Pierson
Human Resource Services/Employee Benefits
333 W. Santa Ana Blvd., Rm. 137
Santa Ana, CA 92701

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Ongoing Administration

1. ASO Base Fees

Fee Charges Per Employee (or Retiree) Per Month (PEPM)					
Description	**Year 1 2020**	**Year 2 2021**	**Year 3 2022**	***Year 4 if renewed 2023**	***Year 5 if renewed 2024**
ASO Fees	$35.20	$35.20	$35.20	$36.20	$37.22

2. Program & Other Fees

Fee Charges Per Employee (or Retiree) Per Month (PEPM)					
Description	**Year 1 2020**	**Year 2 2021**	**Year 3 2022**	**Year 4 if renewed 2023**	**Year 5 if renewed 2024**
Value Added Programs, e.g. Shield Advocate Suite with Telehealth, Prenatal Program, Wellvolution Next	$7.69	$7.69	$7.69	$7.92	$8.16

Fees Assumptions:

Fees are based on 6,453 total subscribers and 10,131 members. If actual enrollment or ACS changes by +/- 20% from the anticipated enrollment, Contractor may re-evaluate the fees based on the final enrollment.

Core fee includes costs for out-of-state claims processing, Blue Card and Consortium fees for 562 subscribers. Access fees are billed separately.

Blue Shield of California maintains the Shield Savings Program to mitigate the Plan Sponsor's exposure to costs associated with care delivered to covered members by non-contracted providers outside of the Blue Shield of California/national Blue Card network. This program will pursue healthcare savings through provider bill negotiation, access to third party provider contracts, and proprietary fee schedules on behalf of the Plan Sponsor. Blue Shield of California will retain a portion of savings equal to 35% of obtained savings when reductions from billed charges are successfully obtained and realized by the Plan Sponsor. This Program is an integrated component of our Administrative Services Proposal. Please contact your Blue Shield Sales representative for additional information.

Blue Shield has undertaken its best efforts to analyze and implement the requirements of the federal Patient Protection and Affordable Care Act ("PPACA"). The information included in this quote includes those benefit changes, taxes and fees that we understand at this time are required by the Act. Should federal regulators issue new regulations and other regulatory guidance, the final plan and rates may be different than those stated herein to accommodate any additional changes required by the PPACA.

Patient Centered Outcome Research Institute (PCORI):
Contractor has NOT included any amount related to PCORI in the core fee nor can it collect or submit fees on behalf of the Client or Plan Sponsor per the regulations. The collection and submission of this fee is the responsibility of the Client and/or Plan Sponsor.

Should Contractor be assessed any Federal, State, or ACA fees/taxes on account of any of the health benefit plans included in this contract, but not presently included in the fees, Contractor reserves the right to amend the fees to include such fees/taxes. In the case of federal excise taxes, Contractor also reserves the right to amend the fees to include any increased federal income taxes to Contractor associated with such federal excise taxes.

3. Wellness Credit to the County:

Wellness	Year 1 2020	Year 2 2021	Year 3 2022	*Year 4 if renewed 2023	*Year 5 if renewed 2024
Contractor's Wellness credit to the County for wellness, implementation, or communication activities. This amount is separate credit provided by Contractor and is not included as part of the ASO fee.	$250,000	$250,000	$250,000	$250,000	$250,000

Contractor is offering $250,000 wellness. The credit only applies if the County stays with the Contractor for a period of no less than 12 months. Should the County terminate with the Contractor prior to the 12 months, Contractor reserves the right to rescind the credit and group will need to refund the credit back to the Contractor.

4. Wellwise Retiree Non-Smoker Incentive

The County will reimburse the Contractor for Wellwise Retiree Non-Smoker Incentive payments made via check directly to retirees. The Contractor will be responsible for providing a detail file itemizing the Wellwise Retiree Non-Smoker Incentive payment in 2nd quarter of the year following Plan Year, e.g. 2nd quarter of 2021, for 2020 Plan Year when invoicing the County for reimbursement. The final plan year Incentive will be processed as run out services.

5. **PPO Network Savings Guarantees**

Contractor guarantees to the County PPO Network Savings during the contract period as set forth below.

Contractor guarantees to County of Orange PPO Network Savings during the contract period as set forth in this exhibit. Retroactive adjustment to the administrative fee shall be as follows and subject to the Definitions and Calculations as stated below:

PPO In-Network Discount Guarantee	
Difference in In-Network Savings	**Retro % Adjustment to Admin Fee**
>0.0%	No Adjustment
<0.0%	-35.00%

Definitions and Calculations:

Target In-Network discount percentage (Illustrative)			**53.0%**
Risk Free Corridor			0.0%
Period Covered	January 1, 2020	to	December 31, 2020
Assumed number of active members in Blue Shield PPO plan			10,342
Assumed number of active employees in Blue Shield PPO plan			6,516

- Network Savings are defined as the difference between the covered billed charges (excluding non-covered benefits) submitted by the network provider and the amount based on the negotiated rate with that provider. The calculation is performed before the application of co-payments, deductibles, or other coinsurance, and includes reductions in allowance for clinical code edits.
- The risk free corridor means no adjustment to the fees will be made for discount at or above target.
- Network Savings are calculated excluding the following claims:
    - Claims for non-covered benefits
    - Out-of-network claims
    - Mental health and chemical dependency claims
    - Coordination of Benefit claims
    - Medicare claims
    - Client-specific network claims
    - Claims where the effective discount is less than 1%
- Entire facility claims where billed charges exceed $150,000 are excluded from the Network Savings calculation.
- The 53% Network Savings Guarantee is blended based on discounts of 56% Inpatient Facility, 51% Outpatient Facility, and 53% Professional with an assumed distribution of 24%, 34%, and 42%, respectively. The applicable Retrospective Percent Adjustment to the Administrative Fee will be calculated on the actual billed charge distribution of Inpatient Facility, Outpatient Facility, and Professional allowed claims for County of Orange during the reporting period.
- This guarantee is effective for claims incurred during the period of 1/1/2020 through 12/31/2020. Network Savings shall be calculated on incurred claims for the reporting period with four months runout. The guarantee will not apply if termination of the policy occurs prior to the end of the guarantee period.
- Blue Shield reserves the right to revise the savings guarantee under the following circumstances:
    - There is a change of more than 10% in employee enrollment in Metropolitan Statistical Areas with more than 200 eligible employees.
    - There is a change of more than 10% in employee enrollment in states with more than 200 eligible employees.
    - There is a change of more than 10% in employee enrollment in the aggregate eligible employees.
    - The benefits requested and/or quoted change prior to or after the effective date of this guarantee.
    - An award is not made within 90 days of the issuance of this quotation.
    - Changes in federal, state, or other applicable legislation or regulation require changes to this quotation.
- This guarantee is eligible for renewal in ongoing annual Agreement periods and is subject to Blue Shield's determination that the minimum Employee enrollment requirements are met. Blue Shield reserves the right to revise the discount targets for subsequent Agreement periods based on the market distribution percentages and provider discounts then in effect.

