No. 811370A

ADMINISTRATIVE SERVICES AGREEMENT

AGREEMENT NUMBER ASA-811370A

This Administrative Services Agreement (hereinafter "Services Agreement") is made and entered into by and between Aetna Life Insurance Company on behalf of itself and its affiliated health maintenance organizations ("HMOs") (collectively "Aetna") and Polk County, a political subdivision of the State of Florida (hereinafter "Customer").

WHEREAS, Customer has established a self-funded employee health benefits plan (the "Plan") for certain eligible individuals described in Appendix I (such Appendix to contain a description of such benefits of the Plan document) of this Services Agreement; and

WHEREAS, pursuant to the Plan, Customer wishes to make available one or more coverage products offered by the HMOs (the "Products"), as specified in Appendix I of this Services Agreement; and

WHEREAS, Aetna has arranged to provide integrated administration of these Product(s) and, if requested by the Customer, has also agreed to provide certain supplemental administrative services and Products not available through the HMOs;

THEREFORE, in consideration of the mutual covenants and promises stated herein and other good and valuable consideration, the parties hereby enter into this Services Agreement. This Services Agreement includes and incorporates by reference the attached Service and Fee Schedule, General Conditions Addendum, Description of Services Addendum, National Advantage Program Addendum, and Appendices.

Customer hereby elects to receive the Services for Products/Programs designated in the Service and Fee Schedule as well as any supplemental Services identified therein. The corresponding Service Fees effective for the period beginning January 1, 2013 and ending December 31, 2013 are specified in the Service and Fee Schedule, which shall be amended for future periods, in accordance with Section 3 of the General Conditions Addendum, to reflect the Services elected and corresponding Service Fees for such periods.

The HMOs include the following entities to the extent that Plan beneficiaries elect coverage under Products offered in geographic areas served by such entity: Aetna Health Inc. (CT), Aetna Health Inc. (ME), Aetna Health Inc. (MA), Aetna Health Inc. (NH), Aetna Health Inc. (NY), Aetna Health Inc. (DE), Aetna Health Inc. (NJ), Aetna Health Inc. (PA), Aetna Health Inc. (MD), Aetna Health Inc. (FL), Aetna Health Inc. (TN), Aetna Health Inc. (GA), Aetna Health of the Carolinas Inc., Aetna Health Inc. (LA), Aetna Health Inc. (CO), Aetna Health of Illinois Inc., Aetna Health Inc. (MI), Aetna Health Inc. (MO), Aetna Health Inc. (OH), Aetna Health Inc. (OK), Aetna Health Inc. (TX), Aetna Health Inc. (AZ), Aetna Health Inc. (WA). Aetna Life Insurance Company is authorized to represent the HMOs for purposes of the execution and administration of this Services Agreement, including receipt of any notices to Aetna required hereunder.

This Services Agreement (including incorporated attachments) constitutes the complete and exclusive contract between the parties and supersedes any and all prior or contemporaneous oral or written communications or proposals not expressly included herein. No modification or amendment of this Services Agreement shall be valid unless in a writing signed by a duly authorized representative of Aetna and a duly authorized representative of Customer. By executing this Services Agreement, Customer acknowledges and agrees that it has reviewed all terms and conditions incorporated into this Services Agreement and intends to be legally bound by the same.

The Effective Date of this Services Agreement shall be January 1, 2013.

IN WITNESS WHEREOF, the parties hereto have caused this Services Agreement to be executed by their duly authorized representatives.

POLK COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF FLORIDA ("CUSTOMER")

AETNA LIFE INSURANCE COMPANY ("AETNA")
By:

Mark T. Bertolini

Chief Executive Officer and President

Date: October 1, 2012

Financial Verification:

ATTEST:

RICHARD WEISS
CLERK OF THE BOARD

By: _____
Deputy Clerk

Polk County, a political subdivision of the State of Florida

By: _____
Sam Johnson, Chairman
Board of County Commissioners

Date Signed By Chairman _____

Reviewed as to form and legal sufficiency:

10/3/2012

County Attorney's Office Date

SEAL

SERVICE AND FEE SCHEDULE

This Service and Fee Schedule is an attachment to Services Agreement Number ASA-811370A between Aetna and Customer (as identified therein) and is incorporated into the Services Agreement by reference.

Customer hereby elects to receive the Services for Products/Programs designated below. The corresponding Service Fees effective for the period beginning January 1, 2013 and ending December 31, 2013 are specified below. It shall be amended for future periods, in accordance with Section 3 of the General Conditions Addendum to reflect the Services elected and corresponding Service Fees for such periods.

MEDICAL PRODUCTS

Services	Medicare Direct Indemnity	AHF Aetna Choice™ POS II (HRA)	AHF Aetna Choice™ POS II (HSA)	Open Access™ Aetna Select
I. Administration Services	Included	Included	Included	Included
II. Aetna Health Connections℠ Services				
Utilization Management Inpatient and Outpatient Precertification	Included	Included	Included	Included
Utilization Management Concurrent Review	Included	Included	Included	Included
Utilization Management Discharge Planning	Included	Included	Included	Included
Utilization Management Retrospective Review	Included	Included	Included	Included
Next Generation Case Management	Included	Included	Included	Included
Infertility Case Management	Included	Included	Included	Included
National Medical Excellence/Institutes of Excellence with transportation and lodging expense	Included	Included	Included	Included
MedQuery ℠ with Basic Member Messaging	Included	Included	Included	Included
MedQuery ℠ with Enhanced Member Messaging	Not Included	Not Included	Not Included	Not Included
Aetna Health Connections℠ Disease Management	Not Included	Included	Included	Included
Beginning Right ℠ Maternity Program	Not Included	Included	Included	Included
Informed Health Line as follows:				
Nurseline 1-800# Only	Included	Included	Included	Included
Service Plus Components	Not Included	Not Included	Not Included	Not Included
Optional Service Components	Not Included	Not Included	Not Included	Not Included
Wellness Counseling	Not Included	Not Included	Not Included	Not Included
Healthy Body, Healthy Weight	Not Included	Not Included	Not Included	Not Included

Enhanced Member Outreach Program℠				
Level One	Not Included	Not Included	Not Included	Not Included
Level Two	Not Included	Not Included	Not Included	Not Included
Healthy Insights Member Newsletter	Not Included	Not Included	Not Included	Not Included
Preventive Mailings	Not Included	Not Included	Not Included	Not Included
Worksite Services	Not Included	Not Included	Not Included	Not Included
Simple Steps To A Healthier Life®	Included	Included	Included	Included
Personal Health Record				
Health History Report	Included	Included	Included	Included
CareEngine-Powered PHR	Not Included	Included	Included	Included
PHR Health Tracker Incentive	Not Included	Not Included	Not Included	Not Included
Focused Psychiatric Review	Included	Not Included	Not Included	Not Included
Managed Behavioral Health	Not Included	Included	Included	Included
Intensive Case Management	Not Included	Included	Included	Included
Medical/Psychiatric Case Management	Not Included	Included	Included	Included
Depression Disease Management	Not Included	Not Included	Not Included	Not Included
Anxiety Disease Management	Not Included	Not Included	Not Included	Not Included
Alcohol Disease Management	Not Included	Not Included	Not Included	Not Included
Psychiatric Disability Case Management	Not Included	Not Included	Not Included	Not Included
Quit Tobacco Program℠	Not Included	Not Included	Not Included	Not Included
Pharmacy Aetna RX Check	N/A	N/A	N/A	N/A
Healthy Lifestyle Coaching Healthy Weight	Not Included	Included	Included	Included
High Tech Radiology Program	Not Included	Not Included	Not Included	Not Included
Flexible Medical Model				
Flex Option 1	Not Included	Included	Included	Included
Flex Option 2	Not Included	Included	Included	Included
Flex Option 3	Not Included	Included	Included	Included
Frequent ER Visits	Not Included	Included	Included	Included
Cancer Management	Not Included	Included	Included	Included
Informed Health Line Call Backs	Not Included	Not Included	Not Included	Not Included
Post Partum Calls	Not Included	Not Included	Not Included	Not Included
Pharmacy Non-Compliance	Not Included	Not Included	Not Included	Not Included

Multiple Visits to Providers	Not Included	Not Included	Not Included	Not Included
e.Plan Sponsor Monitor™ Reporting				
-Level A Reporting	Included	Included	Included	Included
-Level B Reporting	Included	Included	Included	Included
-Level C Reporting	Included	Included	Included	Included
-Level D Reporting	Not Included	Not Included	Not Included	Not Included
Aetna Compassionate Care Program	Included	Included	Included	Included
Aetna Healthy Actions	Not Included	Included	Included	Included
Value Added Programs				
Fitness Program (GlobalFit)	Included	Included	Included	Included
Aetna Natural Products and Services Program	Included	Included	Included	Included
Aetna Weight Management Discount Program	Included	Included	Included	Included
Aetna Hearing Discounts	Included	Included	Included	Included
Aetna Vision Discounts	Included	Included	Included	Included
Member Internet Services				
DocFind	Included	Included	Included	Included
Aetna IntelliHealth	Included	Included	Included	Included
Learning Resources	Included	Included	Included	Included
Staying Healthy	Included	Included	Included	Included
Estimate the Cost of Care Tool	Included	Included	Included	Included
Claim Research/ Forms/ Contact Us	Included	Included	Included	Included
Spanish Versions	Included	Included	Included	Included
Aetna Health Information Advantage	Included	Included	Included	Included
Aetna Navigtor Reporting	Included	Included	Included	Included
Aetna Claim Fiduciary Services - Process 1	Included	Included	Included	Included
HIPAA Certificates (Per Employee* Per Month)	Included	Included	Included	Included
Importing 3rd Party Rx Data	Included	Included	Included	Included
Exporting medical claim data to Truven Health Analytics	Included	Included	Included	Included
1 Ad Hoc Care Management Report /Quarter	Included	Included	Included	Included

III. Network Access Services	N/A	Included	Included	Included
Total Fee (Per Employee* Per Month)**	$18.41	$38.59	$38.59	$38.59

*A person in those classes of employees, retirees, COBRA continuees and any other persons within classes that are specifically described in Appendix I, including employees, retirees, COBRA continuees and any other persons within classes of subsidiaries and affiliates of Customer who are reported, in writing, to Aetna for inclusion in the Services Agreement.

IV. Aetna Subrogation Program	27% of recovered amount will be retained for administrative expenses	
V. National Advantage Program (NAP)		
National Advantage - Facility Charge Review (NAP-FCR)	Included	National Advantage Access Fee:
National Advantage - Facility Charge Review (NAP-FCR/MBB)		
National Advantage - Facility Charge Review (NAP-FCR/FD)		
National Advantage–Itemized Bill Review(IBR)	Included	50% of Aggregate Savings - Fee will be included in Plan Benefit Funding Request from Bank

****Wellness/Communication Allowance** – Aetna is including a wellness allowance of up to $30,000.00 for each of the 2013, 2014 and 2015 plan years that may be used toward reasonable wellness/communication services procured by Customer from third-party vendors to pay for wellness/communication-related expenses incurred during the 2013, 2014, 2015 plan years. This includes, but is not limited to wellness fairs, biometric screenings, onsite flu vaccinations, etc. These funds will be available after the first month of service fees have been paid. Aetna will pay wellness/communication-related expenses after Customer has presented the invoice(s) outlining the expenses they incurred. Invoices must be submitted to Aetna within 60 days of the service being incurred. After December 31st of each plan year, any remaining unused amount of the wellness allowance for that plan year will not continue into the following plan year and will be forfeited.

Any amounts ("wellness/communication allowance") that Aetna pays to a plan sponsor to offset or reimburse such plan sponsor for any expense or costs incurred as a result of contracting with Aetna for benefits plan administration services, will be paid in accordance with applicable law. Plan sponsors are advised to determine appropriate accounting for these payments with their own counsel or accountant. Any plan sponsor receiving a wellness allowance or other payments from Aetna that offset or reimburse expenses that would otherwise be paid from plan assets, should consult with their ERISA counsel to determine if such allowance must be credited to plan assets, and for additional counsel regarding the accounting for reporting of such payments.

Guarantee Period

The components of the Fees will be referred to as *Guaranteed Fees*.

The period January 1, 2013 through December 31, 2013 will be referred to as the **First Guarantee Period,** the period January 1, 2014 through December 31, 2014 will be referred to as the **Second Guarantee Period**, and the period January 1, 2015 through December 31, 2015 will be referred to as the **Third Guarantee Period**.

Guaranteed Fees

The fees for the self-funded coverages included in this renewal for the period January 1, 2013 through December 31, 2013 are guaranteed according to the Per Employee Per Month fees provided in Section 3, above. We guarantee that the fees for the Second Guarantee Period will increase over the fees for the First Guarantee Period by 3%. We also guarantee that the fees for the Third Guarantee Period will increase over the fees for the Second Guarantee Period by 3%. For each of the Guaranteed Periods, the fees will increase by 3% unless the fees for a particular Guarantee Period are subject to recalculation as described, below.

Our guaranteed fees have taken into account the overall business relationship we enjoy with Polk County, A Political Subdivision of the State of Florida and have factored into our pricing the economies of offering multiple products and services through Aetna. Aetna reserves the right to recalculate the Guaranteed Fees using its then current book of business formula under the circumstances described below. In such case, Polk County, A Political Subdivision of the State of Florida, will be required to pay any difference between the fees collected and the new fees calculated retroactive to the start of the respective Guarantee Period. Aetna may recalculate:

1. If, for any product identified above, there is a:
   - 15% decrease in the number of enrolled lives during the guarantee period from the Guaranteed Fee Assumptions above (such decrease is to be determined in total for all Medical products combined, or from any reset assumptions (reset if a new Fee is established).
   - 15% increase in the processed claim transactions per employee (PCTs/ee) ratio from the ratio above, or from any subsequently reset assumptions (reset if a new fee is established).
   - 15% increase in the retiree percentage above, or from any subsequently reset assumptions (reset if a new fee is established).
   - 15% increase in the Member to employee ratio above, or from any subsequently reset assumptions (reset if a new fee is established).
2. If a material change in the plan of benefits is initiated by Polk County, A Political Subdivision of the State of Florida or by legislative or regulatory action.
3. If a material change is initiated by Polk County, A Political Subdivision of the State of Florida or by legislative or regulatory action in the claim payment requirements or procedures, claim fiduciary option, account structure, or any other change materially affecting the manner or cost of paying benefits.
4. If the National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs are terminated by Polk County, A Political Subdivision of the State of Florida.
5. If Aetna Programs and Services, including but not limited to Aetna Health Connections (AHC) disease management, Active Health Management, Beginning Right(SM) Maternity Program, MedQuery®, Flexible Spending Accounts, Informed Health® Line (IHL) are terminated by Polk County, A Political Subdivision of the State of Florida.
6. If Polk County, A Political Subdivision of the State of Florida terminates any other Aetna products and services not addressed within this renewal package. If one of the circumstances identified above should occur, then the additional financial guarantees between Aetna and Polk County, A Political Subdivision of the State of Florida including but not limited to claim based performance guarantees, may also be modified or terminated as well based upon the financial conditions contained within those documents.

Late Payment Charges

If Customer fails to provide funds on a timely basis to cover Plan benefit payments as provided in Section 5 of the General Conditions Addendum, and/or fails to pay Service Fees on a timely basis as provided in Section 3 of such Addendum, Aetna will assess a late payment charge. Unless otherwise communicated in writing by Aetna to reflect the annual corporate percentage for 2013 should such percentage change prior to January 1, 2013 for Aetna's business, the per annum charge for 2013 will be as follows:

(i) late funds to cover benefit payments (e.g., late wire transfers): 12% annual rate
(ii) late payments of Service Fees: 12% annual rate

provided, however, in no event will the late payment charge exceed the maximum amount permitted by Section 218.74, Florida Statutes, part of the Local Government Prompt Payment Act, to the extent such statute is applicable.

In addition, Aetna will make a charge to recover its cost of collection, including reasonable attorneys' fees.

Aetna will provide written notice to the Customer of the late payment charges for subsequent years.

GENERAL CONDITIONS ADDENDUM

This General Conditions Addendum is an attachment to Services Agreement Number ASA-811370A between Aetna and Customer (as identified therein) and is incorporated into the Services Agreement by reference.

Definitions:

In this General Conditions Addendum and in all attachments to the Services Agreement:

(A) "Plan(s)" means only the portions of the Customer's employee benefit plan(s) that are described in Appendix I.

(B) "Employee" means only a person in those classes of employees and retirees that are specifically described in Appendix I, including employees and retirees of subsidiaries and affiliates of Customer who are reported, in writing, to Aetna for inclusion in the Services Agreement..

(C) "Dependent" means only a person in a class described in Appendix I as a dependent of an employee.

(D) "Members" means Employees and Dependents covered under the Plan.

(E) "Bank" means the bank selected by Aetna on which benefit payment checks are drawn in satisfaction of a claim for Plan benefits.

(F) The term "Payment Due Date" shall have the meaning set forth in Section 3 of this General Conditions Addendum.

(G) "Product" means a health benefit plan arrangement such as an indemnity, point of service (POS), preferred provider organization (PPO) or exclusive provider organization (EPO) arrangement.

(H) The term "Service Fees" shall have the meaning set forth in Section 3 of this General Conditions Addendum.

(I) The term "Services Agreement Period" shall have the meaning set forth in Section 2 of this General Conditions Addendum.

(J) The term "Services" shall have the meaning set forth in Section 1 to this General Conditions Addendum.

The following are the terms and conditions under which Aetna agrees to perform Services for Customer:

1. **Purpose.** Customer will purchase and Aetna will provide to Customer the services (collectively the "Services") (i) designated in the Services Agreement, and (ii) such other services Customer requests of Aetna and Aetna agrees in writing to perform, as described in the Service and Fee Schedule and the Description of Services Addendum with respect to the Plan(s), and (iii) (A) such other services Aetna has agreed to perform as described in the Customer's Request for Proposals RFP #12-051, to include all attachments and addenda, and (B) Aetna's best and final responsive proposal thereto, all of which are incorporated into this Agreement by this reference.

2. **Term**. The initial term of the Services Agreement shall be a three (3) year time period that commences on the later of its Effective Date or the date on which it is executed by Customer and shall continue to the third anniversary of the Effective Date, unless terminated by either party in accordance with Section 4 of this General Conditions Addendum. Subject to the other terms and conditions of the Services Agreement and unless sooner terminated by either party in accordance with Section 4 of this General Conditions Addendum, the parties may mutually agree to renew and extend the Services Agreement term for two (2) additional renewal terms (individually, a "renewal term"), each having a twelve (12) month duration. The parties must agree to extend the Agreement via a renewal term at least thirty (30) days prior to the expiration of the initial term or the first renewal term. An amendment that extends the Agreement for a renewal term will list any applicable changes in rates or fees. The parties' failure to timely exercise their right to any renewal term shall terminate their ability to further extend the Services Agreement via a subsequent renewal term. Each year of the initial term and each subsequent renewal term shall hereafter collectively be referred to as "Services Agreement Periods."