6. Value Based Care

Fees will be billed as a line item on the claims funding

7. Wellvolution Next High Acuity Program:

The cost of this program is paid via claims and is on a milestone basis for performance of engagement or outcome as follows:

Milestone	Description	Fee Per Claim

1	Enrollment in the program	$400
2	Engagement 1 month	$200
3	Engagement 2 month	$300
4	Outcome (anytime milestone is achieved)	$900
5	Sustained engagement – 7 months	$150
6	Sustained outcome range 11 months and 13 months	$1,050
	Total Program Cost	$3,000

8. Run-Out Fees

Contractor will process run-out medical claims for a period of twelve months following the termination date. Any and all additional services needed by the County to administer and track Claims run-out, including but not limited to claims reporting, bank reconciliation reports, claim appeals, subrogation, etc., shall be included in the below fees. The amount of the Claims Run-out Fee will be determined as follows:

The Claims Run-out Charge (ASO core fee)) x (the average monthly employee count for the 3 month period prior to termination) x (3). The total processing fees listed above for the entire run-out period shall be payable in two (2) equal monthly installments during the first two (2) months following the Contract termination.

ATTACHMENT C

Staffing Plan

1. **Primary Staff to perform Contract duties**

Name	Classification/Title
Ken Lautsch	Vice President and General Manager, Premier Accounts
Marilyn DeKeyzer	Director, Account Management, Premier Accounts
Julie Ellis	Major Account Manager, Premier Accounts
Jesseca Nixon	Senior Account Service Representative, Premier Accounts
William Panek, M.D.	Medical Director, Premier and Strategic Accounts
Franklin Woo, DDS	Dental Director
Matthew Sandlow, RN	Manager, Case Management
Jennifer Stanley	Premier Priority Lead, County of Orange Ombudsman
Janine Boyer	Director, Specialty Benefits Vendor Management
Amy Hodnett	Medical Informatics Analyst
Angie Kalousek	Director, Lifestyle Medicine
Suzanne Kudirka	Retention Marketing Manager, Premier Accounts
Lorie Jones	Senior Manager, Sales Analysis and Operations

2. **Alternate staff** (for use only if primary staff are not available)

Name	Classification/Title
Robert Rugani	Premier Priority Supervisor

Substitution or addition of Contractor's key personnel in any given category or classification shall be allowed only with prior written approval of the County Program Manager.

The Contractor may reserve the right to involve other personnel, as their services are required. The specific individuals will be assigned based on the need and timing of the service/class required. Assignment of additional key personnel shall be subject to County Program Manager approval. County reserves the right to have any of Contractor personnel removed from providing services to County under this Contract. County is not required to provide any reason for the request for removal of any Contractor personnel.

3. **Sub-contractor(s), if applicable**

In accordance with Article 11, "Assignment or Sub-Contracting", listed below are Sub-contractor(s) anticipated by Contractor to perform services specified in this Contract.

Company Name	Service
American Specialty Health Plans	American Specialty Health Plans provides access to their chiropractic, acupuncture, and podiatry networks.

Arvato Digital Services	Arvato produces our member ID cards.
BenefitFocus	BenefitFocus intakes electronic enrollment files from multiple trading partners and formats them into simplified Blue Shield 834 files.
Broadridge	Broadridge provides production services for explanation of benefits documents and checks, producer payments, bills, statements, life certificates, as well as letters and other various correspondence.
Commerce Printing	Commerce Printing provides printing services.
CVS Health	CVS Health provides exclusive mail service, pharmacy and rebate contracting for our commercial and Medicare members. CVS Specialty, a division of CVS Health, provides exclusive specialty pharmacy services for our commercial members.
Diego & Son Printing, Inc.	Diego & Son Printing, Inc. provides printing services.
Eliza Corporation	Eliza Corporation provides telephonic and email outreach in support of our CareTips clinical messaging program.
Fiserv Solutions	Fiserv Solutions provides on-demand services via multiple channels for Blue Shield clients and members to pay their healthcare insurance premiums.
Fong Brothers	Fong Brothers provides printing, inventory management, kitting, and mailing fulfillment of member welcome kits.
Gemini Health	Gemini Health provides a HIPPA-compliant and member-specific drug cost transparency service to prescribers within their electronic health record workflow.
Heal	Heal delivers high quality, on-demand, doctor house calls to Blue Shield PPO members of all ages for urgent, primary and preventative care.
HealthSparq	HealthSparq is an industry leader in transparency solutions, and administers our online treatment cost and quality tool to help members shop, compare, and save on their health care.
Health Trust	Health Trust, an operating foundation providing health advocacy and community health services, administers an evidence-based self-management program as part of our Shield Advocate program.
Healthwise	Healthwise supplies a robust health and wellness knowledgebase product for use on our website.
Hewlett-Packard	Hewlett-Packard provides information systems and reporting services.
Hinduja Global Solutions	Hinduja provides claims edit resolution services and provider outreach services.
HRGi	HRGi provides Blue Shield with innovative cost-containment solutions to more effectively manage out-of-network expenses.
LabCorp	LabCorp provides access to a network of clinical laboratories.
Language Line	Language Line provides language services to assist non-English speaking members.

Magellan Health, Inc.	Magellan Health, Inc. serves as Blue Shield's Mental Health Service Administrator (MHSA). Additionally, they administer our LifeReferrals 24/7 program, including organizational services, and elements of our Shield Advocate program.
McKesson Health Solutions	McKesson Health Solutions offers a fraud and abuse detection and management solution (ClaimCheck/ClaimsXten) integrated with our claims processing engines for prepayment audits.
MedeAnalytics	MedeAnalytics delivers performance management solutions across the healthcare system—including hospitals, physician practices, and payers—to ensure accountability and improve financial, operational, and clinical outcomes.
National Imaging Associates	National Imaging Associates provides prior authorization services for interventional pain and spine surgery, and prior authorization and medical management services for outpatient radiology services.
Novologix	Novologix specializes in the processing of home infusion and specialty drug claims processed under the medical benefit.
NovuHealth	NovuHealth provides incentives in order to close gaps in care.
OCE Business Services	OCE Business Services provides print and mailing services for communications to members, including federally-required mailings.
O'Neil Data Systems	O'Neil Data Systems provides print/mail production services for Medicare member ID cards and Welcome Kits.
Optum	Optum currently administers Blue Shield's Predictive Triage Engine and the following care management programs: Prenatal Program; CareTips clinical care gap messaging; NurseHelp 24/7; and some elements of our Shield Support, Shield Advocate, and Shield Concierge programs.
OptumInsight, Inc.	OptumInsight, Inc. provides payment integrity and Medicare Risk Adjustment services.
Partners in Care Foundation	Partners in Care Foundation administers an evidence-based self-management program as part of our Shield Advocate program.
Quest Diagnostics	Quest Diagnostics provides access to a network of clinical laboratories.
Radiant Services, LLC, (a wholly owned subsidiary of Accenture)	Radiant Services performs a percentage of the following functions on behalf of Blue Shield: prior authorization processing, including intake and clinical review to determine if requests can be approved; clinical review of claims post service; medical policy archive support; provider dispute resolution processing; enrollment processing, including member enrollment data entry and pend processing; provider demographic information data entry; and resolution of "Provider Not Found" claims.