3. **Service Fees; Renewals**. The Service Fees payable by Customer to Aetna for the Services shall be determined in accordance with the Service and Fee Schedule identified in the Services Agreement. No Services other than those identified in the Service and Fee Schedule are included in the Service Fees. The Services to be provided by Aetna and the Service Fees may be adjusted annually effective on the anniversary of the Effective Date (the "Contract Anniversary Date") by Aetna. Aetna shall give Customer ninety (90) days prior written notice of such adjustments in Services and Service Fees. Aetna also may adjust the Service Fees at other times in accordance with the terms and conditions of the Service and Fee Schedule.

   Aetna shall submit to Customer a statement for each month this Services Agreement is in effect showing the Service Fees for that month. Customer shall pay Aetna the amount of the Service Fees no later than forty-five (45) calendar days following the first calendar day of the month in which the services are provided (the "Payment Due Date").

   Customer shall reimburse Aetna for additional expenses incurred by Aetna and agreed to by the parties on behalf of the Plan or Customer which are necessary for the administration of the Plan, including, but not limited to, special hospital audit fees, fees paid or expenses incurred to recover Plan assets and customized printing fees, clerical listing of eligibility, Customer audits exceeding limits in General Conditions Addendum and for any other services performed which are not Services under the Services Agreement. The payment by Aetna on behalf of Customer of any such expenses shall constitute part of the Services hereunder; provided, however, with respect to payments made by Aetna on behalf of and at the request of the Customer to Customer's vendors, Customer shall be responsible for filing any notices, such as Form 1099 or other forms.

   In circumstances where Aetna may have a contractual, claim or payment dispute with a provider, the settlement of that dispute with the provider may include a one time payment in settlement to the provider or to Aetna, or may otherwise impact future payments to providers. Aetna, in its discretion, may apportion the settlement to self-funded Plan sponsors based upon specific applicable claims, proportional membership or some other allocation methodology, after taking into account Aetna's costs including Aetna's internal costs of recovery and distribution.

   All overdue amounts shall be subject to the late charges set forth in the Service and Fee Schedule.

   Following the close of a Service Agreement Period, Aetna will prepare and submit to the Customer a report showing the Service Fees paid.

4. **Termination**. The Services Agreement may be terminated by Aetna or the Customer as follows:

   (A) **Legal Prohibition** - If any state or other jurisdiction enacts a law which prohibits the continuance of this Services Agreement, or an existing law is interpreted to so prohibit the continuance of this Services Agreement, the Services Agreement shall terminate automatically as to such state or jurisdiction on the effective date of such law or interpretation; provided, however, that if only a portion of the Services Agreement is prohibited by such law, only that portion of the Services Agreement shall be affected, and the Services Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted.

   (B) **Customer Termination** - Customer may terminate the Services Agreement with respect to all Employees (including their Dependents) or any group of Employees included under the Services Agreement or any subsidiary or affiliate of Customer that is covered under the Services Agreement by giving Aetna at least ninety (90) days written notice stating when, after the date of such notice, such termination shall become effective.

   (C) **Aetna Termination** -

      (1) Aetna may terminate the Services Agreement by giving to Customer at least ninety (90) days written notice stating when, after the date of such notice, such termination shall become effective.

      (2) If Customer fails to respond to Aetna's or the Bank's initial request to provide funds to the Bank for the payment of checks or other payments approved and recorded by Aetna, Aetna shall have the right to cease processing of benefit payment requests and suspend other Services until the requested funds have been provided. Aetna may terminate the Services Agreement immediately upon transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail) if (a) Customer fails to provide the requested funds within (5) business days of such notice by Aetna, or (b) Aetna determines that Customer will not meet its obligation to provide such funds within such five (5) business days.

(3) If Customer fails to pay Service Fees by the Payment Due Date, Aetna shall have the right to suspend Services until the charges have been paid. Aetna may terminate the Services Agreement immediately upon transmission of notice to Customer by mail, facsimile transmission or other means of communication (including electronic mail) if (a) Customer either fails to pay such charges within five (5) business days of such notice of unpaid Service Fees by Aetna, or (b) Aetna determines that Customer will not meet its obligation to pay such charges within such five (5) business days.

(4) Any acceptance by Aetna of funds or Service Fees described in paragraphs (2) or (3) above, after the grace periods specified therein have elapsed and prior to any action by Aetna to suspend Services or terminate the Services Agreement, shall not constitute a waiver of Aetna's right to suspend Services or terminate the Services Agreement in accordance with this section with respect to any other failure of Customer to meet its obligations hereunder.

(D) **Responsibilities on Termination** - Upon termination of the Services Agreement, Aetna will continue to process runoff claims for Plan benefits that were incurred prior to but not processed as of the termination date which are received by Aetna not more than twelve (12) months following the termination date. The Service Fee for such activity is included in the Service Fee described in Section 3 of this General Conditions Addendum. The procedures and obligations described in the Services Agreement, to the extent applicable, shall survive the termination of the Services Agreement and remain in effect with respect to such claims. Benefit payments processed by Aetna with respect to such claims which are pended or disputed will be handled to their conclusion by Aetna and the procedures and obligations described in the Services Agreement, to the extent applicable, shall survive the expiration of the twelve (12) month period. Requests for benefit payments received after such twelve (12) month period will be returned to the Customer or, upon its direction, to a successor administrator at the Customer's expense.

Customer will be liable for all Plan benefit payments made by Aetna in accordance with the preceding paragraph (D) following the termination date or which are outstanding on the termination date. Customer will continue to fund benefit payments through the banking arrangement described in Section 5 of this General Conditions Addendum and agrees to instruct its bank to continue to make funds available until all outstanding benefit payments have been funded by the Customer or until such time as mutually agreed upon by Aetna and Customer (e.g., Customer's wire line and bank account from which the Bank requests funds must remain open for one (1) year after runoff processing ends, two (2) years after termination).

Upon termination of the Services Agreement and provided all Service Fees have been paid, Aetna will release to Customer or to a successor administrator, in Aetna's standard format, all claim data, records, and files within a reasonable time period following the termination date. All costs associated with the release of data, records, and files from Aetna to Customer shall be paid by Customer.

Subsidiaries and affiliates of Customer who are covered under the Services Agreement may be terminated by Customer giving timely written notice to Aetna.

5. **Funding of Plan Benefits**. Benefit payments and related charges of any amount payable under the Plan shall be made by check drawn by Aetna payable through the Bank or by electronic funds transfer or other reasonable transfer method. Customer, by execution of the Services Agreement, expressly authorizes Aetna to issue and accept such checks on behalf of Customer for the purpose of payment of Plan benefits and other related charges. Customer agrees to provide funds through its designated bank sufficient to satisfy all Plan benefits and related charges upon notice from Aetna or the Bank of the amount of payments made by Aetna. Customer agrees to instruct its bank to forward an amount in Federal funds on the day of the request equal to such liability by wire transfer or such other transfer method agreed upon between Customer and Aetna. As used herein, "Plan benefits" means payments under the Plan, excluding copayments, coinsurance, or deductibles required by the Plan.

A stop payment will be made on all outstanding benefit checks (checks which have not been presented for payment) on the sooner of:

(A) one (1) year following the date Aetna completes its runoff processing obligations.

(B) the date, following five (5) days written notice by Aetna to the Customer of the Customer's failure to provide requested funds or pay Service Fees due, the Customer fails to fund benefits payments or pay Service Fees due in accordance with Section 4(C).

6. **Customer's Responsibilities**. Customer shall supply Aetna in writing or by electronic medium acceptable to Aetna with all information regarding the eligibility of Members including but not limited to the identification of any Sponsored Dependents defined in Appendix I and shall notify Aetna by the tenth day of the month following any changes in Plan participation. Aetna has no responsibility for determining whether an individual meets the definition of a Sponsored Dependent. Aetna shall not be responsible in any manner, including but not limited to, any obligations set forth in Section 12 below, for any delay or error caused by the Customer's failure to furnish accurate eligibility information in a timely fashion. Customer shall provide Aetna with all Plan documents at least thirty (30) days prior to the Effective Date or such other date as may be mutually agreed upon by the parties. Customer shall notify Aetna in writing of any changes in Plan documents or Plan benefits at least thirty (30) days prior to the effective date of such changes. Aetna shall have thirty (30) days following receipt of such notice to inform Customer of whether it will administer such proposed changes. Appendix I hereto shall be deemed to be automatically modified to reflect such proposed changes if Aetna either agrees to administer the changes as proposed or fails to object to such changes within thirty (30) days of receipt of the foregoing notice. The description of Plan benefits in Appendix I may otherwise be amended only by mutual written agreement of the parties. Aetna may charge additional fees relating to any increase in cost to administer the Plan because of changes which Aetna agrees to administer.

   Customer shall immediately provide Aetna with such information regarding administration of the Plan as Aetna may request from time to time. Aetna is entitled to rely on the information most recently supplied by Customer in connection with Aetna's Services and its other obligations under the Services Agreement. Aetna shall not be responsible for any delay or error caused by Customer's failure to furnish correct information in a timely manner.

   Customer agrees that it will provide Aetna with a copy of its Summary Plan Description (SPD), so that Aetna may reconcile any potential differences that may exist among the SPD, the description of Plan benefits in Appendix I and Aetna's internal policies and procedures. Customer also agrees that it is responsible for satisfying any and all Plan reporting and disclosure requirements imposed by law.

7. **Services**. Aetna shall perform the Services set forth in the Service and Fee Schedule and the Description of Services Addendum identified in the Services Agreement. Customer acknowledges that Aetna may utilize the services of external reviewers or contractors in performing these services.

8. **Standard of Care**. Aetna will discharge its obligations under the Services Agreement with that level of reasonable care which a similarly situated administrator of claims would exercise under similar circumstances. In connection with its fiduciary powers and duties hereunder, Aetna shall observe the standard of care and diligence required of a fiduciary.

9. **Fiduciary Duty**. It is understood and agreed that the Customer retains complete authority and responsibility for the Plan, its operation, and the benefits provided thereunder, and that Aetna is empowered to act on behalf of Customer in connection with the Plan only to the extent expressly stated in the Services Agreement or as agreed to in writing by Aetna and Customer.

   Customer and Aetna agree that Aetna will be the "appropriate named fiduciary" of the Plan for purpose of reviewing denied claims under the Plan. In exercising such fiduciary responsibility, Aetna will have discretionary authority to determine entitlement to Plan benefits as determined by the Plan Documents for each claim received and to construe the terms of the Plan. However, Customer has the sole and complete authority to determine eligibility of persons to participate in the Plan. It is also agreed that Aetna's decision on any claim is final and that Aetna has no other ERISA Fiduciary responsibility under the Plan.

10. **Records**. Customer acknowledges and agrees that Aetna or one of its affiliates or authorized agents shall have the right to use all documents, records, reports, and data, including data recorded in Aetna's data processing systems ("Documentation"), for legitimate Plan, health operations, research or public health purposes, including without limitation: claims payment and fraud prevention; preventive health, early detection and disease management programs;

coordination of patient care; member education; quality improvement/management assessment; utilization review and management; design of benefit plans; provider network activities; fulfilling certain state and federal requirements; HEDIS and similar data collection and reporting; accreditation by the National Committee for Quality Assurance and other accrediting organizations; and statistical research; provided, that in all respects Aetna shall use Documentation in compliance with privacy laws and regulations, including without limitation regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996.

Upon reasonable prior written request, subject to the provisions of Sections 11 and 17 hereof, and as permitted by law or regulation, the benefit payment information contained in the Documentation shall be made available to Customer or, at Customer's request, to a third party designated by Customer for inspection during regular business hours at the place or places of business where it is maintained by Aetna, for purposes related to the administration of the Plan. Aetna may assess a charge to recover costs in connection with documentation requests which are excessively repetitive or burdensome. Such Documentation will be kept by Aetna for seven (7) years after the year in which a claim is paid, unless Aetna turns such Documentation over to Customer or a designee of Customer.

11. Audit rights.

(A) General Guidelines - For the purpose of this contract, an "audit" is defined as performing a review of claim transactions for the purpose of assessing the accuracy of benefit determinations.

Audits must be commenced within two (2) years following the period being audited.
Audits of performance guarantees must be commenced in the year following the period to which the performance guarantee results apply.

The size of the audit sample may not exceed 250 claims transactions, without Aetna's written consent and the payment of fees as assessed by Aetna.

Audits must be performed at the location where Customer's claims are processed.

Aetna is not responsible for paying Customers' audit fees or the costs associated with the audit. Customer shall pay Aetna fees for any audit which (i) cannot be completed within a five (5) day period, (ii) contains a sample size in excess of 250 claims transactions, or (iii) otherwise creates exceptional administrative demands upon Aetna. To the extent practicable, Aetna will provide estimates of such fees to Customer prior to the Customer incurring additional fees.

Any requested payment from Aetna resulting from the audit must be based upon documented findings, agreed to by both parties, and must be solely due to Aetna's actions or inactions.

(B) Auditor Qualifications and Requirements - Customer will utilize individuals to conduct audits on its behalf who are qualified by appropriate training and experience for such work and will perform its review in accordance with published administrative safeguards or procedures against unauthorized use or disclosure (in the audit report or otherwise) of any individually identifiable information (including health care information) contained in the information to be audited. Customer and such individuals will not make or retain any record of provider negotiated rates included in the audited transactions, or payment identifying information concerning treatment of drug or alcohol abuse, mental/nervous or HIV/AIDS or genetic markers, in connection with any audit. There must be no conflict of interest or past business or other relationship which would prevent the auditor from performing an independent audit to conclusion. A conflict of interest includes (but is not limited to) a situation in which the audit agent (a) is employed by an entity which is a competitor to Aetna's claims administration business; or (b) has terminated from Aetna within the past 12 months; or (c) is affiliated with a vendor subcontracted by Aetna to adjudicate claims; or (d) is compensated in a manner which could financially incent the agent to overstate or misconstrue data. Determination of the nature of a conflict of interest shall be in the sole discretion of Aetna. Aetna reserves the right to refuse to allow an auditor to conduct an audit in the event Aetna determines the auditor has a conflict of interest. The auditor chosen by the Customer must be mutually agreeable to both Customer and Aetna. Auditors may not be compensated on the basis of a contingency fee or a percentage of overpayments identified, in accordance with the provisions of Section 207 through 8.209 of the International Federation of Accountant's (IFAC) Code of Ethics For Professional Accountants (Revised 2004).

Audits of any services are subject to any related proprietary and confidentiality requirements protecting the nature of the data.

(C) **Audit Coordination** - The account representative must be contacted to initiate an audit. The representative will identify an audit coordinator who will have day-to-day responsibility for coordinating and facilitating the audit.

Customer will provide reasonable advance notice of its intent to audit and will complete an Audit Request Form providing information reasonably requested by Aetna. Further, Customer or its representative will provide the account representative at least four (4) weeks advance notice of the audit, with a complete and accurate listing of the transactions to be pulled for the audit and identification of the potential auditor. Notification requirements may exceed four weeks for unusual audit requests, including but not limited to audits involving large sample sizes (e.g., greater than 250 transactions). Aetna will communicate these requirements to Customer upon receipt of the completed Audit Request Form. No audit may commence until the Audit request Form is completed and executed by the Customer and auditor. Aetna recommends that any auditor being considered by the Customer be identified to Aetna as soon as possible so that any potential conflicts or past relationships or issues may be determined.

(D) **Identification of Audit Sample** - Prior to the audit, the auditors will provide a listing of the transactions selected for testing and the specific service for which each item is being tested. Unless otherwise specified in Appendix II, Performance Guarantees, The sample must be based on a statistical random sampling methodology (e.g., systematic random sampling, simple random sampling, stratified random sampling). Aetna reserves the right to review and approve the sample size, the objectives of the audit and the sampling methodology proposed by the auditors.

(E) **Closing Meeting** - The auditors will provide their draft audit findings to Aetna, in writing, before a final audit report is presented to Customer. This draft will provide the basis for discussions between Aetna and the auditors to resolve disagreements and summarize the audit findings.

(F) **Audit Reports** - Aetna will have a right to review the final Audit Report, before delivery to the Customer. Auditors shall provide Aetna with a copy of the final audit report delivered to Customer and Aetna shall have the right to include with the final Audit Report a supplementary statement containing facts that Aetna considers pertinent to the audit.

Unless auditors are compliant with paragraphs (E) and (F), the audit will not be completed and its results are presumed invalid.

12. **Recovery of Overpayments.** The parties will cooperate fully to make reasonable efforts to recover overpayments of benefits under the Plan. If it is determined that any payment has been made by Aetna to or on behalf of an ineligible person or if it is determined that more than the appropriate amount has been paid, Aetna shall undertake good faith efforts to recover the erroneous payment. For the purpose of this provision, "good faith efforts" means that Aetna will contact the responsible party twice via letter, phone, email or other means to try to make the recovery. If those efforts are unsuccessful in obtaining recovery, Aetna may use an outside vendor, collection agency or attorney to pursue recovery. Except as stated in this section, Aetna has no other obligation with respect to the recovery of overpayments.

Overpayment recoveries made through third party recovery vendors, collection agencies, or attorneys are credited to Customer net of fees charged by them.

Overpayments must be determined by direct proof of specific claims. Overpayments may not be determined by (a) indirect or inferential methods of proof, such as statistical sampling, extrapolation of error rate to the population, etc. or (b) application of software or other review processes that analyze claims in a manner different from the claim determination and payment procedures and standards used by Aetna.

Customer may not seek collection, or use a third party to seek collection, of overpayment from contracted providers pursuant to audits conducted in accordance with Sections 11. and 13., since all such recoveries are subject to the terms and provisions of the providers' contracts with Aetna. For the purpose of determining whether a provider has or has not been overpaid, Customer agrees that the rates paid to contracting providers for Covered Services shall be governed by Aetna's contracts with those providers, and shall be effective upon the loading of those contract rates into Aetna's systems, but no later than three (3) months after the effective date of the providers' contracts.

13. Indemnification.

(A) By its entering into this Services Agreement the Customer does not intend and in no way waives any sovereign immunity rights that it possesses. Therefore, the Customer will only to the extent allowable under Section 768.28, Florida Statutes, indemnify Aetna and hold Aetna, its directors, officers, employees and agents harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses, Aetna incurs, including reasonable attorneys' fees, which arise out of the gross negligence or willful misconduct of the Customer's employees acting within the scope of the employees' office or employment when in the performance of the Customer's obligations under this Agreement, except where there has been a finding of gross negligence or willful misconduct in the performance of Aetna's obligations under this Agreement or where there has been material breach of this Agreement by Aetna, as determined by a court or other tribunal having jurisdiction of the matter. Nothing stated in this Section 13 or stated in any other provision of this Agreement shall be interpreted or construed as (i) a waiver of the Customer's sovereign immunity rights, (ii) an extension of the limited waiver of the Customer's sovereign immunity as stated in Section 768.28, Florida Statutes; (iii) a waiver of any requirement or condition stated in Section 768.28, Florida Statutes; or (iv) the Customer's consent to be sued.. Any claims asserted against the Customer must comply with the procedures stated in Section 768.28, Florida Statutes.