Silverlink Communications, Inc.	Silverlink Communications, Inc. delivers multi-channel communications capabilities to support Blue Shield's Prevention Program Outreach service.
Solera Health	Solera Health administers our diabetes prevention program and a curated network of lifestyle medicine providers for our Wellvolution Next offering.
SourceHOV, LLC	SourceHOV provides paper claims and correspondence mailroom, imaging, and data entry services.
SQM (Service Quality Management)	SQM conducts member service satisfaction and first call resolution surveys.
Teladoc, Inc.	Teladoc provides telehealth services, and handles inbound calls and written correspondence for telehealth providers participating in our commercial network.
Teleperformance Group	Teleperformance assists with eligibility, billing, and claims questions for members with portfolio plans. In addition, Teleperformance provides back office member correspondence and back-up call support for commercial members.
Tivity Health	Tivity Health administers our gym membership discount program.
TTEC	TTEC assists with handling phone calls members with portfolio plans, as well as commercial provider calls and correspondence.
The Rawlings Group	Rawlings provides investigation and recovery functions.
VitalsChoice	VitalsChoice offers a physician rating and patient experience platform for our members to access transparent cost and quality information.

ATTACHMENT D

Implementation Plan and Project Schedule

County of Orange - January 1, 2020 ACO PPO Implementation	Target Date	Resource
Initiate implementation upon notification from account	Completed	Blue Shield
Implementation Kick-Off Meeting	7/1/2019	Blue Shield, CoO
Determine implementation meeting schedule	7/1/2019	Blue Shield, CoO
Confirm plans and programs	7/9/2019	Blue Shield, CoO
Outline CoO key deliverables, benefit strategy, and timelines	7/9/2019	Blue Shield, CoO
Benefits / Programs / Contracts		
Draft and provide ASO benefit matrices	7/15/2019	Blue Shield
Review and approve or request edits to benefit matrices	7/19/2019	Blue Shield, CoO
Draft benefit summaries	7/24/2019	Blue Shield
Review and approve or request edits to benefit summaries	7/31/2019	CoO
Draft SBCs	8/14/2019	BSC Custom Product
Approve and Finalize SBCs	8/21/2019	CoO
Draft ASO Agreement	12/6/2019	Blue Shield
Approve and sign revised ASO Agreement	12/27/2019	CoO
Pharmacy Carve Out Pharmacy Benefit Manager Integration (assuming current CoO PBM, OptumRx, agrees to add CoO accumulation to existing accumulator and eligibility interfaces) *Limited release date, all testing must be successful, if this date is not met the next opportunity for deployment is approximately one month later		
Pharmacy Integration Kick-Off Meeting	7/3/2019	Blue Shield, CoO, CoO PBM
Validation of shared accumulator categories (deductible, copay, etc.)	7/12/2019	Blue Shield, CoO, CoO PBM
Review and alignment of Blue Shield's outbound 834 companion guide layout	7/12/2019	Blue Shield, CoO PBM
Confirmation re. use of shared Blue Shield ID number and co-branded ID Cards	7/12/2019	Blue Shield, CoO, CoO PBM
Align around milestones and finalize project timeline	7/12/2019	Blue Shield, CoO, CoO PBM
Requirements and Design completed	8/14/2019	Blue Shield, CoO PBM

QA/SIT/UAT start date	8/16/2019	Blue Shield, CoO PBM
Mid-point review	9/27/2019	Blue Shield, CoO PBM
QA/SIT/UAT end date	10/8/2019	Blue Shield, CoO PBM
Code freeze	10/11/2019	Blue Shield, CoO PBM
Regression testing start date	10/15/2019	Blue Shield, CoO PBM
Final regression fix deploy	10/25/2019	Blue Shield, CoO PBM
Regression testing end date	10/28/2019	Blue Shield, CoO PBM
Mock start date	10/29/2019	Blue Shield, CoO PBM
Mock end date	11/4/2019	Blue Shield, CoO PBM
Go/No Go decision date	11/15/2019	Blue Shield, CoO PBM
Deployment end date	*11/10/19	Blue Shield
Go live validation	1/2/2020 - 1/18/2020	Blue Shield, CoO PBM
Group Design, Billing, Reporting		
Draft group structure revisions	7/9/2019	Blue Shield
Review and finalize group structure revisions	7/12/2019	Blue Shield, CoO
Update banking forms related to ASO claims funding process (as applicable)	10/31/2019	CoO
Open Enrollment Readiness		
Confirm open enrollment schedule	8/30/2019	Blue Shield, CoO
CoO Benefits Administrator	CoO Benefits Administrator	CoO Benefits Administrator
Determine appropriate open enrollment materials	TBD based on OE schedule	Blue Shield, CoO
Provide open enrollment materials	TBD based on OE schedule	Blue Shield
Attend events and provide printed materials, as needed	TBD based on OE schedule	Blue Shield
Product Configuration and Group Build		
Initiate Product Build and Group Order Requests	7/31/2019	Blue Shield
Configure Product and complete QA	8/14/2019	Blue Shield Configuration
Complete group build in BSC system	7/18/2019	BSC Install
Eligibility and Enrollment - Electronic Enrollment (inbound to BSC EDI 834 File) - **MEDICAL FILE**		
Revise group structure mapping	7/17/2019	Blue Shield eExchange Vendor
Review revised group structure mapping	7/18/2019	Blue Shield eExchange Vendor, CoO Benefits Administrator
EDI file testing initiated	8/16/2019	CoO Benefits Administrator

EDI file testing completed and production file approved	9/16/2019	Blue Shield eExchange Vendor, CoO Benefits Administrator
Production file received	12/4/2019	CoO Benefits Administrator
Complete loading and audit of enrollment	12/11/2019	Blue Shield
Eligibility and Enrollment - Electronic Enrollment (outbound to OptumRx - EDI 834 File, assumption that OptumRx is the selected PBM due to existing file interface for CoO)		
Review revised group structure mapping	7/18/2019	Blue Shield, CoO PBM
Crosswalk from prior group structure configured	8/29/2019	Blue Shield
EDI file testing initiated	9/12/2019	Blue Shield, CoO PBM
EDI file testing completed and production file approved	10/10/2019	Blue Shield, CoO PBM
Eligibility file transmitted	12/13/2019	Blue Shield
ID Cards - MEDICAL PLANS		
Discuss ID card revisions	7/26/2019	Blue Shield, CoO
Review initial ID card proofs	8/9/2019	Blue Shield, CoO
Approve ID card proofs	8/16/2019	Blue Shield, CoO
Review and approve production ID cards	12/10/2019	Blue Shield, CoO
Provide membership report	12/12/2019	Blue Shield
Print and Mail ID cards	12/19/2019	Blue Shield
Review vendor mailing report (as applicable)	12/20/2019	Blue Shield
Post Implementation Support		
Validate ongoing eligibility files successfully setup	1/4/2020	Blue Shield, CoO Benefits Administrator
Confirm monthly admin fee bill is accurate	1/11/2020	Blue Shield
Verify weekly claim invoices are generating appropriately	1/11/2020	Blue Shield

ATTACHMENT E

Performance Standards

Self-reported medical claims processing quality results will be based on a monthly minimum sample size of 200 County of Orange medical claims selected at random, using a financial stratified sampling approach. Self-reported customer service call quality results will be based on a minimum monthly sample size of 100 County of Orange calls selected at random from all calls handled by the customer service unit servicing the County.