(B) Aetna will indemnify Customer, its affiliates and their respective directors, officers, employees (acting in the course of their employment, but not as Members) and agents, and hold Customer harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses, that Customer incurs, including reasonable attorneys' fees, which arise out of Aetna's gross negligence or willful misconduct in the performance of Aetna's obligations under this Agreement or Aetna's material breach of this Agreement, as determined by a court or other tribunal having jurisdiction of the matter.

(C) The party seeking indemnification under (A) or (B) above must notify the indemnifying party within 30 days in writing of any actual or threatened action, suit or proceeding to which it claims such indemnification applies. Failure to so notify the indemnifying party shall not be deemed a waiver of the right to seek indemnification, unless the actions of the indemnifying party have been prejudiced by the failure of the other party to provide notice within the required time period.

The indemnifying party may then take steps to be joined as a party to such proceeding, and the party seeking indemnification shall not oppose any such joinder. Whether or not such joinder takes place, the indemnifying party shall provide the defense with respect to claims to which this Section applies and in doing so shall have the right to control the defense and settlement with respect to such claims.

The party seeking indemnification may assume responsibility for the direction of its own defense at any time, including the right to settle or compromise any claim against it without the consent of the indemnifying party, provided that in doing so it shall be deemed to have waived its right to indemnification except in cases where the indemnifying party has declined to defend against the claim.

(D) Customer and Aetna agree that: (i) Aetna does not render medical services or treatments to Members; (ii) neither Customer nor Aetna are responsible for the health care that is delivered by contracting health care providers; (iii) health care providers are solely responsible for the health care they deliver to Members; (iv) health care providers are not the agents or employees of Customer or Aetna; and (v) the indemnification obligations of (A) or (B) above do not apply to any portion of any loss, liability, damage, expense, settlement, cost, or obligation caused by the acts or omissions of health care providers with respect to Members.

14. Defense of Claim Litigation. In the event of a legal, administrative or other action arising out of the administration, processing or determination of a claim for Plan benefits, Aetna shall undertake the defense of such action at Aetna's expense and settle such action when in its reasonable judgment it appears expedient to do so. If the Customer is also named as a party to such action, Aetna will defend Customer PROVIDED the action relates solely and directly to actions or failure to act by Aetna and there is no conflict of interest between Aetna and Customer. Customer agrees to pay the amount of Plan benefits included in any judgment or settlement in such action, but shall not be liable for any other part of such judgment or settlement, including but not limited to legal expenses and punitive damages, except to the extent provided in Section 13(B) above.

15. Remedies. Neither party shall be liable to the other for any consequential, incidental, or punitive damages whatsoever.

16. **Mediation**. In the event that any dispute, claim, controversy of any kind or nature relating to this Agreement arises between the parties, the parties agree to meet and make a good faith effort to resolve the dispute. If the dispute is not resolved within thirty (30) days after the parties first met to discuss it, and either party wishes to purse the dispute further, the party shall refer the dispute to non-binding mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"). In no event may the mediation be initiated more than ninety (90) days after the date one party first gave written notice of the dispute to the other party. A single mediator engaged in the practice of law, who is knowledgeable about employee benefit plan administration, shall conduct the mediation under the current rules of the AAA. The mediation shall be held in Polk County, Florida, or another mutually agreeable site. Notwithstanding the forgoing, either party may reject the recommendation of the non-binding mediator within sixty (60) days of such recommendation, and avail itself to the state courts located in Polk County, Florida or in the appropriate federal court located in the State of Florida, as applicable.

17. **Confidentiality.**

(A) Each party acknowledges that performance of the Services Agreement may involve access to and disclosure of data, rates, procedures, materials, lists, systems, and other information (collectively "Confidential Information") belonging to the other. The parties further acknowledge and agree that Aetna operates in a highly regulated and competitive environment and that the unauthorized disclosure or use of Confidential Information may cause irreparable harm and significant injury to Aetna which will be difficult to measure with certainty or to compensate through monetary damage. Accordingly, the parties agree that injunctive or other equitable relief may be appropriate in the event of any breach by Customer, or their agents related to Confidential Information, in addition to such other remedies as may be available to Aetna at law. No Confidential Information shall be disclosed to any third party except as required by the County under the Public Records Law F.S. 119.07 or through a subpoena issued by a court of law (and in such cases the County shall provide Aetna with prompt notice of such requirement prior to any such disclosures), or other than representatives of such party who have a need to know such Information, provided that such representatives are informed of the confidentiality provisions hereof and agree to abide by them. All such Information must be maintained in strict confidence. In addition, each party will maintain the confidentiality of medical records and confidential patient information as required by law. Upon termination of the Services Agreement, each party, upon the request of the other, will return or destroy all copies of all of the other's Confidential Information in its possession or control except to the extent such Information must be retained pursuant to applicable law, or except as otherwise provided under the attached Appendix A , "Health Insurance Portability and Accountability Act (HIPAA)", provided, however, that Aetna may retain copies of any such Information it deems necessary for the defense of litigation concerning the services it provided under the Services Agreement. Customer agrees that Aetna may make lawful references to Customer in its marketing activities and in informing health care providers as to the organizations and plans for which Services are to be provided. Each party will execute and cause its employees and agents to execute any documents the other reasonably requires in connection with this confidentiality provision.

(B) In addition to the provisions of the foregoing paragraph (A), any information with respect to Aetna's or any of its affiliate's fees or specific rates of payment to health care providers, and any information which may allow determination of such fees or rates, and any of the terms and provisions of the health care providers' agreements with Aetna or its affiliates are deemed to be Aetna's Confidential Information. No disclosure of any such information may be made or permitted to Customer or to any third party whatsoever, except as required by the County under Public Records Law F.S. 119.07 or through a subpoena issued by a court of law (and in such cases the County shall provide Aetna with prompt notice of such requirement prior to any such disclosures), and including, but not limited to, any broker, consultant, auditor, reviewer, administrator, or agent unless (i) Aetna has consented in writing to such disclosure and (ii) each such recipient has executed a confidentiality agreement in form satisfactory to Aetna's counsel.

(C) Customer acknowledges that compliance with the provisions of the foregoing paragraphs (A) and (B) are necessary to protect the business and good will of Aetna and its affiliates and that any actual or prospective breach may irreparably cause damage to Aetna or its affiliates for which money damages may not be adequate. Customer therefore agrees that if Customer breaches or attempts to breach the Confidentiality obligations set forth in paragraphs (A) or (B) hereof, Aetna or an affiliate may be entitled to obtain temporary, preliminary, and permanent equitable relief, without bond, to restrain such breaches, together with any and all other legal and equitable remedies available under applicable law or under the Services Agreement Aetna shall be entitled to recover from Customer the reasonable attorneys' fees and costs Aetna expends in any action related to such breach or attempted breach of the Confidentiality obligations set for the in paragraphs (A) or (B).

18. **Relationship of the Parties**. It is understood and agreed that Aetna is an agent with respect to claim payments and an independent contractor with respect to all other Services being performed pursuant to the Services Agreement. Aetna makes no guarantee and disclaims any obligation to make any specific health care providers or any particular number of health care providers available for use by Members or that any level of discounts or savings will be afforded to or realized by Customer, the Plan, or Members.

19. **Subcontractors**. The work to be performed by Aetna under the Services Agreement may, at its discretion, be performed directly by it or wholly or in part through a subsidiary or affiliate or under a contract with an organization of its choosing. Aetna will remain liable for Services under the Services Agreement.

20. **Advancement of Funds.** If, in the normal course of business under the Services Agreement, Aetna, or any other financial organization with which Aetna has a working arrangement, chooses to advance any funds, Customer shall reimburse Aetna or such other financial organization for such payment. In no event shall such advances by Aetna or any other financial organization be construed as obligating Aetna or such organization to make further advances, or to assume liability of Customer for the payment of Plan benefits.

21. **Communications.** Aetna and Customer shall be entitled to rely upon any communication believed by them to be genuine and to have been signed or presented by the proper party or parties.

    Neither party shall be bound by any notice, direction, requisition or request unless and until it shall have been received in writing at (i) in the case of Aetna, 151 Farmington Avenue, Hartford, Connecticut 06156, Attention: Plan Sponsor Services Site Manager, Aetna, (ii) in the case of Customer, at the address shown below, or (iii) at such other address as either party specifies for the purposes of the Services Agreement by notice in writing addressed to the other party. Notices or communications shall be sent by mail, facsimile transmission, or other means of communication.

    Risk Management Director
    Polk County Board of County Commissioners
    2135 Marshall Edwards Drive
    Bartow, FL 33830

22. **Employee Notices.** Customer agrees to furnish each Employee covered by the Plan written notice, satisfactory to Aetna, that Customer has complete financial liability for the payment of Plan benefits. Customer shall pay Aetna the amount of any and all actual loss, damage, and expense (including reasonable attorneys' fees) sustained by Aetna as a direct result of any failure by Customer to give such notice.

23. **Force Majeure.** Aetna shall not be liable for any failure to meet any of the obligations or provide any of the services or benefits specified or required under the Services Agreement where such failure to perform is due to any contingency beyond the reasonable control of Aetna, its employees, officers, or directors. Such contingencies include, but are not limited to: acts or omissions of any person or entity not employed or reasonably controlled by Aetna, its employees, officers or directors; acts of God; fires; wars; accidents; labor disputes or shortages; governmental laws, ordinances, rules, regulations, or the opinions rendered by any Court, whether valid or invalid.

24. **Non-Aetna Networks**

    If Aetna is requested by Customer to arrange for network services to be provided for Employees and their Dependents in a geographic area where Aetna does not have a network of providers under contract to provide those services, Aetna may contract with another network of non-contracted providers ("non-Aetna networks") to provide the requested services. With respect to the services provided by providers who are not under contract to Aetna or any of its subsidiaries ("non-Aetna providers"), Customer acknowledges and agrees that, any other provisions of the Services Agreement notwithstanding:

    1. Aetna does not credential, monitor, or oversee the providers or the administrative procedures or practices of any non-Aetna networks;

    2. No particular discounts may, in fact, be provided or made available by any particular providers;

    3. Such providers may not necessarily be available, accessible, or convenient;

4. Any performance guarantees appearing in the Services Agreement shall not apply to services delivered by non-Aetna providers or networks;

5. Neither non-Aetna providers nor non-Aetna networks are to be considered contractors or subcontractors of Aetna; and

6. Such providers are providers in private practice, are neither agents nor employees of Aetna, and are solely responsible for the health care services they deliver.

Customer further agrees that, if Aetna subsequently establishes its own contracted provider network in a geographic area where services are being provided by a non-Aetna network, Aetna may terminate the non-Aetna network contract, and begin providing services through a network that is subject to the terms and provisions of the Services Agreement. Customer acknowledges that such conversion may cause disruption, including the possibility that a particular provider in a non-Aetna network may not be included in the replacement network.

25. Health Insurance Portability And Accountability Act (HIPAA) Compliance

In accordance with the services being provided under the Services Agreement, Aetna will have access to, create, and/or receive certain Protected Health Information ("PHI" as defined in Appendix A), thus necessitating a written agreement that meets the applicable requirements of the privacy and security rules promulgated by the Federal Department of Health and Human Services ("HHS"). Customer and Aetna mutually agree to satisfy the foregoing regulatory requirements through Appendix A to the Services Agreement.

As of the effective dates set forth below therein the provisions of Appendix A supercede any other provision of the Services Agreement, which may be in conflict with such Appendix on or after the applicable effective date.

26. Venue. The Services Agreement shall be governed by, and interpreted in accordance with, applicable Florida law. To the extent such Florida law does not govern, the Services Agreement shall be governed by Federal law. The courts in Polk County, Florida, or the applicable federal court in Florida, shall have sole and exclusive jurisdiction of any dispute related hereto or arising hereunder. No delay or failure of either party in exercising any right hereunder shall be deemed to constitute a waiver of that right. There are no intended third party beneficiaries of the Services Agreement. This Section and Sections 3 through 12 and 14 through 17 shall survive termination of the Services Agreement. The provisions of Section 13 shall survive termination only to the extent stated therein. The headings in the Services Agreement are for reference only and shall not affect the interpretation or construction of the Services Agreement.

DESCRIPTION OF SERVICES ADDENDUM

This Description of Services Addendum is an addendum to Services Agreement Number ASA-811370A between Aetna and Customer (as identified therein) and is incorporated into the Services Agreement by reference.

Subject to the terms and conditions of the Services Agreement, the Services available from Aetna are described below. Unless otherwise agreed in writing, only the Services selected by Customer in the Service and Fee Schedule (as modified by Aetna from time to time pursuant to Section 3 of the General Conditions Addendum) will be provided by Aetna. Additional Services may be provided at Customer's written request under the terms of the Services Agreement.

I. Administration Services:

A. Member and Claim Services:

1. Requests for Plan benefit payments for claims shall be made to Aetna on forms or other appropriate means approved by Aetna. Such forms (or other appropriate means) may include a consent to the release of medical, claims, and administrative records and information to Aetna. Aetna will process and pay the claims for Plan benefits incurred after the Effective Date using Aetna's normal claim determination, payment, and audit procedures, and applicable cost control standards in a manner consistent with the terms of the Plan and the Services Agreement. With respect to any Member who makes a request for Plan benefits which is denied on behalf of the Customer, Aetna will notify said Member of the denial and of said Plan Member's right of review of the denial in accordance with applicable state and federal law.

2. Whenever it is determined that benefits and related charges are payable under the Plan, Aetna will issue a payment of such benefits and related charges on behalf of the Customer. Funding of benefits and related charges shall be made as provided in Section 5 of the General Conditions Addendum.

3. Where the Plan contains a coordination of benefits clause, antiduplication clause, or provision(s) reducing benefits for injuries or illness caused or alleged to be caused by third parties, Aetna will administer all claims consistent with such provisions and any information concurrently in its possession as to duplicate coverage or the cause of the injury or illness. Aetna shall have no obligation to recover sums owed to the Plan by virtue of the Plan's rights to coordinate where the claim was incurred prior to the Effective Date. Aetna has no obligation to bring actions based on subrogation or lien rights, unless Subrogation Services are included herein, in which event its obligations are governed by Article IV of this Description of Services Addendum.

B. Plan Sponsor Services:

1. Aetna will assign an Account Executive to the Customer's account. The Account Executive will be available to assist the Customer in connection with the general administration of the Plan, ongoing communications with the Customer and administration, and record-keeping systems for ongoing operation of the Plan.

2. Upon request by the Customer and consent by Aetna, Aetna will implement amendments or modifications to the Customer's Plan. A charge may be assessed for implementing such amendment or modification. The Customer's administration services fees, as set forth in the Service and Fee Schedule, will be revised if the foregoing amendments or modifications increase Aetna's costs.

3. Aetna will provide the following reports to the Customer for no additional charge:

   (a) Monthly/Quarterly/Annual Accounting Reports - Aetna shall prepare the following accounting reports in accordance with the benefit-account structure for use by the Customer in the financial management and administrative control for the Plan benefits:

      (i) a monthly listing of funds requested and received for payment of Plan benefits;

      (ii) a monthly reconciliation of funds requested to claims paid within the benefit-account structure;

      (iii) a monthly or quarterly or annual listing of paid benefits;

(iv) quarterly or annual standard claim analysis report.

(b) Annual Accounting Reports - Aetna shall prepare standard annual accounting reports for each major benefit line under the Plan for the Services Agreement Period that include the following:

(i) forecast of claim costs;

(ii) accounting of experience; and

(iii) calculation of Customer reserve.

Any additional reporting formats and the price for any such reports shall be mutually agreed upon by the Customer and Aetna.

4. Aetna shall develop and install all agreed upon administrative and record keeping systems, including the production of employee identification cards.

5. Aetna shall design and install a benefit-account structure separately by class of Employees, division, subsidiary, associated company, or other classification desired by the Customer.

6. Aetna shall provide plan design and underwriting services in connection with benefit revisions, additions of new benefits, and extensions of coverage to new Employees and their Dependents.

7. Aetna shall provide cost estimates and actuarial advice for benefit revisions, new benefits, and extensions of coverage being considered by Customer.

8. Upon request of the Customer, Aetna will provide the Customer with information reasonably available to Aetna which is reasonably necessary for the Customer to prepare reports for the United States Internal Revenue Service and Department of Labor.

9. (a) Upon request of the Customer, Aetna shall prepare an Aetna standard Plan description, including benefit revisions, additions of new benefits, and extension of coverage under the Plan. If the Customer elects to have an Aetna non-standard Plan description, Aetna will provide a custom Plan description with all costs borne by the Customer; or

(b) Upon request of the Customer, Aetna will review the Customer prepared employee Plan descriptions, subject to the Customer's final and sole authority regarding benefits and provisions in the self-insured portion of the Plan. The Customer acknowledges its responsibility to review and approve all Plan descriptions and any revisions thereto, and to consult the Customer's legal counsel, at its discretion, with said review and approval.

Aetna shall have no responsibility or liability for the content of any of Customer's Plan documents, regardless of the role Aetna may have played in the preparation of such documents.

If the Customer requires both preparation (a) and review (b), there may be an additional charge.

10. Upon request by the Customer, Aetna will arrange for the printing of Plan descriptions, with all costs borne by the Customer.

11. Upon request by the Customer, Aetna will arrange for the custom printing of forms and identification cards, with all costs borne by the Customer.

II. Aetna Health Connections[SM] Services:

1. **Utilization Management Inpatient and Outpatient Precertification:**

   Inpatient Precertification: A process for collecting information prior to an inpatient confinement. The precertification process permits eligibility verification/confirmation, determination of coverage, and communication with the physician and/or Member in advance of the procedure, service or supply. Precertification also allows Aetna to identify Members for pre-service discharge planning and to identify and register Members for specialized programs such as Case Management and Disease Management.

   Outpatient Precertification (not applicable to Indemnity or PPO Products): A process for reviewing selected ambulatory procedures, surgeries, diagnostic tests, home health care, and durable medical equipment. The goals of this process are:

   a. Assessment of the level and quality of the services provided;

   b. Determination of the coverage of the proposed treatment;

   c. Identification of care and treatment alternatives, when appropriate; and

   d. Identification of Members for referral to specialized programs.

2. **Utilization Management Concurrent Review:** Concurrent review encompasses those aspects of patient management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment.

   Inpatient concurrent review is conducted telephonically or on-site at the facility where care is delivered.

   The concurrent review process includes:

   a. Obtaining necessary information from practitioners and providers regarding the care being provided to Members;

   b. Assessing the clinical condition of Members and the ongoing provision of medical services and treatments to determine benefit coverage;

   c. Notifying practitioners and providers of coverage determinations in the appropriate manner and within the appropriate time frame;

   d. Identifying continuing care needs early in the inpatient stay to facilitate discharge to the appropriate setting; and

   e. Identifying Members for referral to covered specialty programs such as Case Management, Behavioral Health and Disease Management.

3. **Utilization Management Discharge Planning:** This is an interdisciplinary process that assists Members as their medical condition changes and they transition from the inpatient setting. Discharge planning may be initiated at any stage of the Patient Management process. Assessment of potential discharge planning needs begins at the time of notification, and coordination of discharge plans commences upon identification of post discharge needs during precertification or concurrent review. This program may include evaluation of alternate care settings and identification of care needed after discharge. The goal is to provide continuing quality of care and to avoid delay in discharge due to lack of outpatient support.

4. **Utilization Management Retrospective Review:** Retrospective review is the process of reviewing coverage requests for initial certification after the service has been provided or when the Member is no longer an inpatient or receiving the service. Retrospective review includes making coverage determinations for the appropriate level of service consistent with the Member's needs at the time the service was provided after confirming eligibility and the availability of benefits within the Member's benefit plan.

5. **Next Generation Case Management:** The Aetna Case Management program is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

   Those Members with diagnoses and clinical situations where a specialized nurse, working with the Member and their physician, can make an impact to the course or outcome of care and/or reduce medical cost will be accepted into the program. Case Management staff strives to enhance the Member's quality of life, support continuity of care, facilitate provision of services in the appropriate setting and manage cost and resource allocation to promote quality, cost-effective outcomes. Case Managers collaborate with the Member, family, caregiver, physician and healthcare provider community to coordinate care, with a focus on closing gaps in the Member's care and maximizing quality outcomes.

   Aetna operates two types of case management programs:

   a. Complex Case Management targets Members who have already experienced a health event and are likely to have care and benefit coordination needs after the event. The objective for Case Managers is to identify care or benefit coordination needs which lead to faster/better clinical outcomes and/or reduced medical costs.

   b. Proactive Case Management targets Members who are misusing, over-using or under-using the health care system, leading them towards avoidable and costly health events. This program's objective is to confirm gaps in Members' care leading to their over-use, misuse or under-use, and working with the Member and their physician to close those gaps.

6. **Infertility Case Management:** Aetna's Infertility Case Management Program provides education and information resources for Members who are experiencing infertility. Depending on the plan selected, the program may guide eligible Members to a select network of infertility providers for covered or non-covered services. If the services are covered, Aetna's Infertility Management Unit issues any appropriate authorizations required under the Member's plan.

   Aetna's Basic Infertility Program coordinates covered diagnostic services and treatment of the underlying medical causes of infertility, helps Members understand complex infertility treatments and helps control treatment costs through care coordination and patient education.

7. **National Medical Excellence/Institutes of Excellence Program:** The National Medical Excellence program was created to help arrange for access to effective care for Members with particularly difficult conditions requiring transplants or complex cardiac, neurosurgical or other procedures, when the needed care is not available in a Member's service area. The program utilizes a national network of experienced providers and facilities selected based on their volume of cases and outcomes. The National Medical Excellence Unit provides specialized Case Management through the use of nurse case managers, each with procedure and/or disease specific training.

   The Aetna **Institutes of Excellence (IOE)** transplant network was established to enhance quality standards and lower the cost of transplant care for Aetna Members. It is made up of a select group of hospitals and transplant centers that meet quality standards for the number of transplants performed and their outcomes, as well as access criteria for Aetna Members. IOE facilities have agreed to specific contractual terms and conditions and are selected and recognized by transplant type. The following criteria is applied to each facility prior to being selected for the IOE network.

   a. Quality - enhanced organ-specific credentialing and quality standards.

   b. Access - the national availability of, and need for, transplant facilities on a transplant-specific basis. Need is assessed relative to the distribution of membership and relative incidence of transplant types.

c. Cost - provider contracts reflect lower negotiated rates.

8. **MedQuery℠:** The MedQuery program is a data-mining initiative, aimed at turning Aetna's data into information that physicians can use to improve clinical quality and patient safety. Through the program, Aetna's data is analyzed and the resulting information gives physicians access to a broader view of Aetna Member's clinical profile. The data which fuels this program includes claim history, current medical claims, pharmacy, physician encounter reports, and patient demographics. Data is mined on a weekly basis and compared with evidence-based treatment recommendations to find possible errors, gaps, omissions (meaning perhaps that certain accepted treatment regimens may be absent) or co-missions in care (meaning, for example, drug-to-drug or drug-to-disease interactions). When MedQuery identifies an Aetna Member whose data indicates that there may be an opportunity to improve care, outreach is made to the treating physician based on the apparent urgency of the situation. For Customers who have elected the buy-up of MedQuery with Member Messaging feature, in certain situations outreach will be made directly to the Member by MedQuery requesting that the Member discuss with their physician, specific opportunities to improve their care.

9. **Aetna Health Connections℠ Disease Management:** Aetna Health Connections℠ is Aetna's new approach to medical management, and is a critical component of Aetna's ongoing commitment to improve care for Members. Most traditional medical management programs focus only on the 20% of Members who are typically in poor health and represent the majority of medical costs. Aetna Health Connections℠ will continue to identify those Members at highest risks of deteriorating health, but expands its focus and programs to include well Members, too. Regardless of their health status, Members will find that Aetna offers programs or web-based tools to help them become more informed health consumers, more aware of their own health status, and more engaged in taking action to improve or maintain their health.

   Aetna Health Connections℠ also includes all of Aetna's existing medical management programs. However, some of the new and enhanced programs include:

   a. Enhanced Case Management Services.

   b. Redesigned and enhanced wellness offerings.

   c. A new, broadened disease management program.

   Aetna Health Connections℠ Disease Management is an enhancement to Aetna's medical/disease management spectrum and will target Members at risk for high cost who have actionable gaps in care, engage the Members at the appropriate level, and close gaps in care in order to avoid complications, improve clinical outcomes and demonstrate medical cost savings.

   While traditional disease management is focused on delivering education to Members about a specific chronic condition, Aetna Health Connections℠ focuses on the entire person with specific interventions driven by the CareEngine System.

10. **Beginning Right ℠ Maternity Program:** Beginning Right ℠ Maternity Program offers many benefits. Through an intensive focus on prevention, early treatment and education, the program provides women with the tools to help improve pregnancy outcomes and control maternity-care costs through a variety of services - including risk identification, care coordination by obstetrical nurses and board certified OB/GYNs and Member support.

11. **Informed Health Line:** Informed Health Line (IHL) provides Members with a toll-free 24-hour/7 day health telephonic access to registered nurses experienced in providing information on a variety of health topics. The nurses can contribute to informed health care decision-making and optimal patient/provider relationships through coaching and support. The nurses cannot diagnose, prescribe treatment or give medical advice but they can provide Members with information on a broad spectrum of health issues, including self-care, prevention, chronic conditions and complex medical situations. Members can also access the Audio Health Library, a recorded collection of more than 2,000 health topics, available in English and Spanish. Members can register on Aetna Navigator, our Member and consumer website, and access Healthwise Knowledgebase, another valuable resource of information on thousands of health topics.

The range of available service components are purchased according to the following categories:

a. **Nurseline 1-800# Only.** This includes toll-free telephone access to the Informed Health Line Nurseline.

b. **Service Plus**. This includes the following components:

   i. Toll-free telephone access to the Informed Health Line Nurseline.
   ii. Introductory program announcement letter.
   iii. Reminder postcards mailed directly to Members' homes through the year.
   iv. Semi-annual Activity Utilization (Customer reporting) Report.

c. **Optional Service Features**. These features may be purchased in conjunction with the "Service Plus" package and include:

   i. Additional introductory kit including Informed Health handbook, flyer with attached wallet cards, refrigerator magnet and package.
   ii Annual Member survey and Comprehensive Results Report which reflects outcomes, Member satisfaction and savings results.

12. **Wellness Counseling:** This service provides personalized decision support, educational materials, and targeted nurse outreach coaching Members to a healthier lifestyle through behavioral modification, education, and facilitation of the most effective utilization of Members' benefits. Additionally, action plans may be developed and reviewed with Members, as appropriate. Members are identified for participation in wellness counseling through completion of the Simple Steps To A Healthier Life® health risk assessment.

13. **Healthy Body, Healthy Weight:** This service is a voluntary, one-year program. Eligible Members access the program by taking the Web-based Simple Steps To A Healthier Life® health risk assessment. Participants are categorized as low, intermediate or high-risk. The frequency and intensity of program interactions are determined based on the Members' risk stratification and health status.

    All program participants receive an initial call from an Aetna registered nurse/nutritionist who will:

    a. Provide information on nutrition, healthy menus and exercise.

    b. Review available health information resources.

    c. Provide motivational tools, including a pedometer and discounts to a participating community-based weight loss program.

    d. Identify opportunities for referral to other Aetna programs (e.g., Disease Management, Case Management, Behavioral Health).

    e. Place a follow-up call to review the participant's progress and offer support.

    f. Based on their individual risk factors and health status, participants may also receive:

       i. Ongoing telephone outreach from and access to a weight loss therapist, to include a nutritional and "readiness-to-change" assessment.
       ii. Additional motivational tools to encourage participation.
       iii. Regular follow ups at 3-, 6-, and 9-month intervals to monitor weight loss, medication compliance (if applicable) and adherence to recommended exercise program.

14. **Enhanced Member Outreach Program℠:** This is a program which provides the Customer the option to purchase additional clinical services beyond Aetna's base patient management programs.

For Customers who have elected Level One Only:

Aetna will engage in outbound Member outreach calls to provide education and coaching to Members based on specific criteria. For example, nurses will contact Members by telephone before and after all scheduled overnight hospital stays (excluding maternity confinements). By reaching out to Members before and after scheduled hospital confinements, Aetna will provide Members with ways to better manage their health events, such as:

a. Assessment of a Member's preparedness for admission.

b. Evaluation for potential discharge planning needs.

c. Better education on how to avoid post-surgery complications through medication and treatment plan compliance.

For Customers who have elected a buy-up to Level Two (this is in addition to Level One):

Customers have the flexibility of selecting from the following 4 categories for additional outreach calls:

a. Frequent emergency room visits.

b. Pharmacy non-compliance (Aetna pharmacy data or imported pharmacy data required).

c. Multiple visits to multiple providers.

d. Non-compliant behavior (Med-Query program required).

15. **Healthy Insights Member Newsletter:** *Healthy Insights* is a newsletter that provides information to Members about Aetna's products, services and resources. It is the vehicle chosen to deliver many of Aetna's NCQA-required notices to its membership.

16. **Preventive (Health and Wellness) Mailings:** To support Customers' ongoing health and wellness strategies, Aetna sends reminders to HMO-based plan Members by mail and electronically at certain ages and stages of their lives. These reminders, which are sent at no cost to the Customer, make Members aware of important regular health screenings and other preventive services. They also assist Aetna with meeting regulatory and accreditation requirements. They include:

a. Adolescent Immunization Reminder.

b. Childhood Immunization Reminder.

c. Preventive Reminder for Influenza and Pneumococcal Vaccines and Colorectal Cancer Screening.

d. Hypertension and Cholesterol Management Reminders.

e. Women's Health Recommended Preventive Care Guidelines (for women ages 18-39).

f. Women's Health Recommended Preventive Care Guidelines (for women ages 40+).

In addition, Aetna will offer the following optional Health and Wellness mailings to Customers:

a. Women's Health Recommended Preventive Care Guidelines (for women ages 18-39 and women ages 40+). (Available to Customers with PPO based plans.)

b. "How to Talk to Your Doctor" booklet (in English and Spanish). (Available to HMO and PPO Customers.)

17. **Worksite Services:** Aetna's Worksite Services help employers engage and educate their employees about wellness at the workplace. These offerings provide turnkey solutions to support employers' overall wellness strategies, increase consumerism and promote informed-decision making. Offerings include:

    a. Onsite Health Screenings (blood pressure, diabetes, cholesterol, DMI, etc.).

    b. Onsite Workshops: education on specific health conditions and diseases (cardiovascular disease, diabetes, cancer screening, etc.).

    c. Special Awareness Campaigns: health campaigns that can be customized to meet Customer needs.

    d. Worksite Educational Resources: turnkey educational programs that focus on Women's Health, Men's Health and Children's Health.

18. **Simple Steps To A Healthier Life®:** Aetna InteliHealth Inc. ("Aetna InteliHealth"), a Delaware corporation and an indirect wholly-owned subsidiary of Aetna Inc. and an affiliate of Aetna Life Insurance Company ("Aetna") (Aetna InteliHealth and Aetna are collectively referred to as "InteliHealth"), has developed an internet-based comprehensive management information resource, known as "Simple Steps To A Healthier Life" (the "Life Program") and located at www.simplestepslife.com, to be hosted by Aetna InteliHealth and designed for the eligible employees and dependents of subscribing employers (the "Users"). The Life Program is an online service that offers advice relating to disease prevention, condition education, behavior modification and health promotion programs that may contribute to the health and productivity of employees. The Life Program allows Users to create a health risk assessment profile that generates a personalized health action plan. The health action plan identifies certain potential risks and directs participants to personalized programs and services encouraging healthy lifestyle changes.

    Refer to Appendix B for features, system requirements and certain terms and conditions for use of this service. Customer affirms that by selecting Simple Steps To A Healthier Life® on the Service and Fee Schedule attached to and made a part of the Services Agreement, Customer agrees to the terms and conditions of use set forth in Appendix B.

19. **Personal Health Record:** Personal Health Record (PHR) is a collection of personal health information about an individual Member that is stored electronically. The PHR is designed so that the member can maintain his or her own comprehensive health record. In a PHR developed by a health plan, health information is commonly derived from claims data collected during plan administration activities. Health information may be supplemented with information entered by the health plan member.

    Aetna offers the Aetna ***CareEngine*®-Powered PHR** (for Customers who have elected this buy-up option). The *CareEngine*-Powered *PHR* combines the basic functions of a PHR with a personalized, proactive, evidence-based messaging platform. As above, it's pre-populated with health information from Aetna's claims system. Members can also input personal health information themselves. An online health assessment is available to facilitate the self-reporting process. The Aetna *CareEngine-Powered PHR* also offers:

    Personalized messaging and alerts based on medical claims, pharmacy claims, and demographic information, and lab reports.

    Original condition-specific content developed and reviewed by doctors from the Harvard Medical School and the Aetna InteliHealth editorial team.

    Aetna's personalized, interactive health and wellness program, *Simple Steps To A Healthier Life.*

    Informed Care Decisions, an online decision support tool that provides treatment information for more than 40 diseases and conditions.

    Aetna offers a PHR program called Health Trackers Incentive that may include an incentive to encourage members to enter their personal information and create a more complete picture of their health. This incentive will be paid out on a quarterly basis; the amount of the incentive is determined by the Customer.

20. **Focused Psychiatric Review (FPR):** This is a program which provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to appropriate lengths, assess medical necessity and appropriateness of care, and control costs. This program includes a precertification process which collects information prior to an inpatient confinement, determination of the coverage of the proposed treatment, assessment of the level of services provided, as well as concurrent review which monitors a Member's progress after a patient is admitted.

21. **Managed Behavioral Health:** This is a set of services that includes both inpatient and outpatient care management.

    a. Inpatient Care Management provides phone-based utilization review of inpatient behavioral health (mental health and chemical dependency) admissions intended to contain confinements to appropriate lengths, assure medical necessity and appropriateness of care, and control costs. Inpatient Care Management provides precertification, concurrent review and discharge planning of inpatient behavioral health admissions. These services also include identification of Members for referral to specialized programs such as Behavioral Health Disease Management programs, Intensive Case Management or Medical Psychiatric Case Management.

    b. Outpatient Care Management includes precertification on a limited number of selected services. Where precertification is required, the request for services is reviewed against a set of criteria established by clinical experts and administered by trained staff, in order to determine coverage of the proposed treatment. Where precertification is not required, cases are identified for outpatient case management through the application of clinical algorithms.

22. **Intensive Case Management:** This program is designed for Members who have complex behavioral health (mental health and chemical dependency) conditions that require a specialized approach in order for care to be effective in relieving symptoms and improving the quality of their lives. Intensive Case Management is a process of identifying these high risk persons, assessing opportunities to coordinate care among multiple providers, identifying opportunities to improve treatment compliance, and facilitating coordination among support groups and supportive family members. These activities are designed to improve the individual Member's clinical condition and lower readmission rates.

23. **Medical Psychiatric Case Management:** The Medical Psychiatric Case Management program (Med Psych) is designed to help Members who have simultaneous medical and behavioral health conditions. As one condition may affect the successful treatment of the other, the need for care coordination between Medical Management nurses and Behavioral Health case managers is high. Members enrolled in this program are identified through the efforts of our medical and behavioral health case/disease managers who screen for co-morbid conditions. Additionally, enrollees can be identified through Aetna's predictive models and clinical algorithms. The Med Psych case managers provide service coordination with medical case managers as well as follow-up support for the Member.

24. **Depression Disease Management:** This program facilitates the application of evidence-based treatment intervention and enhances the cost-effective use of pharmacy benefits to maximize responses to antidepressant medication. The program consists of the following components: self-assessment for depression and co-morbid disorders; online services related to depression and its treatment; decision-support tools; and case management telephonic outreach and coordination with pharmacy, primary care physicians and behavioral health professionals to coordinate care and access to services as well as enhance compliance.

25. **Anxiety Disease Management:** This program facilitates the application of evidence-based treatment interventions and enhances the cost-effective use of pharmacy benefits to maximize management of, and recovery from, the symptoms of anxiety disorders. Members are identified for this program, using claims data and referrals and are then screened by a behavioral health professional to determine appropriate intervention. For those Members identified with chronic anxiety diagnoses and/or medical diagnoses with associated anxiety, case management may be deemed appropriate.

26. **Alcohol Disease Management:** This program varies to best meet the needs of the Member who has been identified, early in the course of the disease, the more chronic alcoholic, or an individual with another psychiatric disorder such as depression. As appropriate, clinicians with expertise in alcohol treatment reach out to the Member to provide support and education using case management and relapse prevention strategies. There can be collaboration with behavioral health providers, the primary care physician or family members and facilitated linkages for services.

27. **Psychiatric Disability Case Management:** This holistic program helps Members on disability who struggle with psychiatric problems by assessing their individual needs, coordinating appropriate treatment, and developing an effective overall case management plan. The program offers face-to-face evaluation during the first week of disability; individualized assessment and case management plan; one disability care clinician to manage the case and serve as the point of contact in coordinating care; access to specialty-trained disability network health care professionals; support for the transition back to work and post-employment follow up with Member and physician to ensure care needs are being met.

28. **Quit Tobacco:** This program is designated to provide helpful tools to Members who want to stop using tobacco. Members may opt to participate in the voluntary, limited-duration program by calling a toll-free number, or by using Aetna's Navigator internet site. The program offers Members access to telephonic counseling, educational materials, including a self-help guide, and interactive web tools. Members who have registered for the program, completed the health assessment questionnaire and completed certain coaching sessions may also have access to the limited supply of over the counter nicotine replacement therapy items (gum, patch and lozenge).

29. **Aetna's Rx Check:** Rx Check is a suite of 6 rapid retrospective clinical drug utilization review programs designed to promote Member safety and increase cost-savings. Programs generate letters to specific physicians and Members who meet program criteria informing them of opportunities to improve quality and/or save money. The six programs are:

    a. **Acute Frequency** - A prescription filled for a multiple daily dose of a proton pump inhibitor which may be able to be controlled with a once-daily dosing.

    b. **Therapeutic Duplication** - Prescriptions filled for two medications in the same therapeutic class.

    c. **Drug Interaction** - Prescriptions filled for any of approximately sixty medication combinations that have been identified as having a "clinically significant" interaction when used together.

    d. **High Utilization** - Multiple prescriptions filled for medications that potentially may be misused.

    e. **Brand to Generic** - Prescriptions filled for brand-name medications that have A-rated generic equivalents available.

    f. **Retail to Mail** - Program will educate Members in selected plans, who fill maintenance medications at a participating retail pharmacy, of the cost savings they can realize by using Aetna Rx Home Delivery on future prescriptions.