The service performance standards indicating Book of Business (BOB) shall be measured by the Contractor for all Contractor customers utilizing the same process platform.

Reporting Frequency and Annual Calculation

Contractor will provide County with reports setting forth the performance of the Contractor against each of the metrics in accordance with the reporting schedule set forth for each metric described below. Unless otherwise noted, reports will be generated within 60 days after the close of each reporting period.

At the close of the calendar year, Contractor will prepare a single report which sets forth Contractor's performance against each of the metrics. The penalty for each quarter will be totaled annually for year. The total annual penalty shall be applied against the annual ASO fees which includes ASO base fees and Program and other Fees.

Annually, County will select a sampling of performance guarantees and request detailed back-up documentation to validate results. In the event Contractor has failed to meet any metric, payment by Contractor of the applicable performance penalty will be sent to County within 60 days after the issuance of the annual report.

When performance issues are identified, Contractor will agree to provide a corrective action plan within 72 hours of identification of the issue. Once agreed to by the County, the actions and timelines will be adhered to.

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Performance Area	Standard	Definition	Measurement/ Frequency	Penalty/ Amount at risk
Medical Claims Processing				
1. Overall Claims Processing Accuracy	≥ 97%	The percentage of audited County claims processed accurately. Calculated as the total number of audited claims processed without error, divided by the total number of audited claims. Definition of "error" includes any type of error (e.g. coding, procedural, system, payment, etc.) whether a payment or non-payment error. Each type of error is counted as one full error and no more than one error can be assigned to one claim. County specific results.	Quarterly, with monthly client specific reporting to County.	2% of annual base administrative fees. Penalty will be ¼ for each period standard is not met.
2. Financial Payment (Dollar) Accuracy	≥ 99.30%	The percentage of audited County claims dollars paid accurately. Calculated as total audited paid dollars minus the absolute value of over and underpayments, divided by total audited paid dollars. County specific results.	Quarterly, with monthly client specific reporting to County.	3% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
3. Claims Payment Accuracy	≥ 98%	The percentage of audited County claims processed without payment error. Calculated as the total number of audited claims minus the number of claims processed with "payment" error, divided by the total number of audited claims. Definition of error includes any type of error (e.g., coding procedural, system payment (etc.) that results in a payment error. County specific results.	Quarterly, with monthly client specific reporting to County.	2% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
4. Turnaround Time - Target 1 (TAT)	≥ 94% of all claims processed within 14 calendar days.	The percentage of claims processed within a specified number of calendar days. TAT is measured from the date the claim is received by Contractor to the date it is processed (i.e., paid, denied, or pended for external information). County specific results.	Quarterly, with monthly client specific reporting to County.	2% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.

Performance Area	Standard	Definition	Measurement/ Frequency	Penalty/ Amount at risk
5. Turnaround Time - Target 2	≥ 99% of all claims processed within 30 calendar days.	The percentage of claims processed within a specified number of calendar days. TAT is measured from the date the claim is received by Contractor to the date it is processed (i.e., paid, denied, or pended for external information). County specific results.	Quarterly, with monthly client specific reporting to County.	1% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
Customer/Member Service				
6. Telephone Response Time	≥ 90% of calls answered in 30 seconds or less.	The amount of time that elapses between the time a call is received to the time answered by a representative (live voice answer). County specific results. *Call volume does not include calls that are handled by an IVR system*.	Quarterly, with monthly client specific reporting to County.	2% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
7. Call Quality	≥ 95% (*standard to be finalized based on Contractor's internal call quality program and performance objective*).	The average of all calls quality results for the reporting period. County specific results.	Quarterly, with monthly client specific reporting to County.	1% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
8. First Call Resolution Rate	≥ 90% of calls to customer service will be resolved within 2 business days	The percentage of incoming calls that did not require a second call from the plan member or provider. Resolution definition is the time taken in days (excluding weekend and holidays) by Member Service Representatives to close call inquiries placed by plan participants to the service facility. Reporting will be based on a 45-day look forward and backward from the date of the call for another call on the same topic or issue. If another call is found within this window, the call would not be counted as a first call resolution. County specific results.	Quarterly, with monthly client specific reporting to County.	1% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.

Performance Area	Standard	Definition	Measurement/ Frequency	Penalty/ Amount at risk
9. Member appeal response time	Review and respond to 99% of all formal written appeals within 30 calendar days.	Measured from date of appeal receipt to date response mailed to member. Response to appeal is defined as a thorough review of all information related to the appeal followed by a detailed explanation of the final determination in writing, citing specific reasons for denials.	Quarterly, with monthly client specific reporting to County.	1% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
Administrative Issues				
10. Plan administration accuracy	≥ 98%	Contractor guarantees that ninety-eight percent (98%) of standard plan design and benefit set-up changes, including pricing contract terms, will be made accurately after reviewing the requested plan designs for deviation against Blue Shield standard benefit design, or pricing contract. If needed, Blue Shield will request a review with the group to align on benefit intent for non-Blue Shield standard benefit requests. Blue Shield will need 60 days to release plans for testing, and up to 100 days if non-Blue Shield standard designs are requested. This performance guarantee is based upon Contractor's ability to set up new or revised plan design changes based upon receipt of signed documentation from the client. Measure quarterly and reconcile annually upon County specific data.	Quarterly	1% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
11. Overpayment Recoveries	Agree to initiate ≥ 85% of overpayment recoveries within 120 calendar days of overpayment identification.	County specific results, based on Contractor's internal reporting.	Quarterly, with monthly client specific reporting to County.	1% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.