30. **Healthy Lifestyle Coaching:** The Healthy Lifestyle Coaching program provides online educational materials, web-based tools and telephonic coaching interventions with a primary health coach that utilizes incentives and rewards to encourage engagement and continued program participation. The program is designed to help members quit smoking, manage their weight, deal more effectively with stress and learn about proper nutrition and physical fitness.

31. **High Tech Radiology Program**: The radiology program is to promote the most appropriate and effective use of outpatient diagnostic imaging services. Aetna will maintain broad and national or regional access and experience interacting with free-standing radiology network facilities which include the following services: Computed Tomography/Coronary Computed Tomography Angiograph (CT/CTA), Magnetic Resonance Tomography, Magnetic Resonance Angiography (MRIs/MRAs), Nuclear Medicine and Positron Emission Tomography (PET) and/or PET/CT Fusion. The High Tech Radiology Program will be administered by Aetna vendors through a clinical certification process. This program should result in the following benefits:

- Immediate reductions in current radiology spent for unnecessary or inappropriate services
- Utilization management for clinically appropriate and cost-effective use of Diagnostic Imaging Services.
- Improved services and quality and customer satisfaction.

Vendors can assist physicians or their staff in finding the most cost-effective, quality radiology facility closest to the managed member's home. Aetna will maintain oversight on Vendors operations and ensure procedures are consistent with Company policies and procedures and meet with the accreditation standards of NCQA and URAC.

32. **Flexible Medical Model**: This program provides the Customer with the option to purchase more clinical resources devoted specifically to their Members. The Flex Model provides a Single Point of Contact Nurse (SPOC) and designated team to handle all case management activities for three levels of Flex Model Options, as elected. Aetna will engage in outbound Member outreach calls to provide case management support based on specific criteria.

    Includes a designated team to provide centralized case management services for all case management activities (i.e., Case Management referrals, PULSE assessment and High Dollar Claims)

    - Single Point of Contact Nurse designated for the plan sponsor, with appropriate back up.
    - Nurse Case Managers make pre-admission and post discharge calls, for a limited number of targeted diagnoses, to assess the Member's health care needs and to provide information that will help meet their specific needs. To accomplish this, the Case Managers:

      Assess the Member's preparedness for admission.

      Evaluate the potential for discharge planning needs.

      Provide guidance on how to avoid post-surgery complications, using pain medications as prescribed, following their treatment plan, and contacting their physician early if they have questions about the course of recovery.

    - Customization to the CM trigger list, such as High Dollar claims reviewed at a lower threshold.

    Includes Option 1 elements plus:

    - Pre-admission and Post Discharge calls for all diagnoses/conditions except maternity and behavioral health.
    - Outreach to Members based on PULSE assessment who have scores of 10 or greater or one or more action flags.

    Includes Option 2 elements plus:

    - Additional outreach options as determined by the plan sponsor:

      Frequent Emergency Room Visits.

      Informed Health Line call backs;

      Post Partum Calls.

      Pharmacy Non-Compliance (Aetna pharmacy data or imported pharmacy data required).

      Multiple Visits to Multiple Providers.

III. Network Access Services:

A. Aetna shall provide Members with access to Aetna's network hospitals, physicians and other health care providers ("Network Providers") who have agreed to provide services at agreed upon rates and are participating in the Plan covering the Members.

B. Aetna reserves the right to set a minimum plan benefit design structure for in-area network claims to which Customer must comply in order to participate in Aetna's network program.

C. Aetna will provide Customer with physician directories in an amount up to 100% of eligible Employees plus 20% of the current enrolled Employees. Customer shall pay the costs of providing any additional directories which it requests.

IV. Subrogation Services:

Aetna will provide assistance to Customer for subrogation/reimbursement services, which will be delegated to an organization of Aetna's choosing in accordance with the Section 19 of the General Conditions Addendum. Any reference in this section to "Aetna" shall be deemed to include a reference to its contracted representative, unless a different meaning is clearly required by the context.

Subrogation/ reimbursement language must be included in the Customer's summary plan description (SPD) and the SPD must be finalized and available to Customer's employees before subrogation/reimbursement matters can be investigated and pursued. Aetna will continue to process claims during the investigation process. Aetna will not pend or deny claims for subrogation/reimbursement purposes.

Aetna or its contracted representative shall retain a percentage of any monies collected while pursuing subrogation/ reimbursement recoveries. This is referred to as the "standard fee" and includes reasonable expenses. Reasonable expenses include but are not limited to (a) collection agency fees, (b) police and fire reports, (c) asset checks, (d) locate reports and (e) attorneys' fees.

Aetna shall advise Customer if the pursuit of recovery requires initiation of formal litigation. In such event, Customer shall have the option to approve or disapprove the initiation of litigation.

Aetna will credit net recoveries to the Customer. Aetna does not adjust individual member claims for subrogation/reimbursement recoveries.

With the exception of any claims made by the Customer's employees that are covered under the Customer's Workers Compensation policy, Aetna has the exclusive discretion: (a) to decide whether to pursue potential recoveries on subrogation/reimbursement claims; (b) to determine the reasonable methods used to pursue recoveries on such claims, subject to the proviso with respect to initiation of formal litigation above; and (c) to decide whether to accept any settlement offer relating to a subrogation/ reimbursement claim.

If no monies are recovered as a result of the subrogation/reimbursement pursuit, no fees or expenses incurred by Aetna for subrogation/reimbursement activities will be charged to Customer.

Notwithstanding the above, except for (i) claims made by the Customer's employees that are covered under the Customer's Workers Compensation policy, and (ii) those claims where Aetna has decided not to pursue potential recoveries on subrogation/reimbursement claims, should Customer pursue, recover by settlement or otherwise, waive any subrogation/ reimbursement claim, or instruct Aetna to cease pursuit of a potential subrogation claim, Aetna will be entitled to its standard fee, which will be calculated based on the full amount of claims paid at the time Customer resolves the file or instructs Aetna to cease pursuit.

If Customer notifies Aetna of its election to terminate the Services provided by Aetna, all claims identified for potential subrogation/reimbursement recovery prior to the date notification of such election is received (i.e., pending claims) shall be handled to conclusion by Aetna and shall be governed by the terms of this provision, unless otherwise mutually agreed. Aetna will not investigate or handle subrogation/reimbursement cases or recoveries on any matters identified after Customer's termination date.

NATIONAL ADVANTAGE PROGRAM ADDENDUM

The National Advantage Program ("NAP") is an addendum to Services Agreement Number ASA-811370A between Aetna and Customer (as identified herein) and is incorporated into the Services Agreement by reference.

I. National Advantage Program

A. Summary

NAP provides access to contracted rates for many medical claims that would otherwise be paid as billed under indemnity plans, the out-of-network portion of managed care plans, or for emergency/medically necessary services not provided within the network. When available, these contracted rates will produce savings for the Customer.

Aetna contracts with several national third-party vendors to access their contracted rates. In addition, a significant number of Aetna directly-contracted rates are available for members with indemnity benefits. Aetna will access third-party vendor rates where Aetna directly-contracted rates are not available. If no contracted rate is available, Aetna will attempt to negotiate an Ad-Hoc Rate (case specific discount) with non-NAP participating providers for certain larger claims or will apply Facility Charge Review, as applicable and as described below.

B. Claim Submission/Payment Process

Providers should bill Aetna directly for Covered Services. The Member should not make payment at the time of service. When the Provider submits the claim, Aetna will process it at the contracted rate (when applicable) and reflect the contracted amount in any explanation of payments made that the Member and Provider receives. The Member would then be responsible for any applicable coinsurance, deductible or non-covered service, based upon the plan of benefits.

II. National Advantage Program – Facility Charge Review

Facility Charge Review is an optional component of NAP. It is only available in conjunction with the National Advantage Program, and is not available separately.

A. Summary

Where a contracted rate is not available under NAP, the Facility Charge Review Program provides reasonable charge allowances for most inpatient and outpatient facility claims under Members' indemnity plans and the out-of-network portion of Members' managed care plans or for emergency/medically necessary services not provided within the network. When utilized, these reasonable charges will produce savings for the Customer.

B. Claim Submission/Payment Process

When an inpatient or outpatient facility claim exceeds a threshold (currently $ 1,000) and Aetna does not have access to a contracted rate, Aetna will review billed charges for financial reasonableness for the geographic area where the service was provided. Payment to the facility will be based on the Reasonable Charge Amount. Any excess will be considered not covered as it exceeds the reasonable charge (as defined under the Plan).

Though many facilities accept the Reasonable Charge Amount as payment in full, there may be circumstances where facilities may not accept the determination of the reasonable charge and may balance bill the Member. In the event that a Member is balance billed, Aetna has a review process and will initiate negotiations with the facility in an attempt to come to a mutually agreeable payment amount.

Aetna will negotiate with the facility so that the Member is not responsible for any charges in excess of any applicable deductible and coinsurance/copayments.

The explanation of benefits that the Member receives from Aetna, if applicable, will indicate that the amount paid is based upon the Reasonable Charge Amount and will request that the Member contact Aetna should the Member be balance billed.

The amount actually paid to the provider under the Facility Charge Review Program will be used as the basis for the calculation of the Member's coinsurance and deductibles.

III. National Advantage Program – Itemized Bill Review

Itemized Bill Review is an optional component of NAP. It is only available in conjunction with the National Advantage Program, and is not available separately.

Prior to claim adjudication when an inpatient facility claim exceeds a threshold (currently $20,000) and Aetna's contracted rate with provider uses a "percentage of billed charges" methodology, Aetna will forward the claim to the vendor for review. The billed charges will be reviewed for billing inconsistencies and errors. The vendor examines each claim and provides Aetna with billing error detail and the amount of eligible covered (payable) charges. Aetna then pays the claim using the contracted rate, a percentage of this adjusted amount.

When an inpatient facility claim is reduced based on the bill review, the Member's EOB will identify an IBR reduction in the "not payable" column to show that the Member is not responsible for the difference between the billed charges and the actual paid amount. The amount actually paid to the provider under the Program will be used as the basis for the calculation of the Member's coinsurance and deductibles. The Member is only responsible for the applicable coinsurance and deductible. Our provider contracts do not permit the facility to bill the member for the billing adjustments.

IV. Terms and Conditions

A. Customer Charges For Provider Payments

Subject to the terms herein, Aetna agrees that for Covered Services rendered by a Provider for which Aetna has a) accessed a contracted rate, or b) negotiated an Ad-Hoc rate, or c) applied a Reasonable Charge Amount for facility services, or d) applied an Itemized Bill Review reduction, Customer shall be charged the amount paid to the Provider. This amount shall be equal to the contracted rate, Ad-Hoc Rate, or Reasonable Charge Amount less any payments made by the Member in accordance with the Plan.

B. Access Fees

1. As compensation for the services provided by Aetna under NAP for savings achieved, Customer shall pay an Access Fee to Aetna as described in the Service and Fee Schedule (excluding Aggregate Savings with respect to claims for which Aetna is liable for funding, e.g., claims in excess of an individual or aggregate stop loss point).

2. Access Fees shall be paid by the Bank to Aetna via wire transfer or such other reasonable transfer method agreed upon by Aetna and the Bank. The Customer agrees to provide funds through its designated bank sufficient to satisfy the Access Fee in accordance with the banking agreement between the Customer and the Bank, i.e., Access Fees will be included in the request from the Bank for payment/funding of claims.

3. An Access Fee will be credited to the Customer for any Aggregate Savings subsequently reduced or eliminated for which the Customer has already paid an Access Fee.

4. Aetna shall provide a quarterly report of Aggregate Savings and Access Fees. Access Fees may be included with claims in other reports.

C. Member Information Regarding National Advantage Program

For most products/plans, Customer will inform Members of the availability of NAP. Further, a Customer's Plan document language defining reasonable charge or recognized charge must conform to Aetna requirements. Aetna shall provide information regarding participating Providers on DocFind®, Aetna's online provider listing, on our website at www.Aetna.com or by other comparable means.

D. Definitions

As used herein:

"Access Fee" means the amount(s) to be paid by Customer to Aetna for access to the savings provided under NAP.

"Ad-Hoc Rate" means the rate which was negotiated for a specific claim in the absence of a pre-negotiated contracted rate with a Provider.

"Aggregate Savings" means the difference between (i) the amount which would have been due or otherwise paid to Providers for Covered Services without the benefit of NAP, and (ii) the amount due Providers for Covered Services as a result of NAP.

"Covered Services" means the health services subject for which charges are paid pursuant to the Plan.

"Member" means a person who is eligible for coverage as identified and specified under the terms of the Plan.

"Plan" means the portion of Customer's employee welfare benefit plan, which provides medical benefits to Members as administered by Aetna.

"Providers" means those physicians, hospitals and other health care providers whose services are available at a savings under NAP.

"Reasonable Charge Amount" means the amount determined by Aetna to be a reasonable charge for a service in the geographic area where the service was provided to the Member.

E. Customer Acknowledgements

Customer acknowledges that:

1. The NAP listing of Providers includes Providers that are (i) participating by virtue of direct contracts with Aetna and its affiliates, and (ii) participating by virtue of Aetna's contracts with unaffiliated third parties that have contracts with Providers, and provide Aetna with access to these contracted rates for the purpose of NAP.

2. Aetna does not guarantee (a) any particular discounts or any level of discount will be made available through providers listed as participating in NAP; (b) any obligation to make any specific Providers or any particular number of Providers available for use by Plan participants. Aetna does not credential, monitor or oversee those Providers who participate through third party contracts. Providers listed as participating in NAP may not necessarily be available or convenient.

3. Aetna is not responsible for the acts or omissions of any provider listed as participating in NAP. All such providers are providers in private practice, are neither agents nor employees of Aetna, and are solely responsible for the health care services they deliver.

4. The following claim situations may not be eligible for NAP:

   - Small claims (currently certain claims below $151 and claims below $1000 for which there is no contracted rate).
   - Claims involving Medicare or coordination of benefits (COB).
   - Claims that have already been paid directly by the Member.

F. General Provisions

1. Neither party shall be liable to the other for any consequential or incidental damages whatsoever. Aetna's aggregate cumulative liability to the Customer for all losses or liabilities arising under or related to this Addendum, regardless of the form of action, shall be limited to the Access Fees actually paid to Aetna by the Customer for services rendered; provided, however, this limitation will not apply to or affect any performance standards set forth in the Agreement.

2. The terms and conditions of this Addendum shall remain in effect for any claims incurred prior to the termination date that are administered by Aetna after the termination date. Except as provided herein, this Addendum is subject to all of the provisions of the Services Agreement, provided, however, in the event of any conflict between this Addendum and the Services Agreement, the terms of this Addendum shall govern.

APPENDIX A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

THIS APPENDIX between Polk County, a political subdivision of the State of Florida("Customer") and Aetna Life Insurance Company or any of its corporate affiliates ("Aetna") is an attachment to Services Agreement Number ASA-811370A between Aetna and Customer (the "Agreement") and is incorporated by reference therein.

In conformity with the regulations at 45 C.F.R. Parts 160-164 (the "Privacy and Security Rules") Aetna will under the following conditions and provisions have access to, maintain, transmit, create and/or receive certain Protected Health Information:

1. **Definitions.** The following terms shall have the meaning set forth below:

   (a) C.F.R. "C.F.R." means the Code of Federal Regulations.
   (b) Designated Record Set. "Designated Record Set" has the meaning assigned to such term in 45 C.F.R. 164.501.
   (c) Electronic Protected Health Information. "Electronic Protected Health Information" means information that comes within paragraphs 1(I) and (ii) of the definition of "Protected Health Information", as defined in 45 C.F.R. 160.103.
   (d) Individual. "Individual" shall have the same meaning as the term "individual" in 45 C.F.R. 160.103 and shall include a person who qualifies as personal representative in accordance with 45 C.F.R. 164.502 (g).
   (e) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C.F.R. 160.103, limited to the information created or received by Aetna from or on behalf of Customer.
   (f) Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 C.F.R. 164.103.
   (g) Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
   (h) Security Incident. "Security Incident" has the meaning assigned to such term in 45 C.F.R. 164.304.
   (i) Standard Transactions. "Standard Transactions" means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 C.F.R., Parts 160-162.

2. **Obligations and Activities of Aetna**

   (a) Aetna agrees to not use or disclose Protected Health Information other than as permitted or required by this Appendix or as Required By Law.
   (b) Aetna agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Appendix.
   (c) Aetna agrees to mitigate, to the extent practicable, any harmful effect that is known to Aetna of a use or disclosure of Protected Health Information by Aetna in violation of the requirements of this Appendix.
   (d) Aetna agrees to report to Customer any Security Incident or any use or disclosure of the Protected Health Information not allowed by this Appendix of which it becomes aware, except that, for purposes of the Security Incident reporting requirement, the term "Security Incident" shall not include inconsequential incidents that occur on a daily basis, such as scans, "pings", or other unsuccessful attempts to penetrate computer networks or servers containing electronic PHI maintained by Aetna.
   (e) Aetna agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Aetna on behalf of Customer agrees to the same restrictions and conditions that apply through this Appendix to Aetna with respect to such information.
   (f) Aetna agrees to provide access, at the request of Customer, and in the time and manner designated by Customer, to Protected Health Information in a Designated Record Set, to Customer or, as directed by Customer, to an Individual in order to meet the requirements under 45 C.F.R. 164.524.
   (g) Aetna agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Customer directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Customer or an Individual, and in the time and manner designated by Customer.
   (h) Aetna agrees to make (i) internal practices, books, and records, including policies and relating to the use and disclosure of Protected Health Information received from, or created or received by Aetna on behalf of, Customer, and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to the Secretary, in a time and manner designated by the Secretary, for purposes of the Secretary determining Customer's compliance with the Privacy and Security Rules.
   (i) Aetna agrees to document such disclosures of Protected Health Information as would be required for Customer to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

(j) Aetna agrees to provide to Customer, the information collected in accordance with this section, to permit Customer to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.
(k) With respect to Electronic Protected Health Information, Aetna shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Customer, as required by 45 C.F.R. Part 164, Subpart C.
(l) With respect to Protected Health Information, Aetna shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information, agrees to implement reasonable and appropriate safeguards to protect it.
(m) If Aetna conducts any Standard Transactions on behalf of Customer, Aetna shall comply with the applicable requirements of 45 C.F.R. Parts 160-162.

3. **Permitted Uses and Disclosures by Aetna**

3.1 General Use and Disclosure

Except as otherwise provided in this Appendix, Aetna may use or disclose Protected Health Information to perform its obligations under the Agreement, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Customer or the minimum necessary policies and procedures of Customer.