Performance Area	Standard	Definition	Measurement/ Frequency	Penalty/ Amount at risk
Account Management & Implementation				
12. Account Team Performance Appraisal	Overall Account Team performance is a composite score of 3 or better.	County will evaluate each member of Contractor's designated Account Management Team. Scale is as follows: **Score / Description** 5 - Exceptional 4 - Exceeds Expectations 3 - Meets Expectations 2 - Minimally Meets Expectations 1 – Does Not Meet Expectations	Quarterly, with client specific reporting to County.	2% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met. Establish weekly conference calls until issue is resolved and client is satisfied.
13. Report delivery	Reports delivered within 20 calendar days following end of reporting period.	Delivery shall be complete upon receipt of reports by the County. Reports are monthly, quarter-to-date, year-to-date, paid claims and lag reports	Quarterly, with client specific reporting to County.	$250 for each day report delivery is delayed.
14. Medical ID Card Mailing	≥95% of ID cards will be issued and mailed within 7 working days of receipt of request for enrollment data.	The amount of time elapsed from the date of receipt of eligibility information or request from Covered Person to the date ID cards are mailed to members. County specific results.	Quarterly, with monthly client specific reporting to County.	1% of annual base administrative fees. Penalty will be ¼ for each period the standard is not met.
Clinical Program Performance				
15. Member Engagement: Shield Advocate Care Management	1%	1% of total eligible population are engaged in Shield Advocate Care Management. Denominator: Average of monthly client eligibility for the measurement period. Numerator: Number of engaged members enrolled in Shield Advocate Care Management during the measurement period. This metric is client-specific. Minimum group size is 1000+.	Annual	1% of annual base administrative fees**.**

Performance Area	Standard	Definition	Measurement/ Frequency	Penalty/ Amount at risk
16. High-Cost Outreach: Shield Advocate Care Management	≥ 90%	The percentage of members identified for Shield Advocate within the first three quarters of the measurement period, who were reached, assessed, and agreed to participate in high acuity case management will complete at least 2+ calls with a case manager. Members who become unreachable after engagement will be excluded from this metric. Denominator: Members who were identified for Shield Advocate, reached, assessed, and agreed to participate in high acuity case management within the first three quarters of the measurement period who were not unable to reach once engaged. Numerator: Subset of denominator who completed 2+ calls with a case manager during the measurement period. Minimum denominator of 30 members. If the minimum denominator is not met, this metric shall be null and void. Results are Client specific. Annual measurement available 60 days after close of measurement period. For 2020, there will be no fees at risk and no target as we collect a baseline. Once baseline is determined, Blue Shield will set and agree to target and fees at risk. .	Annual	1% of annual base administrative fees

Performance Area	Standard	Definition	Measurement/ Frequency	Penalty/ Amount at risk
17. Post-Discharge Rate	≥ 90%	Members with an acute hospitalization not currently engaged in a Care Management Program are attempted to be outreached for follow-up and post-discharge support based upon notification of discharge to home from the facility. Client-specific. Annual measurement available 60 days close of measurement period.	Annual	1% of annual base administrative fees.
Satisfaction				
18. Member Satisfaction	≥ 83% overall satisfaction.	Blue Shield will conduct a Customer Service Satisfaction Survey based on at least 80% of Premier members responding "9" or "10" on an 11-point response scale regarding their service. Premier Accounts-specific, not Client-specific.	Semi-annually	1% of annual base administrative fees.
19. Net Promoter Score	Appropriate target to be established when this reporting becomes available.	Blue Shield currently does not participate in Net Promoter Score (NPS) survey measurement. We may utilize NPS to measure member satisfaction in the future, therefore, we agree to establish an appropriate target and fees at risk when this reporting becomes available.	Annual	Appropriate penalty/amount at risk to be established when this reporting becomes available.

Performance Area	Standard	Definition	Measurement/ Frequency	Penalty/ Amount at risk
Prescription Drug Accumulator				
21. Sharewell Prescription Drug Accumulator	98%	Contractor guarantees to daily file load of 98% with less than 2% fallout for County's PBM. Accuracy – At least 98% of accumulator extract data will be populated accurately based on plan set up and eligibility feeds. Timeliness - within 1 business day of receipt of file. Business days only include Monday thru Friday *PG will not apply to files that cannot be loaded due to errors, format issues, etc *Files received after 12pm(PT) will be considered received the following business day	Annual	2% of annual base administrative fees.

ATTACHMENT F

Data Interfaces

Contractor agrees to develop, transmit and or receive, and reconcile the following interface files and other interfaces files as required to administer the Plans.

To Contractor:

From	Purpose/Data to be Provided	Frequency	Comments
County's Benefits Center, currently Secova or other Health and Welfare eligibility administrator selected by the County.	Eligibility records for subscribers and dependents in Medical Plans.	Weekly, within 3 business days of receiving eligibility files from Benefits Center or other health and welfare vendor selected by the County.	Full file with reconciliation.
OptumRx or other Pharmacy Benefit Manager selected by County.	Prescription Data for Disease Management Programs.	Monthly.	
OptumRx or other Pharmacy Benefit Manager selected by County.	Prescription claims data for out-of-pocket cost accumulators (deductibles and out-of-pocket maximums) for Sharewell Plans	Near Real Time (NRT).	
Blue Shield of California.	Medical claims history for run-out claims.	Monthly in 2020.	Format to be determined between Blue Shield of California and Contractor.

From Contractor:

To:	Purpose	Frequency	Comments
OptumRx or other Pharmacy Benefit Manager selected by County.	Eligibility records for subscribers and dependents enrolled in the Wellwise Plans and Sharewell Plans**.**	Weekly, within 3 business days of loading eligibility files from County's Benefits Center, currently Secova or other health and welfare vendor selected by the County.	

ATTACHMENT G

Contractor Named Claim Fiduciary

County hereby delegates to Contractor fiduciary responsibility and discretion to determine all matters relating to the interpretation and operation of the health plan(s) as it relates to the administration and payment of disputed benefit claims in accordance with the terms of the health plan(s), the Agreement and to the extent provided in this Attachment G.

Notwithstanding any provision in this Agreement to the contrary, the parties agree that Contractor shall provide claim appeal fiduciary services subject to the terms and conditions set forth below and in accordance with the requirements set forth in the Patient Protection and Affordable Care Act, and the regulations issued thereunder, or any other applicable federal and state law or regulation, with regards to denied claims and appeals of denied claims under group health plans. The parties acknowledge that Contractor has received and accepted additional fees/compensation from the County, under this Agreement, for the specific purpose of acting as claims fiduciary for the Plan(s).

Fiduciary Claims Appeal Services

Contractor shall act as the claims fiduciary under the health plan(s) for the appeal of disputed claims under the applicable health plan(s). For purposes of this Agreement, a disputed claim is a claimant's written request for review and reconsideration of a claim for benefits initially denied in whole or in part by Contractor. Except to the extent Plan Participants file additional appeals as specified in the Participant's applicable Plan Document, any action taken by Contractor in that capacity shall be fully binding upon the health plan and County. As claims fiduciary, Contractor shall take all actions and retain all experts and outside resources, at its own cost and expense that it deems necessary and appropriate to act in the capacity of claims fiduciary.