3.2 Specific Use and Disclosure Provisions

(a) Except as otherwise provided in this Appendix, Aetna may use Protected Health Information for the proper management and administration of Aetna or to carry out the legal responsibilities of Aetna.
(b) Except as otherwise provided in this Appendix, Aetna may disclose Protected Health Information for the proper management and administration of Aetna, provided that disclosures are Required by Law, or Aetna obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Aetna of any instances of which it is aware in which the confidentiality of the information has been breached.
(c) Except as otherwise provided in this Appendix, Aetna may use Protected Health Information to provide data aggregation services to Customer as permitted by 45 C.F.R. 164.504(e)(2)(i)(B).
(d) Aetna may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. 164.502(j)(1).

4. **Obligations of Customer**

4.1 Provisions for Customer to Inform Aetna of Privacy Practices and Restrictions

(a) Customer shall notify Aetna of any limitation(s) in its notice of privacy practices of Customer in accordance with 45 C.F.R. § 164.520, to the extent that such limitation(s) may affect Aetna's use or disclosure of Protected Health Information.
(b) Customer shall provide Aetna with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Aetna's use or disclosure of Protected Health Information.
(c) Customer agrees that it will not furnish or impose by arrangements with third parties or other Covered Entities or Business Associates special limits or restrictions to the uses and disclosures of its PHI that may impact in any manner the use and disclosure of PHI by Aetna under the Services Agreement and this Appendix, including, but not limited to, restrictions on the use and/or disclosure of PHI as provided for in 45 C.F.R. 164.522.

4.2 Permissible Requests by Customer

Customer shall not request Aetna to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rules if done by Customer.

5. **Term and Termination**

(a) Term. The provisions of this Appendix shall take effect (i) with respect to 45 C.F.R. Part 164, Subpart E (the "Privacy Rule"), on the effective date of the Agreement, and (ii) with respect to 45 C.F.R. 164, Subpart C (the "Security Rule"), the later of (1) April 21, 2005, or the compliance date applicable to the Customer under the Security Rule, if different than April 21, 2005, and (2) the effective date of the Agreement, and shall terminate when protections are extended to Protected Health Information, in accordance with Section 5(c) of this Appendix.

(b) Termination for Cause. Without limiting the termination rights of the parties pursuant to the Agreement and upon Customer's knowledge of a material breach by Aetna, Customer shall either:

(i) provide an opportunity for Aetna to cure the breach or end the violation or terminate the Agreement, if Aetna does not cure the breach or end the violation within the time specified by Customer;

(ii) immediately terminate the Agreement, if cure of such breach is not possible;

(iii) if neither termination nor cure are feasible, Customer shall report the violation to the Secretary.

(c) Effect of Termination. The parties mutually agree that it is essential for Protected Health Information to be maintained after the expiration of the Services Agreement for regulatory and other business reasons. The parties further agree that it would be infeasible for Customer to maintain such records because Customer lacks the necessary system and expertise. Accordingly, Customer hereby appoints Aetna as its custodian for the safe keeping of any record-containing PHI that Aetna may determine it is appropriate to retain. Notwithstanding the expiration of the Services Agreement, Aetna shall extend the protections of this Appendix to such Protected Health Information, and limit further use or disclosure of the Protected Health Information to those purposes that make the return or destruction of the Protected Health Information infeasible.

6. **Miscellaneous**

(a) Regulatory References. A reference in this Appendix to a section in the Privacy and Security Rules means the section as in effect or as amended, and for which compliance is required.

(b) Amendment. Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, the safeguarding of Electronic Protected Health Information, or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend the Agreement and this Appendix in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such amendment, it shall so notify the first party in writing within thirty (30) days of the notice. If the parties are unable to agree on an amendment within thirty (30) days thereafter, then either of the parties may terminate the Agreement on thirty (30) days written notice to the other party.

(c) Survival. The respective rights and obligations of Aetna under sections 5(c) and 6 of this Appendix shall survive the termination of this Appendix.

(d) Interpretation. Any ambiguity in this Appendix shall be resolved in favor of a meaning that permits Customer to comply with the Privacy and Security Rules.

(e) No third party beneficiary. Nothing express or implied in this Appendix or in the Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever.

(f) Governing Law. This Appendix shall be governed by and construed in accordance with the same internal laws as that of the Agreement.

The parties hereto have executed this Appendix with the execution of the Agreement.

APPENDIX B

SIMPLE STEPS TO A HEALTHIER LIFE – FEATURES, SYSTEM REQUIREMENTS AND TERMS AND CONDITIONS OF USE

I. Base Features:

Simple Steps to a Healthier Life (the "Life Program") includes the following base features:

Employer Features:

- Display of Employer Corporate Logo (optional feature) – the corporate logo of the Employer will be displayed within the Life Program navigation.
- Employer Broadcast Messaging by Location (optional feature) – text area used to broadcast health and benefits information to the User demographically. Limited to one update per quarter.
- Your Health Benefits – up to 10 links to Employer-specified Web sites of health-care insurers (Aetna Navigator).
- Other References & Resources - links to Employer-specified health and wellness references and resources. The User will need to register separately, if registration is applicable, to access these links from the Life Program.
- Standard Quarterly Management Reports are consistent with HIPAA guidelines (reports will not be provided to the Employer if the User population, by a specific category, is below 30).
- Event Tracking (optional feature) – ability to track an event/activity and a certain time period in order to provide incentives to the User. The fulfillment of the incentives is on behalf of the Employer and Employer understands and agrees that Employer is solely responsible for all costs and expenses in connection with the Rewards and Incentive Program. InteliHealth to provide Employer with a monthly report outlining Users who have completed events/activities, as defined by Employer.
- Reward Program (optional feature) – Opt in page will be displayed for Employers Users to enroll in the Reward Program and educate themselves about the rules of the program.
- Communications and Promotional Kit – a CD-based resource to assist in the coordination, preparation and communication strategies for the pre-launch, launch and on-going support of the Life Program.

User Features:

- Online Health Risk Assessment (the "HRA") – the User completes an online health risk assessment (the "HRA") that is a set of health-related questions. The HRA evaluates the answers, provided by the User, based on a series of clinical risk factors that are used to determine if the User is at risk for one or more medical conditions. The User will receive a summary report, identifying the at-risk conditions, as well as other health-related areas the User may need to focus on.
- Health Action Plan - in addition to the summary report, the User will receive a health action plan that is generated based upon the User's completed HRA. The health action plan is stored within the "Take Action" section of the Life Program homepage. The health action plan provides information on certain ways to achieve better health.
- Healthy Living and Other Programs - once a User completes the HRA, the User can access certain healthy living programs from the health action plan. These programs provide information on particular at-risk conditions identified by the completed HRA.
- Preventive Health Schedule - a listing of certain preventive health-care activities applicable to the User, based on the User's age and gender.

- Condition Module - certain condition modules will provide educational information, interactive illustrations and videos, human-interest stories, if any, relating to the condition, and healthy living information.

- Wellness Kits To Go – tools to enhance a User's knowledge about healthy lifestyle changes and how to effectively communicate with their health care providers.

- Informed Health Line Text Promotional Message (optional feature)– this is a separately purchased product outside of the Life Program. A text 800 number message, to contact a nurse virtually 24 hours a day, 7 days a week, will be displayed within the Life Program navigation if the Employer purchased the product through Aetna Inc.

- Data Feed to Aetna's Electronic Total Utilization Management System (eTUMS) (optional feature) – opt-in page for Users to consent to have their self-reported data sent to an Aetna healthcare professional (case manager).

II. User System Requirements

The User will need the following system requirements to access the Life Program:

- Standard Web Browser Requirement: Netscape Navigator 4.x or Microsoft Internet Explorer, versions 4.0 or higher. If the desktop is on a network with a firewall, the network must accept multiple cookies and javascripts; and

- Online Access Requirement: use of a computer system to connect to InteliHealth's system hosting the Life Program via the Internet using a standard Web browser.

III. Simple Steps To A Healthier Life Agreement

1. Grant of License. Subject to all the terms and conditions of the Service Agreement and this Appendix B, InteliHealth hereby grants Customer a non-exclusive, nontransferable, world-wide right and license to use the Life Program software and documentation, together with all updates, enhancements, modifications, and fixes thereto, which are owned by InteliHealth and/or its licensors for the benefit of Customer's Users. The Life Program is more fully described in Parts I and II of this Appendix B, above. Subject to the license granted to Customer hereunder, InteliHealth shall retain sole and exclusive ownership of all right, title and interest (including all associated intellectual property rights) in and to the Life Program.

2. Warranty Disclaimer. EXCEPT AS EXPRESSLY SET FORTH IN THIS APPENDIX B, INTELIHEALTH DOES NOT MAKE, AND SPECIFICALLY DISCLAIMS, ANY REPRESENTATIONS OR WARRANTIES, EXPRESS OR IMPLIED, INCLUDING ANY IMPLIED WARRANTY OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, AND IMPLIED WARRANTIES ARISING FROM COURSE OF DEALING OR PERFORMANCE. INTELIHEALTH DOES NOT WARRANT AND SPECIFICALLY DISCLAIMS ANY REPRESENTATION THAT THE LIFE PROGRAM, ANY DOCUMENTATION, ANY ADDITIONAL WORK, OR ANY COMPONENT OF ANY OF THE FOREGOING WILL MEET EMPLOYER'S OR ITS USERS' REQUIREMENTS OR THAT EMPLOYER'S OR ITS USERS' USE OF THE LIFE PROGRAM WILL BE UNINTERRUPTED OR ERROR FREE. INTELIHEALTH MAKES NO WARRANTY AS TO THE RELIABILITY, ACCURACY, TIMELINESS, USEFULNESS OR COMPLETENESS OF THE INFORMATION. INTELIHEALTH CANNOT AND DOES NOT WARRANT AGAINST HUMAN AND MACHINE ERRORS, OMISSIONS, DELAYS, INTERRUPTIONS OR LOSSES, INCLUDING LOSS OF DATA. INTELIHEALTH CANNOT AND DOES NOT GUARANTEE OR WARRANT THAT FILES AVAILABLE FOR DOWNLOADING FROM THE LIFE PROGRAM WILL BE FREE OF INFECTION OR VIRUSES, WORMS, TROJAN HORSES OR OTHER CODE THAT MANIFEST CONTAMINATING OR DESTRUCTIVE PROPERTIES.

   THE INFORMATION CONTAINED IN THE LIFE PROGRAM IS PRESENTED "AS IS" AND IN SUMMARY FORM ONLY AND INTENDED TO PROVIDE BROAD CONSUMER UNDERSTANDING AND KNOWLEDGE OF HEALTH CARE TOPICS. THE INFORMATION SHOULD NOT BE CONSIDERED EXHAUSTIVE AND SHOULD NOT BE USED IN PLACE OF A VISIT, CALL, CONSULTATION OR ADVICE OF A PHYSICIAN OR OTHER HEALTH CARE PROVIDER. INTELIHEALTH DOES NOT RECOMMEND THE SELF-MANAGEMENT OF HEALTH PROBLEMS. INFORMATION OBTAINED BY USING THE LIFE PROGRAM DOES NOT COVER ALL DISEASES, AILMENTS, PHYSICAL CONDITIONS OR THEIR TREATMENT. SHOULD A USER OF THE LIFE PROGRAM HAVE ANY HEALTH CARE-RELATED QUESTIONS, SUCH USER SHOULD CALL OR SEE

THEIR PHYSICIAN OR OTHER HEALTH CARE PROVIDER PROMPTLY AND SHOULD NEVER DISREGARD MEDICAL ADVICE OR DELAY IN SEEKING IT BECAUSE OF SOMETHING THEY MAY HAVE READ IN THE LIFE PROGRAM.

THE INFORMATION CONTAINED IN THE LIFE PROGRAM IS COMPILED FROM A VARIETY OF SOURCES ("INFORMATION PROVIDERS"). NEITHER INTELIHEALTH AND ITS AFFILIATES NOR ANY INFORMATION PROVIDER SHALL BE RESPONSIBLE FOR INFORMATION PROVIDED HEREIN UNDER ANY THEORY OF LIABILITY OR INDEMNITY.

3. Limitation of Liability. Notwithstanding anything to the contrary contained in the Services Agreement or this Appendix B, in no event shall InteliHealth be liable to Customer for any special, indirect, incidental, punitive or consequential damages, whether based on breach of contract, tort (including negligence or strict liability), or for interrupted communications, or otherwise, whether or not InteliHealth has been advised of the possibility of such damage.

Polk County, A Political Subdivision of the State of Florida

ASC Financial Renewal Overview:
January 1, 2013 through December 31, 2013

Policyholder Number - 811370

Aetna™

Fee Schedule

Polk County, A Political Subdivision of the State of Florida Aetna Life Insurance Company
January 1, 2013 through December 31, 2013
Customer Number - 811370

This exhibit outlines the fees for the contract between Polk County, A Political Subdivision of the State of Florida and Aetna Life Insurance Company (hereinafter "Aetna") for services performed by Aetna under the Administrative Services Agreement (hereinafter "Agreement") for the Guarantee Period January 1, 2013 through December 31, 2013.

		AHF CPII (HRA)	AHF CPII (HSA)	Medicare Direct Indemnity	OA Aetna Select
2013 Guaranteed Billing Fee PEPM*		$38.59	$38.59	$18.41	$38.59
Health Savings Account – HSA PAPM*		$0.00	$3.25	$0.00	$0.00

National Advantage Program™ with Facility Charge Review and Itemized Bill Review –
Included 50.0% of savings.

Guarantee Period

- The components of the Fees will be referred to as *Guaranteed Fees*.

The period January 1, 2013 through December 31, 2013 will be referred to as the **First Guarantee Period,** the period January 1, 2014 through
will be

Guaranteed Fees

Self-Funded Fee Guarantee − The fees for the self-funded coverages included in this renewal for the period January 1, 2013 through December 31, 2013 are guaranteed according to the PEPM fees provided above. We guarantee that the fees for the Second Guarantee Period will increase over the fees for the First Guarantee Period by 3%. We also guarantee that the fees for the Third Guarantee Period will increase over the fees for the Second Guarantee Period by 3%.

* 'Employee' is defined as only those persons in the classes of employee, retiree, COBRA continuee and any other persons within classes that are specifically described in Appendix I of the Services Agreement, including employees, retirees, COBRA continuees and any other persons within classes of Polk County, A Political Subdivision of the State of Florida subsidiaries and affiliates of who are reported, in writing, to Aetna for inclusion in the Services Agreement.

Fee Schedule

Run-off Processing Charges

Polk County, A Political Subdivision of the State of Florida was sold on an incurred (mature) claim basis, which takes into account the expenses associated with the processing of run-off claims following cancellation, subject to the conditions of our financial guarantee.

Additional Services (Direct Charges)

The Guaranteed Fees exclude provisions for certain additional services which may be requested by Polk County, A Political Subdivision of the State of Florida. Please see the attached Services/Direct Charges document for more information and examples of included and excluded charges. Fees for any additional services requested by Polk County, A Political Subdivision of the State of Florida will be billed as described on the Services/ Direct Charges section.

Billing of Fees

We will bill and collect your monthly Medical fees as outlined above. At the end of the Agreement year, Aetna will reconcile the collected fees to those outlined in this exhibit. Any overage due Polk County, A Political Subdivision of the State of Florida, or any shortfall due Aetna, will be payable within the time frame specified in the Agreement.

Healthy Actions − The proposed Per-Employee, Per Month fees noted above include an annual charge for the Aetna Healthy Actions Rewards Tracking program that is amortized on a monthly basis over a 12-month period. As such, no fee reduction will be applied in the event that this program is terminated prior to the end of the policy period.

Commissions

We honor “Agent of Record” or “Broker of Record” letters when an agent, broker, or consultant takes over an Aetna case from another agent, broker, or consultant. The notification of this change must be submitted on your organization’s letterhead and signed by an appropriate representative from your organization. The “Agent of Record” or “Broker of Record” letter that designates a change for commission payment will become effective on the first day of the month following receipt by our commission unit, unless another future date is designated in the letter.

We have various programs for compensating agents, brokers and consultants. If you would like information regarding compensation programs for which your agent, broker, or consultant is eligible, payments (if any) which Aetna has made to your agent, broker, or consultant, or other material relationships your agent, broker, or consultant may have with Aetna, you may contact your agent, broker or consultant, or Natalie Gonder Jones in our Tampa field office. Information regarding our programs for compensating agents, brokers and consultants is also available at **www.aetna.com**.

Fee Schedule

National Advantage™ Program

The National Advantage Program (NAP) offers access to contracted rates for many medical claims that would otherwise be paid at billed charges under indemnity plans, the out-of-network portion of managed care plans, or for emergency and medically necessary services not provided within the standard network. The NAP network consists of many Aetna-contracted hospitals, ancillary providers, and physicians as well as hospitals, ancillary providers and physicians accessed through vendor arrangements where we do not have contractual arrangements.

Facility Charge Review (FCR)

FCR is a feature of NAP. This program provides reasonable charge allowance review for most inpatient and outpatient facility claims where a National Advantage Program contracted rate is not available. Without the advantage of this program, these claims are often paid at billed charges. The program is only available in conjunction with NAP.

Itemized Bill Review (IBR)

IBR is a feature of NAP for self-funded programs. Inpatient facility bills with submitted expenses of $20,000 or more in an Aetna-contracted facility (excluding per diem arrangements) are reviewed for incorrectly billed expenses prior to claim adjudication. Plan Sponsors must participate in the NAP in order to elect IBR.

Late Payment Charges

If Polk County, A Political Subdivision of the State of Florida fails to provide funds on a timely basis to cover benefit payments as provided in the Agreement, Aetna will assess a late payment charge. As an accommodation to Polk County, A Political Subdivision of the State of Florida, Aetna will accept payment of services fees within 45 days. If Polk County, A Political Subdivision of the State of Florida fails to pay service fees within 45 days, Aetna will assess a late payment charge.

Please note that Aetna has not waived and expressly reserves all of its rights to enforce the strict payment time frames and remedies in the Agreement in the future. Aetna will provide you with 30 days written prior notice in the event it decides to end your current accommodation. Any service fees becoming initially due after the end of the 30 day notice period will be subject to the strict terms of the Agreement. Aetna also reserves all rights to enforce Agreement remedies as to any service fees overdue under your current accommodation.

To the maximum extent allowed under applicable law, this notice rescinds, ends, or replaces any prior document, arrangement or understanding (except the Agreement) which may have been made regarding any extension for the payment of service fees.

Fee Schedule

The charges for 2012 are outlined below:

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

Aetna reserves the right to collect any incurred late payment charges through the claim wire on a monthly basis provided there are no other special payment arrangements in-force to fund any incurred late payment charges. Plan Sponsor will be notified by Aetna in writing to obtain approval prior to billing any late payment charges through claim wire.

In addition, Aetna will charge to recover its costs of collection including reasonable attorney's fees.

We will notify Polk County, A Political Subdivision of the State of Florida of any changes in late payment interest rates.

The late payment charges described in this section are without limitation to any other rights or remedies available to Aetna under the Agreement or at law or in equity for failure to pay.