Contractor shall ensure that the content of each written claim denial and/or appeal denial notice shall include all information required to be included in such notice to be compliant with the applicable requirements set forth in the Patient Protection and Affordable Care Act, and the regulations issued thereunder, or any other applicable federal and state law or regulation, with regards to denied claims and appeals for denied claims. The content of such written notices shall specifically include information regarding how the participant can seek an external review of the denied claim or appeal and Contractor shall ensure that each notice is provided in a culturally and linguistically appropriate manner.

Contractor shall, on behalf of the County's health plan(s), enter into contracts with at least three different Independent Review Organizations (IROs) who shall not be eligible for any financial incentives based on the likelihood that the IRO would support the denial of benefits. These contracts entered into between the Contractor and IRO shall comply with all applicable requirements set forth in the Patient Protection and Affordable Care Act, and the regulations issued thereunder, or any other applicable federal and state law or regulation, with regards to denied claims and appeals of denied claims under group health plans.

In the event a claimant files any court action seeking payment on any claim, whether appealed to Contractor or otherwise, Contractor shall take immediately notify County and await instructions and/or direction from County with respect to any further actions to be taken by Contractor.

Contractor shall, at reasonable intervals, provide County with information on the status of such litigation.

In no event may Contractor settle any claim based upon an expense not covered, or in an amount excess of that permitted, under the applicable health plan(s).

Nothing in this Agreement shall be construed as making Contractor a fiduciary for any other activity, function or responsibility in connection with the health plan and in no event will Contractor be liable for any breach of duty by any other fiduciary, of the County.

In carrying out its services under this Attachment, Contractor shall have discretionary authority to interpret the health plan and to determine all issues or questions relating to whether, or to what extent, a claim is payable under the terms of the health plan. Contractor may consult with the County, when appropriate, to determine the intent and best practice of the Plan.

ATTACHMENT H

BUSINESS ASSOCIATE CONTRACT

A. GENERAL PROVISIONS AND RECITALS

1. The Parties agree that the terms used, but not otherwise defined below in Paragraph B, shall have the same meaning given to such terms under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and their implementing regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations") as they may exist now or be hereafter amended.

2. The Parties agree that a business associate relationship under HIPAA, the HITECH Act, and the HIPAA regulations between the Contractor and County arises to the extent that Contractor performs, or delegates to subcontractors to perform, functions or activities on behalf of County pursuant to, and as set forth in, the Contract that are described in the definition of "Business Associate" in 45 CFR § 160.103.

3. The County wishes to disclose to Contractor certain information pursuant to the terms of the Contract, some of which may constitute Protected Health Information ("PHI"), as defined below in Subparagraph B.10, to be used or disclosed in the course of providing services and activities pursuant to, and as set forth, in the Contract.

4. The Parties intend to protect the privacy and provide for the security of PHI that may be created, received, maintained, transmitted, used, or disclosed pursuant to the Contract in compliance with the applicable standards, implementation specifications, and requirements of HIPAA, the HITECH Act, and the HIPAA regulations as they may exist now or be hereafter amended.

5. The Parties understand and acknowledge that HIPAA, the HITECH Act, and the HIPAA regulations do not pre-empt any state statutes, rules, or regulations that are not otherwise pre-empted by other Federal law(s) and impose more stringent requirements with respect to privacy of PHI.

6. The Parties understand that the HIPAA Privacy and Security rules, as defined below in Subparagraphs B.9 and B.14, apply to the Contractor in the same manner as they apply to a covered entity (County). Contractor agrees therefore to be in compliance at all times with the terms of this Business Associate Contract and the applicable standards, implementation specifications, and requirements of the Privacy and the Security rules, as they may exist now or may hereafter be amended, with respect to PHI and electronic PHI created, received, maintained, transmitted, used, or disclosed pursuant to the Contract.

B. DEFINITIONS

1. "Administrative Safeguards" are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect electronic PHI and to manage the conduct of Contractor's workforce in relation to the protection of that information.

2. "Breach" means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the PHI.

   a) Breach excludes:

      i) Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of Contractor or County , if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner

not permitted under the Privacy Rule.

ii) Any inadvertent disclosure by a person who is authorized to access PHI at Contractor to another person authorized to access PHI at the Contractor, or organized health care arrangement in which County participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Rule.

iii) A disclosure of PHI where Contractor or County has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

b) Except as provided in paragraph (a) of this definition, an acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule is presumed to be a breach unless Contractor demonstrates that there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

i) The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;

ii) The unauthorized person who used the PHI or to whom the disclosure was made;

iii) Whether the PHI was actually acquired or viewed; and

iv) The extent to which the risk to the PHI has been mitigated.

3. "Data Aggregation" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.501.

4. "Designated Record Set" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.501.

5. "Disclosure" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

6. "Health Care Operations" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.501.

7. "Individual" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

8. "Physical Safeguards" are physical measures, policies, and procedures to protect CONTRACTOR's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

9. "The HIPAA Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

10. "Protected Health Information" or "PHI" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

11. "Required by Law" shall have the meaning given to such term under the HIPAA Privacy Rule in 45 CFR § 164.103.

12. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

13. "Security Incident" means attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. "Security incident" does not include trivial incidents that occur on a daily basis, such as scans, "pings", or unsuccessful attempts to penetrate computer networks or servers maintained by Contractor.

14. "The HIPAA Security Rule" shall mean the Security Standards for the Protection of electronic PHI at 45 CFR Part 160, Part 162, and Part 164, Subparts A and C.

15. "Subcontractor" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

16. "Technical safeguards" means the technology and the policy and procedures for its use that protect electronic PHI and control access to it.

17. "Unsecured PHI" or "PHI that is unsecured" means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services in the guidance issued on the HHS Web site.

18. "Use" shall have the meaning given to such term under the HIPAA regulations in 45 CFR § 160.103.

C. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR AS BUSINESS ASSOCIATE:

1. Contractor agrees not to use or further disclose PHI County discloses to Contractor other than as permitted or required by this Business Associate Contract or as required by law.

2. Contractor agrees to use appropriate safeguards, as provided for in this Business Associate Contract and the Contract, to prevent use or disclosure of PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County other than as provided for by this Business Associate Contract.

3. Contractor agrees to comply with the HIPAA Security Rule at Subpart C of 45 CFR Part 164 with respect to electronic PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County.

4. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a Use or Disclosure of PHI by Contractor in violation of the requirements of this Business Associate Contract.

5. Contractor agrees to report to County without unreasonable delay and, in any event, within ten business days after discovery, any Use or Disclosure of PHI not provided for by this Business Associate Contract of which Contractor becomes aware. Contractor must report Breaches of Unsecured PHI in accordance with Paragraph E below and as required by 45 CFR § 164.410.

6. Contractor agrees to ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Contractor agree to the same restrictions and conditions that apply through this Business Associate Contract to Contractor with respect to such information.

7. Contractor agrees to provide access, within fifteen (15) calendar days of receipt of a written request by County, to PHI in a Designated Record Set, to County or, as directed by County, to an Individual in order

to meet the requirements under 45 CFR § 164.524.

8. Contractor agrees to make any amendment(s) to PHI in a Designated Record Set that County directs or agrees to pursuant to 45 CFR § 164.526 at the request of County or an Individual, within thirty (30) calendar days of receipt of said request by County. Contractor agrees to notify County in writing no later than ten (10) calendar days after said amendment is completed.

9. Contractor agrees to make internal practices, books, and records, including policies and procedures, relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of, County available to County and the Secretary in a time and manner as determined by County or as designated by the Secretary for purposes of the Secretary determining County's compliance with the HIPAA Privacy Rule.

10. Contractor agrees to document any Disclosures of PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County, and to make information related to such Disclosures available as would be required for County to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR § 164.528.

11. Contractor agrees to provide County or an Individual, as directed by County, in a time and manner to be determined by County, that information collected in accordance with the Contract, in order to permit County to respond to a request by an Individual for an accounting of Disclosures of PHI in accordance with 45 CFR § 164.528.

12. Contractor agrees to satisfy all applicable provisions of HIPAA standards for electronic transactions and code sets, also known as the Electronic Data Interchange (EDI) Standards, at 45 CFR Part 162, as well as all operating rules that apply to standard transactions, submission of certifications to HHS (to the extent HHS permits) concerning standard transactions, and all other electronic data interchange requirements included in the Patient Protection and Affordable Care Act of 2010. Contractor further agrees to ensure that any agent, including a subcontractor that conducts standard transactions on its behalf will comply with the EDI Standards.

13. Contractor agrees that it will determine the minimum necessary type and amount of PHI required to perform its services and will comply with 45 CFR §§ 164.502(b) and 514(d).

14. Contractor agrees to restrict the use or disclosure of PHI as may be agreed to in accordance with 45 CFR § 164.522, to document those restrictions, and to provide to County such documentation upon request and in a prompt and reasonable manner consistent with the HIPAA regulations.

15. Contractor agrees to accommodate alternative means or alternative locations for communicating PHI and to document those alternative means or alternative locations at the request of County or an Individual, pursuant to 45 CFR § 164.522(b), in a prompt and reasonable manner consistent with the HIPAA regulations.

16. Contractor agrees to be the primary party responsible for receiving and resolving requests from an Individual exercising his or her individual rights described in subsections (7), (8), (10), and (15) of this Paragraph C.

17. Contractor agrees that to the extent Contractor carries out County's obligation under the HIPAA Privacy and/or Security rules Contractor will comply with the requirements of 45 CFR Part 164 that apply to County in the performance of such obligation.

18. Contractor shall work with County upon notification by Contractor to County of a Breach to properly determine if any Breach exclusions exist as defined in Subparagraph B.2.a above.

19. Contractor shall not receive direct or indirect remuneration for any exchange of PHI otherwise authorized under the Privacy and/or Security Rules without an Individual's authorization.

D. SECURITY RULE

1. Contractor shall comply with the requirements of 45 CFR § 164.306 and establish and maintain appropriate Administrative, Physical and Technical Safeguards in accordance with 45 CFR § 164.308, § 164.310, § 164.312, and § 164.316 with respect to electronic PHI County discloses to Contractor or Contractor creates, receives, maintains, or transmits on behalf of County. Contractor shall follow generally accepted system security principles and the requirements of the HIPAA Security Rule pertaining to the security of electronic PHI.

2. Contractor agrees to ensure that access to electronic PHI related to County is limited to those workforce members who require such access because of their role or function.

3. Contractor agrees to implement safeguards to prevent its workforce members who are not authorized to access such electronic PHI from obtaining access and to otherwise ensure compliance by its workforce with the HIPAA Security Rule.

4. Contractor shall ensure that any subcontractors that create, receive, maintain, or transmit electronic PHI on behalf of Contractor agree through a contract with Contractor to the same restrictions and requirements contained in this Paragraph D of this Business Associate Contract.

5. Contractor shall report to County immediately any Security Incident of which it becomes aware. Contractor shall report Breaches of Unsecured PHI in accordance with Paragraph E below and as required by 45 CFR § 164.410.

E. BREACH DISCOVERY AND NOTIFICATION

1. Following the discovery of a Breach of Unsecured PHI , Contractor shall notify County of such Breach, however both Parties agree to a delay in the notification if so advised by a law enforcement official pursuant to 45 CFR § 164.412.

    a) A Breach shall be treated as discovered by Contractor as of the first day on which such Breach is known to Contractor or, by exercising reasonable diligence, would have been known to Contractor.

    b) Contractor shall be deemed to have knowledge of a Breach, if the Breach is known, or by exercising reasonable diligence would have known, to any person who is an employee, officer, or other agent of Contractor, as determined by federal common law of agency.

2. Contractor shall provide the notification of the Breach without unreasonable delay and, in any event, within ten business days after discovery, to the County Privacy Officer at:

    a) Contractor's notification may be oral, but shall be followed by written notification within 24 hours of the oral notification.

3. Contractor's notification shall include, to the extent possible:

    a) The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Contractor to have been, accessed, acquired, used, or disclosed during the Breach;

    b) Any other information that County is required to include in the notification to Individual under 45 CFR §164.404 (c) at the time Contractor is required to notify County or promptly thereafter as this

information becomes available, even after the regulatory sixty (60) day period set forth in 45 CFR § 164.410 (b) has elapsed, including:

i) A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;

ii) A description of the types of Unsecured PHI that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

iii) Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;

iv) A brief description of what Contractor is doing to investigate the Breach, to mitigate harm to Individuals, and to protect against any future Breaches; and

v) Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

4. County may require Contractor to provide notice to the Individual and any governmental entities requiring notification at the sole discretion of the County. Such notification will contain the elements required in 45 CFR § 164.410 or applicable state law. Contractor agrees that the County will be given reasonable advance opportunity to review the proposed notice or other related communications to any individual or third party regarding the breach; the County may propose revised or additional content to the materials which will be given reasonable consideration by Contractor (or its agent).

5. In the event that Contractor is responsible for a Breach of Unsecured PHI in violation of the HIPAA Privacy Rule, Contractor shall have the burden of demonstrating that Contractor made all notifications to County consistent with this Paragraph E and as required by the Breach notification regulations, or, in the alternative, that the acquisition, access, use, or disclosure of PHI did not constitute a Breach.

6. Contractor shall maintain documentation of all required notifications of a Breach or its risk assessment under 45 CFR § 164.402 to demonstrate that a Breach did not occur.

7. Contractor shall provide to County all specific and pertinent information about the Breach, including the information listed in Section E.3.b.(1)-(5) above, if not yet provided as soon as practicable, but in no event later than fifteen (15) calendar days after Contractor's initial report of the Breach to County pursuant to Subparagraph E.2 above.