Renewal Assumptions

Polk County, A Political Subdivision of the State of Florida **Aetna Life Insurance Company**
January 1, 2013 through December 31, 2013 **Customer Number - 811370**

Services	AHF CPII (HRA)	AHF CPII (HSA)	Medicare Direct Indemnity	OA Aetna Select
Enrolled Lives	910	51	314	2,963
Projected PCTs per Employee	24.2	21.7	37.2	30.4
Member to Employee Ratio	2.05	2.10	1.00	2.00
Retiree Percentage	5.0%	5.0%	100.0%	1.8%
AVA Level	Level 2	Level 2	Level 2	Level 2
Navigator Enrollment Percent	69.6%	69.6%	69.6%	69.6%
Electronic EOB Percent	72.1%	72.1%	72.1%	72.1%
Manual PCTs Per Employee	7.4	6.7	0.0	8.7

Definitions:
AVA Level − Aetna Voice Advantage Level
Level 1.0 − Automated AVA module; no opt out to Customer Services needed (does not apply to medical)
Level 2.0 − Automated AVA module; member may opt out to Customer Services after automated services are offered.
Level 3.0 − Initial selection AVA module; member may opt out immediately to Customer Services
No AVA − Plan Sponsor elects immediate live voice access by member

Navigator Enrollment
Aetna Navigator® allows members online access to member services.

Manual Processed Claim Transaction (PCT) per Employee
Adjustments are applied reflecting the variation in the number of manually processed PCTs and those auto adjudicated. Claim processing charges increase as manual processing increases.

Renewal Assumptions

Our guaranteed fees have taken into account the overall business relationship we enjoy with Polk County, A Political Subdivision of the State of Florida and have factored into our pricing the economies of offering multiple products and services through Aetna. Aetna reserves the right to recalculate the Guaranteed Fees using its then current book of business formula under the circumstances described below. In such case, Polk County, A Political Subdivision of the State of Florida will be required to pay any difference between the fees collected and the new fees calculated retroactive to the start of the Guarantee Period. Aetna may recalculate:

1. If, for any product identified above, there is a:

    - 15% decrease in the number of enrolled lives during the guarantee period from the Guaranteed Fee Assumptions above (such decrease is to be determined in total for all Medical products combined, or from any reset assumptions (reset if a new Fee is established).

    - 15% increase in the processed claim transactions per employee (PCTs/ee) ratio from the ratio above, or from any subsequently reset assumptions (reset if a new fee is established).

    - 15% increase in the retiree percentage above, or from any subsequently reset assumptions (reset if a new fee is established).

    - 15% increase in the Member to employee ratio above, or from any subsequently reset assumptions (reset if a new fee is established).

2. If a material change in the plan of benefits is initiated by Polk County, A Political Subdivision of the State of Florida or by legislative or regulatory action.

3. If a material change is initiated by Polk County, A Political Subdivision of the State of Florida or by legislative or regulatory action in the claim payment requirements or procedures, claim fiduciary option, account structure, or any other change materially affecting the manner or cost of paying benefits.

4. If the National Advantage™ Program (NAP), Facility Charge Review (FCR) or Itemized Bill Review (IBR) programs are terminated by Polk County, A Political Subdivision of the State of Florida.

5. If Aetna Programs and Services, including but not limited to Aetna Health Connections (AHC) disease management, Active Health Management, Beginning Right(SM) Maternity Program, MedQuery®, Flexible Spending Accounts, Informed Health® Line (IHL) are terminated by Polk County, A Political Subdivision of the State of Florida.

Renewal Assumptions

6. If Polk County, A Political Subdivision of the State of Florida terminates any other Aetna products and services not addressed within this renewal package.

If one of the circumstances identified above should occur, then the additional financial guarantees between Aetna and Polk County, A Political Subdivision of the State of Florida including but not limited to claim based performance guarantees, may also be modified or terminated as well based upon the financial conditions contained within those documents.

Health Care Reform
This renewal is intended to be compliant with health care reform.

The Federal government released regulations related to grandfathering of health plans in existence on March 23, 2010. Under the health care reform legislation, health plans existing prior to the enactment of the legislation may be "grandfathered" and not subject to some of the mandated benefits and reform provisions. Changes in your benefit design as well as your contribution strategy may affect grandfathering. Plan sponsors are required to notify Aetna if their contribution rate changes for a grandfathered plan at any point during the plan year.

Aetna will administer the plan in compliance with Federal external review process

This renewal offering assumes your plan is not grandfathered.

As a non-grandfathered plan, the plan will include Preventive care as defined by regulation without cost sharing on In Network services.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plans grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, Polk County, A Political Subdivision of the State of Florida determines that their coverage could be or is grandfathered, and they want to retain grandfathered status, they should contact Aetna for further instructions.

The benefits and fees within this proposal are subject to change pending any required approvals from state or federal regulatory agencies. If you have questions, please contact your Account Executive.

Any taxes or fees (assessments) applied to self-funded benefit plans related to The Patient Protection and Affordable Care Act (PPACA) will be solely the obligation of the plan sponsor. The administrative service fees that Aetna is presenting do not include any such plan sponsor liability.

Aetna reserves the right to modify its products, services, rates and fees, in response to legislation, regulation or requests of government authorities resulting in changes to plan benefits and to recoup any material fees, costs, assessments, or taxes due to changes in the law even if no benefit or plan changes are mandated.

Medical Program Services

Polk County, A Political Subdivision of the State of Florida Aetna Life Insurance Company
January 1, 2013 through December 31, 2013 Customer Number - 811370

Services and Programs

We have provided a list, by product, of those services and programs that are included or available to Polk County, A Political Subdivision of the State of Florida.

	AHF CPII (HRA)	AHF CPII (HSA)	Medicare Direct Indemnity	OA Aetna Select
General Administration				
Account Management	Included	Included	Included	Included
Customer Team Services	Included	Included	Included	Included
Communication Materials	Included	Included	Included	Included
Eligibility	Included	Included	Included	Included
Customized Forms	Not Included	Not Included	Not Included	Not Included
Printing of Booklets or Certificates	Not Included	Not Included	Not Included	Not Included
Claim Fiduciary - Option 1	Included	Included	Included	Included
External Review	Included	Included	Included	Included
HIPAA Certification	Included	Included	Included	Included
Claims Subrogation	Included	Included	Included	Included
Banking				
Banking Method	ACH Bank Initiated	ACH Bank Initiated	ACH Bank Initiated	ACH Bank Initiated
Funding Basis	Issued	Issued	Issued	Issued
Alternate Stockpiling	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply
Seed Money	Does Not Apply	Does Not Apply	Does Not Apply	Does Not Apply
Claim & Member Services				
Claim Administration	Included	Included	Included	Included
Member Services	Included	Included	Included	Included
Aetna Voice Advantage® (IVR)	Included	Included	Included	Included
Network Administration				
Network Management	Included	Included	Not Included	Included
Provider Relations	Included	Included	Included	Included
National Advantage™ Program	Included	Included	Included	Included
Facility Charge Review	Included	Included	Included	Included
Itemized Bill Review	Included	Included	Included	Included
Rural PPO Network Program	Not Included	Not Included	Not Included	Not Included
Patient Management				
Precertification	Included	Included	Included	Included
Radiology Benefit Management	Not Included	Not Included	Not Included	Not Included
Case Management	Included	Included	Included	Included
Concurrent Review	Included	Included	Included	Included
Discharge Planning	Included	Included	Included	Included
Aetna Compassionate Care℠ Program	Included	Included	Included	Included
National Medical Excellence	Included	Included	Included	Included
Biometric Screenings	Not Included	Not Included	Not Included	Not Included
Aetna Health Connections —	Included	Included	Not Included	Included

Medical Program Services

	AHF CPII (HRA)	AHF CPII (HSA)	Medicare Direct Indemnity	OA Aetna Select
Disease Management				
Flexible Medical Management Model Option 1	Not Included	Not Included	Not Included	Not Included
Flexible Medical Management Model Option 2	Not Included	Not Included	Not Included	Not Included
Flexible Medical Management Model Option 3	Not Included	Not Included	Not Included	Not Included
Care Advocate Team	Not Included	Not Included	Not Included	Not Included
Healthy Lifestyle Coaching	Not Included	Not Included	Not Included	Not Included
Simple Steps To A Healthier Life® or Health Assessment	Included	Included	Included	Included
Aetna Healthy Actions	Included	Included	Not Included	Included
Member Health Engagement Plan (MHEP)	Not Included	Not Included	Not Included	Not Included
CareEngine® Personal Health Record	Included	Included	Not Included	Included
Wellness Counseling	Not Included	Not Included	Not Included	Not Included
Healthy Body, Healthy Weight Program	Included	Included	Not Included	Included
Beginning Right℠ Maternity Program	Included	Included	Not Included	Included
Quit Tobacco Program	Not Included	Not Included	Not Included	Not Included
Informed Health® Line - Nurseline (800 #) only	Included	Included	Included	Included
Informed Health Line - Welcome Letters	Not Included	Not Included	Not Included	Not Included
Informed Health Line - Semi-Annual Reports	Not Included	Not Included	Not Included	Not Included
Informed Health Line - Annual Survey/Results	Not Included	Not Included	Not Included	Not Included
MedQuery® with Basic Member Messaging	Included	Included	Included	Included
- Enhanced Member Messaging	Not Included	Not Included	Not Included	Not Included
Aetna Health Connections – Direct2you				
Full Time Nurse	Not Included	Not Included	Not Included	Not Included
Part Time Nurse (20 hours per week)	Not Included	Not Included	Not Included	Not Included
Full Time Care Management Associate	Not Included	Not Included	Not Included	Not Included
Part Time Care Management Associate (20 hours per week)	Not Included	Not Included	Not Included	Not Included
Customer Specific Network (Acute Care Included)	Not Included	Not Included	Not Included	Not Included
Designated Disease Management	Included	Included	Not Included	Included
Dedicated Disease Management	Not Included	Not Included	Not Included	Not Included
Get Active - Shape up	Not Included	Not Included	Not Included	Not Included
Get Active - Shape up & Stay in Shape	Not Included	Not Included	Not Included	Not Included
Get Active - Welcome Kit (720-ITC Pedometer	Not Included	Not Included	Not Included	Not Included

Medical Program Services

	AHF CPII (HRA)	AHF CPII (HSA)	Medicare Direct Indemnity	OA Aetna Select
Get Active - Welcome Kit (HJ-150 Pedometer)	Not Included	Not Included	Not Included	Not Included
Get Active - Welcome Kit (Std. Pedometer)	Not Included	Not Included	Not Included	Not Included
Value Add Programs				
Fitness Program (GlobalFit™)	Included	Included	Included	Included
Aetna Natural Products & Services℠ Program	Included	Included	Included	Included
Aetna Weight Management℠ Discount Program	Included	Included	Included	Included
Aetna Hearing℠ Discounts	Included	Included	Included	Included
Aetna Vision℠ Discounts	Included	Included	Included	Included
Standard Behavioral Health				
Focused Psychiatric Review	Not Included	Not Included	Included	Not Included
Managed Behavioral Health	Included	Included	Not Included	Included
Behavioral Health Disease Management Programs				
- Alcohol Disease Management	Not Included	Not Included	Not Included	Not Included
- Anxiety Disease Management	Not Included	Not Included	Not Included	Not Included
- Depression Disease Management	Not Included	Not Included	Not Included	Not Included
- Med/Psych Program	Included	Included	Not Included	Included
Case Management Behavioral Health Programs				
- Intensive Case Management	Included	Included	Not Included	Included
Member Internet Services				
Public Sites				
DocFind®	Included	Included	Included	Included
Aetna InteliHealth®	Included	Included	Included	Included
Learning Resources	Included	Included	Included	Included
Secure Sites				
Staying Healthy	Included	Included	Included	Included
Estimate the Cost of Care Tool	Included	Included	Included	Included
Claim Research/Forms/Contact us	Included	Included	Included	Included
Spanish version	Included	Included	Included	Included
Plan Sponsor Internet Services				
e.Plan Sponsor Monitor™ Reporting				
Aetna Integrated Informatics®				
- Level A Reporting	Included	Included	Included	Included
- Level B Reporting	Included	Included	Included	Included
- Level C Reporting	Included	Included	Included	Included
- Level D Reporting	Not Included	Not Included	Not Included	Not Included
Aetna Health Information Advantage™	Included	Included	Included	Included
Aetna Health Information Advantage™ Gold	Not Included	Not Included	Not Included	Not Included
Aetna Navigator® Reporting	Included	Included	Included	Included

Services/Direct Charges

Polk County, A Political Subdivision of the State of Florida
January 1, 2013 through December 31, 2013

Aetna Life Insurance Company
Customer Number - 811370

The Guaranteed Service Fees include a number of services that are routinely performed to administer the Aetna book of business. The guaranteed fees include, but are not limited to, the items identified on the chart on the following pages in the column labeled "Standard Services Examples".

The guaranteed fees also include the following non-standard/direct/custom charges:

- HIPAA Certs
- Aetna Claim Fiduciary (Option 1)
- Data Feeds to MedStat to be reconciled via the annual accounting process
- Level C Reporting to be reconciled via the annual accounting process
- Health Savings Account Per Participant fee of $3.25 PAPM
- Rewards Tracking to be reconciled via the annual accounting process
- Rx data feed for the deductible accumulators at $5,000
- On-going Rx accumulators at $0.60 PEPM for the HSA

The Total Guaranteed Billing Fees exclude provision for non-standard services (direct charges) that may be requested by Polk County, A Political Subdivision of the State of Florida (other than specified above). We will provide you with documentation of these non-standard service requests to apprise you of the additional cost and obtain your approval to proceed with providing these services. The charge(s) for these additional services will be directly billed through the claim wire during the contract period, whenever possible.

Charges for additional services that are excluded from the Total Guaranteed Billing Fees as outlined on the Fee Schedule will be billed in the following way:

Additional non-standard services (direct charges) not collected through the claim wire during the year will either be direct billed or reconciled in conjunction with the year end accounting and may result in an adjustment to the final administration charge.

Services/Direct Charges

The chart on the following pages lists examples of standard services by function as well as some of the more common non-standard services. Your Underwriting Consultant, Simon Ostrov, can provide more detail on the services that are covered by the guaranteed fees as well as information on specific non-standard services previously requested by Polk County, A Political Subdivision of the State of Florida. The pricing shown below is subject to change without notification. Please contact your Account Executive for a customized quote.

Function	Standard Services Examples	Non-Standard Services (Direct Charges) Examples
Banking	- Claims are "stockpiled" until they reach $20,000, on a drafts issued basis, except that on the first banking day of each month, all remaining claims from the prior month are requested regardless of the amount. - 3 Wire lines (Claim Wires) - Daily advice wire notification	- Alternate stockpiling arrangements - Excess of 3 wire lines (claim wires). For 2012 the annual charge is $2,895 per wire line. - Late funds to cover benefit payments (e.g., late wire transfers)
Billing/Fees/Premium Collection	- Standard per billing period within the standard 31-day grace period	- Multiple service fee statements - COBRA and/or Retiree direct billing administration. - Charges for Late Payment of Service Fees & Stop Loss Premium. This charge will be reconciled, based on actual payment activity, at the time of the annual accounting
Claim Administration Services	- Online real time system - Claim Check, used to identify upcoded, unbundled and/or fragmented claim submissions - Maintenance of Plan and Member information for claim calculation - Fraud Prevention Programs - Provider Red Flags - Initial overpayment recovery effort including referral to outside collection agency - Cost containment programs - Application of R & C limits for physician claims for Indemnity and out-of-network PPO and POS plan designs - Application of negotiated fees with providers for in-network portion of plan designs - Claim adjudication based on plan design - Coordination of benefits - Aetna appeal administration only - Standard claim Processing performance targets - Customer claim payment audits <250 claims completed in 5 consecutive business days	- Customized claim forms - Aetna Claim fiduciary - Claim audits of more than 250 claims - Audits other than 5 consecutive business days per 12 month period - Escheat services - Third party data integration services - Customized benefit provisions which require a reduction in auto-adjudication.

Services/Direct Charges

Function	Standard Services Examples	Non-Standard Services (Direct Charges) Examples
	- Runoff Claim Processing	
Drafting	- Preparing Master Services Agreements and other related agreements/amendments - Review Plan Sponsor documents (14 calendar days for 1-2 SPDs, 28 calendar days for 3-4 SPDs and 45 calendar days for 5 or more SPDs) or produce Plan documents in an electronic version for printing (printing not included) or Internet use. - Runoff Claim Processing	- Accelerated Turn Around Time (TAT) - Printing and mailing of Summary Plan Descriptions - Extraordinary Drafting (extensive customization)
Eligibility	- Up to 4 ELRs/segments (physical media or electronic) per submission received weekly, twice a week or every two weeks - Aetna Consolidated Electronic File (CEF) or EDI layout	- Deviations from standard layout or EDI eligibility specs - More than 4 segments/ELRs for single submission - When customer/vendor uses layout other than CEF twice a week or every two weeks - Submissions requiring manual intervention to load into the Aetna system - Submissions via physical media (tape, disk, cartridge, etc.) - More than 50 manual online transactions per month (electronic reporting customers requesting manual online processing and/or requesting paper processing) for customers submitting less frequently than weekly or in certain high resource situations - Twice a month or monthly eligibility submissions - Paper eligibility submissions for customers with more than 3,500 members - Cumulative programming that exceeds 8 days per year - COBRA or other eligibility submitted via a non-standard listing - MEA extracts when there are more than 4 extracts requested per year - DMD Eligibility File with SSNs and unique identifiers - Reformatting of generic audit lists/outbound files - Paper ELR error reports - PCP and PCD interface charge when the PCP and/or PCD data is not provided with normal eligibility submissions where a PCP/PCD is required - Custom Enrollment Forms and Enrollment Form Keying

Services/Direct Charges

Function	Standard Services Examples	Non-Standard Services (Direct Charges) Examples
		- Customized zip code files when we must manipulate a standard zip code file to support such things as account structure or plan changes - Extracting eligibility from a customer or vendor site - HIPAA certifications at $0.26 per employee, per month
Enrollment	- Aetna standard enrollment forms or standard Aetna listing - Completed required enrollment fields - Standard enrollment material	- Customized enrollment forms or listings - Customized annual enrollment materials
Field Sales/Service Support	- Account Management - Open enrollment support	
Financial Underwriting	- Prepare and communicate annual accounting package reconciling fees paid vs. actual charges - Prepare and communicate renewal fees - Provide quotations for alternate benefits and/or levels of administrative services - Support Field/Account Executives with ad hoc issues management	- Custom level financial information (accountings, ratings) - Custom reports
Home Office	- Claim accounting, draft reconciliation, and provider 1099 reporting - Claim Systems production and development - Distribution of drafts, standard EOBs and explanation of provider payments (EPPs)	- Customized EOBs - Production of EOBs for POS, EPO and PPO where there is no member liability
ID Cards	- Standard wording, formatting and mailing - Family ID cards	- Customized ID cards or ID cards issued for non-business reasons - Integration of Third Party RX Vendor Information - Individual ID cards (vs. family ID cards) - Generic stuffers for non-business reasons - Custom ID card stuffers - Zero Day/Overnight/ Two Day Mailing of ID Cards
Member Services	- Documentation of member inquiries - Toll free telephone service provided to members and providers with standard hours of operation from 8 a.m. to 6 p.m. - Access to standard DocFind via Internet - Access to Aetna Navigator via Internet - Member Support - Handle employee appeals, complaints and grievances as appropriate based on fiduciary option.	- Extended hours of operation - Dedicated Resources/Services - Provider Directories

Services/Direct Charges

Function	Standard Services Examples	Non-Standard Services (Direct Charges) Examples
Other Services		- Printing Expenses & Postage – Employee addresses can be extracted for the Aecclaims/ACAS Family File and used to produce address labels. We can also produce letters from a diskette for direct mailings. - Customer negotiated network– arrangement, installation and ongoing maintenance charges. - Interfacing with a third party vendor. - Data integration of third party pharmacy vendor. Charges vary based on data integration requirements
Plan Set-up/Maintenance	- In accordance with Aetna standard structure units - Evaluate changes in account, benefit and billing structures	- Account structure units in excess of standard - Customer requested changes to benefits and/or account structure based on level of complexity.
Reporting	- Standard reports and mediums	- Customized mainframe reports which require development or modification programming are done on a fee for service basis. - Funds Summary Report at the account level. - Custom Claim Detail Reports or Tapes. - Special services not included in the Aetna Integrated Informatics program - Reports in excess of the 25 hours included in the service fees are produced on a fee for service basis. e.Plan Sponsor Monitor™ reports and services are not included in this cost and are billed at the level of service. - Claim Detail Report, Claim Totals Report or Funds Summary Report in excess of the maximum stated as "standard". - Requests to receive Funds Summary data by the 5th business day following the close of the month. - Special handling of monthly reports at the customer's request. - Express of a monthly report (overnight or second day air). - Receipt of Claim Detail Information on magnetic tape, cartridge, diskette or CD ROM. - Receipt of Cumulative Claim Detail Reports, Alternately Sequenced Claim Detail Reports, Large Claim Reports or Outstanding Issued Draft Reports - Standard Third Party Stop Loss Reports are billed from $1,400 to $4,600 based on the frequency of reports. - Retiree Drug Subsidy claim, rebate and eligibility

Services/Direct Charges

Function	Standard Services Examples	Non-Standard Services (Direct Charges) Examples
		reporting.