8. Contractor shall continue to provide all additional pertinent information about the Breach to County as it may become available, in reporting increments of five (5) business days after the last report to County. Contractor shall also respond in good faith to any reasonable requests for further information, or follow-up information after report to County, when such request is made by County.

9. Contractor shall bear all expense or other costs associated with the Breach and shall reimburse County for all expenses County incurs in addressing the Breach and consequences thereof, including costs of investigation, notification, remediation, documentation or other costs associated with addressing the Breach.

F. PERMITTED USES AND DISCLOSURES BY CONTRACTOR

1. Contractor may use or further disclose PHI County discloses to Contractor as necessary to perform functions, activities, or services for, or on behalf of, County as specified in the Contract, provided that

such use or Disclosure would not violate the HIPAA Privacy Rule if done by COUNTY except for the specific Uses and Disclosures set forth below.

a) Contractor may use PHI County discloses to Contractor, if necessary, for the proper management and administration of Contractor.

b) Contractor may disclose PHI County discloses to Contractor for the proper management and administration of Contractor or to carry out the legal responsibilities of Contractor, if:

i) The Disclosure is required by law; or

ii) Contractor obtains reasonable assurances from the person to whom the PHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person and the person immediately notifies Contractor of any instance of which it is aware in which the confidentiality of the information has been breached.

c) Contractor may use or further disclose PHI County discloses to Contractor to provide Data Aggregation services relating to the Health Care Operations of Contractor.

2. Contractor may use PHI County discloses to Contractor, if necessary, to carry out legal responsibilities of Contractor.

3. Contractor may use and disclose PHI County discloses to Contractor consistent with the minimum necessary policies and procedures of County.

4. Contractor may use or disclose PHI County discloses to Contractor as required by law.

5. Contractor shall share PHI as reasonably requested by the County to carry out its responsibilities as plan administrator of the Plan(s), including, without limitation, for purposes of auditing the performance of Contractor.

G. OBLIGATIONS OF COUNTY

1. County shall notify Contractor of any limitation(s) in County's notice of privacy practices in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Contractor's Use or Disclosure of PHI.

2. County shall notify Contractor of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI, to the extent that such changes may affect Contractor's Use or Disclosure of PHI.

3. County shall notify Contractor of any restriction to the Use or Disclosure of PHI that County has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Contractor's Use or Disclosure of PHI.

4. County shall not request Contractor to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy Rule if done by County.

H. BUSINESS ASSOCIATE TERMINATION

1. Upon County's knowledge of a material breach or violation by Contractor of the requirements of this Business Associate Contract, County shall:

a) Provide an opportunity for Contractor to cure the material breach or end the violation within thirty (30) business days; or

b) Immediately terminate the Contract, if Contractor is unwilling or unable to cure the material breach or end the violation within (30) days, provided termination of the Contract is feasible.

2. Upon termination of the Contract, Contractor shall either destroy or return to County all PHI Contractor received from County or Contractor created, maintained, or received on behalf of County in conformity with the HIPAA Privacy Rule.

a) This provision shall apply to all PHI that is in the possession of Subcontractors or agents of Contractor.

b) Contractor shall retain no copies of the PHI.

c) In the event that Contractor determines that returning or destroying the PHI is not feasible, Contractor shall provide to County notification of the conditions that make return or destruction infeasible. Upon determination by County that return or destruction of PHI is infeasible, Contractor shall extend the protections of this Business Associate Contract to such PHI and limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction infeasible, for as long as Contractor maintains such PHI.

3. The obligations of this Business Associate Contract shall survive the termination of the Contract.

ATTACHMENT I

CLAIMS FUNDING ARRANGEMENTS

ARTICLE 1
BANKING ARRANGEMENTS

A. Contractor will establish and maintain a Plan Benefit Account with a Bank agreed to between the Contractor and County to fund all claims cost. County will make proper arrangements with County Bank to accept daily, excluding County holidays, or weekly Automated Clearing House (ACH) debit transaction from the Contractor to facilitate funding of the Plan Benefit Account.

B. Contractor's Bank must be members of the state or local ACH for debits to be processed. Contractor will process the ACH debits according to National Automated Clearing House Association (NACHA) rules and regulations.

ARTICLE 2
AUTHORIZATION TO TRANSFER FUNDS

A. County authorizes Contractor to transfer funds from an account designated by the County at the County Bank to the Contractor Bank in accordance with this Agreement between County and Contractor. These transfers will be through the ACH process and shall be governed by this Agreement and such arrangement as agreed upon between Contractor and County Treasurer-Tax Collector.

B. Contractor operations will process the claim payment cycles and send checks or non-draft payments to providers or make other payments as applicable. Contractor will request funds from the County when the checks are presented for payment and the non-drafts adjustments are passed to the banking system. Contractor will initiate daily or weekly ACH debit to County Bank as denoted in B above.

C. Contractor shall provide to the County a bank cleared register which reconciles to the daily or weekly funding advice and a summary report that reconciles to the bank register must also be provided that includes the amount by plan, eligibility, and enrollment Structure as requested by the County. The bank cleared register shall include name of payee, amount, check date, check number, and claim number. Contractor will provide with the check register a summary report in a format acceptable to the County to support the amount of claim payments issued from County claim accounts.

D. Contractor will email the daily or weekly funding advice to the multiple designated contacts of the County. This advice will be available to the County prior to 11:00 am Pacific Time prior to the day the funds are to be made available. Standard monthly banking reports will confirm and reconcile deposits and charges for each bank day of the month.

E. County authorizes Contractor to transfer funds with the daily, excluding County holidays, or weekly funding advice upon providing backup to multiple designated contacts within County describing the amount of the funds being transferred.

F. County will pay any fees charged by County Bank to service the designated account. Contactor will not charge the County any fees for maintaining the Plan Benefit Account at Contractor Bank.

G. Upon receipt of the notification, County shall fund the account at County Bank within twenty-four (24) hours, excluding weekends and County holidays. Sufficient Funds will be available in the County Bank account to fund ACH debits.

H. County grants Contractor a limited right to transfer funds to satisfy plan claim costs described herein. Contractor has no right to transfer any funds other than expressly outline in this Agreement unless authorized by the County to collect through Account.

ARTICLE 3
TERMINATION

This terms and conditions set forth in this Attachment will continue throughout the term of the Contract, the Run-out Period (as defined herein), and for an additional twelve (12) months following the end of the Run-out Period, at which time this Attachment will automatically terminate. The Contractor will place stop payments on remaining uncashed check and provide the County a detailed listing of the stop payments. The County will recover any monies remaining in the Account and receive all final reports.

Exhibit 1

Wellwise Choice Health Plan Document

See separate attachment

Exhibit 2

Sharewell Choice Health Plan Document

See separate attachment

Exhibit 3

Wellwise Retiree Health Plan Document

See separate attachment

Exhibit 4

Sharewell Retiree Health Plan Document

See separate attachment