Services/Direct Charges / Underwriting Reports Pricing Schedule

Polk County, A Political Subdivision of the State of Florida **Aetna Life Insurance Company**
January 1, 2013 through December 31, 2013 **Customer Number – 811370**

Report Type	Estimated Hours Per Report *	Monthly Basis **	Quarterly Basis **	Semi-Annual Basis **	Annual Basis **
Enrollment Reports					
Enrollment by Service Area	1.0	$1,800	$600	$300	***No Charge
Enrollment by Age Band	1.0	$1,800	$600	$300	***No Charge
Enrollment by Control	1.0	$1,800	$600	$300	***No Charge
Enrollment by Control - by (Tier)	2.0	$3,600	$1,200	$600	$300
Enrollment by Control - Suffix	1.0	$1,800	$600	$300	***No Charge
Enrollment by Control - Suffix by (Tier)	2.0	$3,600	$1,200	$600	$300
Enrollment by Control - Suffix/Account	1.5	$2,700	$900	$450	$225
Enrollment by Control - Suffix/Account by (Tier)	3.0	$5,400	$1,800	$900	$450
Enrollment by Control - Suffix/Account/Plan	1.5	$2,700	$900	$450	$225
Enrollment by Control - Suffix/Account/Plan by (Tier)	4.0	$7,200	$2,400	$1,200	$600
Claim Experience Reports					
Large Claims	1.0	$1,800	$600	$300	***No Charge
Capitations (if Applicable)	1.0	$1,800	$600	$300	***No Charge
Run Off Claims	1.0	$1,800	$600	$300	***No Charge
Date Claim Incurred	1.0	$1,800	$600	$300	***No Charge
Claims by Control	1.0	$1,800	$600	$300	***No Charge
Claims by Control - by Product	1.0	$1,800	$600	$300	***No Charge
Claims by Control – Suffix	1.0	$1,800	$600	$300	***No Charge
Claims by Control - Suffix/Account	1.5	$2,700	$900	$450	$225
Claims by Control - Suffix/Account/Plan	1.5	$2,700	$900	$450	$225
Claim Lag by Control	1.0	$1,800	$600	$300	***No Charge
Claim Lag by Control - by Product	1.0	$1,800	$600	$300	***No Charge
Claim Lag by Control – Suffix	1.0	$1,800	$600	$300	***No Charge
Claim Lag by Control - Suffix/Account	1.0	$1,800	$600	$300	***No Charge
Miscellaneous Reports					
Claims Monitoring Report (CMR) for in force plan sponsors	1.0	No Charge	No Charge	No Charge	**No Charge**
Claims Monitoring Report (CMR) for terminated plan sponsors	1.0	$1,800	$600	$300	$150
Summary Site Match	1.0	$1,800	$600	$300	**No Charge
Age and Gender	1.0	$1,800	$600	$300	**No Charge
Geo Access	2.0	$3,600	$1,200	$600	$ 300
Aetna Health Fund	2.0	$3,600	$1,200	$600	$300
Disruption	2.0	$3,600	$1,200	$600	$300

Adhoc or Non Standard Report Requests – Report costs will be determined prior to any work being completed.

* Estimated hours assume maximum account structure totals of: 1 Control, 5 Suffixes, 15 Accounts, and 5 products

** Additional charges may apply if: account structure exceeds that referenced above, any non-standard formatting is requested, or there are other factors that increase the estimated hours referenced above. A rate of $150/hour will be assessed for any additional reporting hours.

*** These reports will be provided in conjunction with the annual financial renewal package upon request.

Additional Quoted Products/Services

Polk County, a political subdivision of State of Florida
Effective Date: 01-01-2013
Open Access® Aetna Select℠ - ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Incentive Programs	
Preventive Care Services Award	For routine adult physical exams $200 for covered employee and/or spouse per calendar year
Deductible (per calendar year)	$700 Individual $1,900 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.	
Member Coinsurance	20%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$3,800 Individual $11,400 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Only those preferred expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived
7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
Includes routine tests and related lab fees	
Routine Mammograms	Covered 100%; deductible waived
1 baseline for 35-39; 1 annual for females age 40 and over.	
Women's Health	Covered 100%; deductible waived
Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived
For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
For all members age 50 and over.	
Routine Hearing Exams	Covered 100%; deductible waived
1 routine exam per 12 months	
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits to PCP	$20 office visit copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$30 office visit copay; deductible waived
Allergy Testing	Covered as either PCP or specialist office visit; ded waived
Allergy Injections	Covered 100%; deductible waived

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic Laboratory and X-ray	20% after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	
EMERGENCY MEDICAL CARE	**PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay, deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	20% after deductible
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	20% after deductible
HOSPITAL CARE	**PREFERRED CARE**
Inpatient Coverage	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Inpatient Maternity Coverage	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient Surgery	20% after deductible
Outpatient Hospital Expenses (excluding surgery)	20% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	
MENTAL HEALTH SERVICES	**PREFERRED CARE**
Inpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient	First Visit=$0 copay; Visits 2-10=$10 copay; Visits 11+= $20 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**
Inpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient	First Visit=$0 copay; Visits 2-10=$10 copay; Visits 11+= $20 copay
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	
OTHER SERVICES	**PREFERRED CARE**
Convalescent Facility	20% after deductible
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	
Home Health Care	20% after deductible
Unlimited visits-prior hospital confinement not required.	
Hospice Care - Inpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Hospice Care - Outpatient	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
Private Duty Nursing - Outpatient Unlimited Shifts	20% after deductible
Outpatient Short-Term Rehabilitation	20% after deductible
Spinal Manipulation Therapy	$20 copay; deductible waived
Durable Medical Equipment	20% after deductible
Diabetic Supplies	20% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	20% after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived
Transplants Coverage is provided at an IOE contracted facility only.	20% after deductible
Bariatric	20% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Out of Area Dependents	20% after deductible except preventive care covered 100%. All limitations apply.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

FAMILY PLANNING	PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.	
Vasectomy and Tubal Ligation	Member cost sharing is based on the type of service performed and the place of service where it is rendered;

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.

aetna	Polk County, a political subdivision of the State of Florida			
	Effective Date: 01-01-2013			
	Aetna HealthFund™ Aetna Choice™ POS II - ASC			
PLAN DESIGN & BENEFITS				
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY				
FUND FEATURES				
HealthFund Amount	$300	Employee		
	$600	Employee + 1 Dependent		
	$600	Employee + 2 Dependents		
	$600	Family		
Amount contributed to the Fund by the employer				
Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage.				
Fund Coinsurance	100%			
Percentage at which the Fund will reimburse				
Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out-of-Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.			
Employee Termination from Aetna HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's Aetna HealthFund coverage terminates.			
Fund Rollover	Any remaining HealthFund benefit amount at end of plan year is rolled over into next years HealthFund benefit amount.			
Annual Maximum Rollover	No maximum rollover applies. All remaining benefits at plan year end rollover.			
Cumulative Maximum Rollover	No maximum rollover applies. All remaining funds rollover.			
Fund Maximum (Cap)	No maximum rollover applies. All remaining benefits at plan year end rollover.			
Eligible Fund Expenses	Fund covers same expenses as the medical and if included, pharmacy plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.			
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.			
Pro-ration for New Employees	No Pro-ration			
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.			
Incentive Programs				
Preventive Care Services Incentives	For routine adult physical exams.			
Reward	$200 for Employee and $200 for Spouse per calendar year.			
Prescription Drug Plan	Prescription Drug expenses are not integrated with the medical plan (not subject to deductible and not applied towards Out-of-Pocket Limit) or with the Fund (not eligible for reimbursement from the Fund).			
PLAN FEATURES	**PREFERRED CARE**		**NON-PREFERRED CARE**	
Deductible (per calendar year)	$1,650	Employee	$3,250	Employee
	$3,300	Employee + 1 Dependent	$6,500	Employee + 1 Dependent
	$3,300	Employee + 2 Dependents	$6,500	Employee + 2 Dependents
	$3,300	Family	$6,500	Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible.				
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.				
Members with an Employee + 1, Employee + 2, or Family Deductible do not have an Individual Deductible to satisfy.				
Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.				
Member Coinsurance	20%		40%	
Applies to all expenses unless otherwise stated.				

aetna	Polk County, a political subdivision of the State of Florida Effective Date: 01-01-2013			
	Aetna HealthFund™ Aetna Choice™ POS II - ASC			
PLAN DESIGN & BENEFITS				
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY				
Out-of-Pocket Maximum (per calendar year)	$3,300	Employee	$6,500	Employee
	$6,600	Employee + 1 Dependent	$13,000	Employee + 1 Dependent
	$6,600	Employee + 2 Dependents	$13,000	Employee + 2 Dependents
	$6,600	Family	$13,000	Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Out-of-Pocket				
Certain member cost sharing elements may not apply toward the Out-of-Pocket Maximum.				
Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles, (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum.				
Members with an Employee + 1, Employee + 2, or Family Out-of-Pocket Maximum do not have an Individual Out-of-Pocket Maximum to satisfy.				
Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.				
Lifetime Maximum	Unlimited except where otherwise		Unlimited except where otherwise	
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Lifetime Maximum.				
Primary Care Physician Selection	Optional		Not applicable	
Certification Requirements -				
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required.				
Referral Requirement	None		None	
PREVENTIVE CARE	**PREFERRED CARE**		**NON-PREFERRED CARE**	
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived		40% after deductible.	
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.				
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived		40% after deductible.	
7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life; 3 exams 25th-36th months; 1 exam per 12 months thereafter.				
Routine Gynecological Care Exams	Covered 100%; deductible waived		40% after deductible.	
Includes routine tests and related lab fees				
Routine Mammograms	Covered 100%; deductible waived		40% after deductible.	
For covered females age 40 and over.				
Women's Health	Covered 100%; deductible waived		40% after deductible.	
Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling.				
Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.				
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived		40% after deductible.	
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived		40% after deductible.	
Routine Hearing Exams	Covered 100%; deductible waived		40% after deductible.	
1 routine exam per 12 months				
PHYSICIAN SERVICES	**PREFERRED CARE**		**NON-PREFERRED CARE**	
Office Visits to PCP	20% after deductible.		40% after deductible.	
Includes services of an internist, general physician, family practitioner or pediatrician.				
Specialist Office Visits	20% after deductible.		40% after deductible.	
Pre-Natal Maternity	Covered 100%; deductible waived		40% after deductible.	
Maternity Delivery and Post Partum care	20% after deductible.		40% after deductible.	
Allergy Testing	20% after deductible.		40% after deductible.	
Allergy Injections	20% after deductible.		40% after deductible.	

aetna	Polk County, a political subdivision of the State of Florida Effective Date: 01-01-2013

Aetna HealthFund™ Aetna Choice™ POS II - ASC

PLAN DESIGN & BENEFITS

ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	20% after deductible.	40% after deductible.
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing		
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay, deductible waived	40% after deductible.
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible.	20% after deductible.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible.	40% after deductible.
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Surgery	20% after deductible.	40% after deductible.
Outpatient Hospital Expenses (excluding surgery)	20% after deductible.	40% after deductible.
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20% after deductible.	40% after deductible.
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20% after deductible.	40% after deductible.
Hospice Care - Inpatient	20% after deductible.	40% after deductible.
Limited to 30 days per lifetime.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing unlimited shifts	20% after deductible.	40% after deductible.
Outpatient Short-Term Rehabilitation	20% after deductible.	40% after deductible.
Include Speech, Physical, and Occupational Therapy		
Spinal Manipulation Therapy	20% after deductible.	40% after deductible.
Unlimited visits		
Durable Medical Equipment	20% after deductible.	40% after deductible.
Diabetic Supplies	20% after deductible.	40% after deductible.
Prescription Drugs	20% after deductible.	40% after deductible.
Contraceptive drugs and devices not obtainable at a pharmacy	20% (payable as any other covered expense)	40% (payable as any other covered expense)
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Not Covered
Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric	20% after deductible.	40% after deductible.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	20% after deductible.	40% after deductible.
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	

aetna	Polk County, a political subdivision of the State of Florida Effective Date: 01-01-2013

Aetna HealthFund™ Aetna Choice™ POS II - ASC

PLAN DESIGN & BENEFITS

ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	20% after deductible.	40% after deductible.
Diagnosis and treatment of the underlying medical condition.		
Vasectomy	20% after deductible.	40% after deductible.
Tubal Ligation	20% after deductible.	40% after deductible.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived
	After effective date: Waived

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Incentive Programs

Preventive Care Services Incentives	For routine adult physical exams.
Reward	$200 for Employee and $200 for Spouse per calendar year.

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	$1,875	Individual	$3,600	Individual
	$3,750	Family	$7,200	Family

All covered expenses including prescription drugs accumulate toward both the preferred and non-preferred Deductible.
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. There is no Individual Deductible to satisfy within the Family Deductible.

Member Coinsurance	20%		40%	

Applies to all expenses unless otherwise stated.

Payment Limit (per calendar year)	$3,875	Individual	$4,100	Individual
	$7,750	Family	$8,200	Family

All covered expenses including Deductible and prescription drugs accumulate toward both the preferred and non-preferred Payment Limit.
Certain member cost sharing elements may not apply toward the Payment Limit.
Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, and prescription drug copays (except any penalty amounts) may be used to satisfy the Payment Limit.
Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. There is no Individual Payment Limit to satisfy within the Family Payment Limit.

Lifetime Maximum	Unlimited except where otherwise	Unlimited except where otherwise
Primary Care Physician Selection	Optional	Not applicable

Certification Requirements -
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care.
Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required.

Referral Requirement	None	None

PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	40% after deductible
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40% after deductible
7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life; 3 exams in the 25th-36th months of life; 1 exam per 12 months thereafter.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40% after deductible
Includes routine tests and related lab fees		
Routine Mammograms	Covered 100%; deductible waived	40% after deductible
1 routine baseline age 35-39; 1 per calendar year for covered females age 40 and over.		
Women's Health	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered;

Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for Human Immunodeficiency Virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies, and counseling.
Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	40% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	40% after deductible
Routine Hearing Exams 1 routine exam per 12 months	Covered 100%; deductible waived	40% after deductible
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	40% after deductible
Allergy Testing	20% after deductible	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	20% after deductible	40% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	20% after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20% after deductible	40% after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	20% after deductible	40% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	20% after deductible	40% after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20% after deductible	40% after deductible
Limited to 60 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20% after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient Unlimited visits	20% after deductible	40% after deductible
Outpatient Short-Term Rehabilitation	20% after deductible	40% after deductible
Include Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	20% after deductible	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible
Diabetic Supplies	20% after deductible	40% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	20% after deductible	40% after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Not Covered
Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility.
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	20% after deductible	40% after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan; after deductible	
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
Voluntary Sterilization Including tubal ligation and vasectomy.	20% after deductible	40% after deductible
The full cost of the drug is applied to the deductible before benefits are considered for payment under the pharmacy plan.		
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
PLAN INTEGRATED WITH PHARMACY PLAN ADMINISTERED BY WELLDYNE		
Retail- The full cost of the drug is applied to the base medical plan's deductible before any benefits are considered for payment under the pharmacy plan.	Integrated with WellDyne Preventive Medications covered at 100%. All other medications covered at 20% after deductible	40% after deductible

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Mail Order-The full cost of the drug is applied to the base medical plan's deductible before any benefits are considered for payment under the pharmacy plan.	Integrated with WellDyne Preventive Medications covered at 100%. All other medications covered at 20% after deductible	40% after deductible
Self-Injectables		Not Covered

If the member's out-of-pocket maximum has been reached, the plan benefit will pay the balance of the negotiated cost of the

Preventive Medications - Deductible is waived for certain preventive medications. A full list of these drugs is available from your employer.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

GENERAL PROVISIONS

Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days.Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.

No. 811370A

Appendix I

Expanded Temporary Appendix

Describing benefits payable in connection with Administrative Services Agreement ASA-811370A, an agreement between

Aetna Life Insurance Company
("Aetna")

and

Polk County, a Political Subdivision of the State of Florida
(the "Customer")

The Plan described in this Expanded Temporary Appendix is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company (“Aetna”) but will be paid from the Employer’s funds. Until this Expanded Temporary Appendix is otherwise modified or replaced in its entirety by agreement between Aetna and the Customer:

1. Aetna will provide certain administrative services to the Plan as outlined in the Letter of Understanding signed by Aetna and attached to this Appendix I.
2. Aetna will use the description of covered benefits, services and programs outlined in the Plan Design(s) attached to this Appendix I in the administration of the Plan, including any subsequent changes agreed to by Aetna and the Customer.
3. Further, in the administration of the Plan, Aetna will use Aetna’s standard plan General Exclusions and standard Glossary definitions of terms attached to this Appendix I.

When the section entitled “Appendix Contents” of any other Appendix I issued under this contract lists a Booklet or a Summary Plan Description describing certain specific benefits applicable to any class of employees, the terms of this Appendix I shall cease to apply to those benefits for that class.