

RESOLUTION NO. 2011 - 95

**A RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, ACCEPTING THE RECOMMENDATIONS BY THE INSURANCE COMMITTEE TO AMEND AN EXISTING AGREEMENT WITH BLUE CROSS BLUE SHIELD OF FLORIDA, INC. (BCBSFL) TO PROVIDE FOR COMBINED MEDICAL AND PHARMACY CARE SERVICES AND TO EXTEND THE DURATION OF THE AGREEMENT UNTIL DECEMBER 31, 2014; AND AUTHORIZING THE COUNTY ADMINISTRATOR, OR DESIGNEE, TO EXECUTE THE AMENDMENT**

**WHEREAS**, St. Johns County maintains a self-funded health insurance plan for employees of the Board of County Commissioners and Constitutional Officers; and

**WHEREAS**, the current contract for pharmacy services with Caremark expires on April 30, 2011 and the current contract for medical services with Blue Cross Blue Shield of Florida, Inc. expires on December 31, 2011; and

**WHEREAS**, during the Request for Proposals process conducted by the County's Third Party Administrator, a savings was identified by combining the medical and pharmacy services plans' administrative fees; and

**WHEREAS**, on March 24, 2011, the Insurance Committee considered the matter and issued recommendations to: (1) select Blue Cross Blue Shield of Florida to provide pharmacy services; and (2) extend the current Blue Cross Blue Shield of Florida, Inc. medical plan until December 31, 2014; and

**WHEREAS**, the Insurance Committee's recommendations result in an overall savings to the health insurance plan over the course of the three year contract while providing quality service and coverage to participants; and

**WHEREAS**, in amending the existing Blue Cross Blue Shield Administrative Services Agreement, the County is not precluded from changing plans during the contract period subject to applicable penalties; and

**WHEREAS**, the County has determined that approving the Amendment to Administrative Services Agreement (attached hereto and incorporated herein) between the County and Blue Cross Blue Shield of Florida, Inc. in order to provide medical and pharmacy services coverage for participants of the self-funded plan is in the best interests of St. Johns County.

**NOW THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, THAT:**

1. The above Recitals are incorporated by reference into the body of this Resolution and such Recitals are adopted as Findings of Fact.

2. The Board of County Commissioners of St. Johns County, Florida, hereby accepts and the recommendations of the Insurance Committee to: (1) select Blue Cross Blue Shield of Florida, Inc. to provide pharmacy services; and (2) extend the current Blue Cross Blue Shield of Florida, Inc. medical plan until December 31, 2014.
3. The Board of County Commissioners hereby authorizes the County Administrator, or designee, to execute the attached Amendment to the Administrative Services Agreement between the County and Blue Cross Blue Shield of Florida, Inc. to provide for pharmacy services beginning May 1, 2011, and to provide for an extension of the Agreement until December 31, 2014.
4. To the extent that there are typographical or administrative errors that do not change the tone, tenor, or concept of this Resolution, then this Resolution may be revised without subsequent approval of the Board of County Commissioners.

**PASSED AND ADOPTED** by the Board of County Commissioners of St. Johns County, State of Florida, this 14<sup>th</sup> day of April, 2011.

**BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS  
COUNTY, FLORIDA**

By: 

J. Ken Bryan, Chairman

RENDITION DATE 04/21/11

**ATTEST: Cheryl Strickland, Clerk**

By: 

Deputy Clerk



## Attachment A

**AMENDMENT TO ADMINISTRATIVE SERVICES AGREEMENT**

THIS AMENDMENT, entered into on April 8, 2011 is by and between Blue Cross and Blue Shield of Florida, Inc. (hereinafter called the "Administrator") and St. Johns County Board of County Commissioners (hereinafter called the "Employer"). In consideration of the mutual and reciprocal promises herein contained, the Administrative Services Agreement between the Administrator and the Employer (hereinafter "Agreement") effective October 1, 1992 is amended as follows:

1. Section I, subsection A, is hereby amended to extend the term of the Group Health Plan until December 31, 2014 unless the Agreement is terminated earlier in accordance with the terms of the Agreement.
2. Exhibit B to the Agreement is hereby amended, effective May 1, 2011. The revised Exhibit B is attached to this Amendment and replaces the Exhibit B previously attached to the Agreement.
3. Except as otherwise specifically noted in this Amendment, all other terms and conditions of the Agreement shall remain unchanged and in full force and effect.

IN WITNESS WHEREOF, this Amendment has been executed by the duly authorized representatives of the parties.

BLUE CROSS AND BLUE SHIELD  
OF FLORIDA, INC.

ST. JOHNS COUNTY BOARD OF  
COUNTY COMMISSIONERS

By: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

EXHIBIT "B"

to the

ADMINISTRATIVE SERVICES AGREEMENT

between

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

and

ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS

FINANCIAL ARRANGEMENTS  
Banking Arrangement

I. Effective Date.

The effective date of this Exhibit is May 1, 2011.

II. Bank Account.

The Employer agrees to establish a bank account prior to the effective date of this Agreement, in its own name, at the bank designated by the Administrator. The Employer authorizes the Administrator to write checks on the bank account in order to pay claims pursuant to this Agreement. The Employer agrees to maintain the bank account and the reserve amount as set forth below. The Employer shall be responsible for the reconciliation of its bank account, based on information and reports provided by the Administrator and the bank.

III. Special Banking Information.

- A. Name of Employer (as it is to appear on the checks) - no more than 25 characters:

S T J O H N S C O U N T Y B O C C

- B. Employer Bank Account Reference Number - 5 characters:

1 0 0 2 1

- C. Reserve Requirement: \$150,000.

- D. Funding Frequency: Weekly
- E. Method of Funding: ACH

IV. Administrative Fees:

A. ASO and Rx Administrative fees during the term of the Agreement:

\$44.00 per contract per month from May 1, 2011 through December 31, 2011

\$45.25 per contract per month from January 1, 2012 through December 31, 2012

\$46.50 per contract per month from January 1, 2013 through December 31, 2013

\$47.85 per contract per month from January 1, 2014 through December 31, 2014

If the contract is terminated before December 31, 2014, the Employer agrees to reimburse the Administrator an early termination fee of \$75,000.

B. Administrative fees after the termination of the Agreement: 15% of claims paid.

C. The ASO fees outlined above are in exchange for the administration of both the ASO medical plan by BCBSFL and Prescription plan by Prime Therapeutics. These fees are discounted from the original ASO medical plan fee due to the inclusion of the Rx administration effective May 1, 2011.

V. Late Payment Penalty

A. A daily charge of .00038 times the amount of overdue administrative fees.

VI. Expected Enrollment

A. The administrative fees and reserve requirement referenced above are based on an expected enrollment of a total of 2,076 employees.

B. If the actual enrollment is materially different from this expected enrollment, the Administrator reserves the right to adjust the administrative fees and the reserve requirement as set forth in the Agreement. Actual administrative fees will be charged based on actual enrollment.

## Attachment B

---

ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS  
MINUTES OF THE INSURANCE COMMITTEE MEETING  
March 24, 2011

---

A meeting of the Insurance Committee of St. Johns County was held at the Supervisor of Elections conference room at 10:00 a.m. on March 24, 2011.

Present: Debbie Weiner, Rachael Lando, Kim Dacosta, Natasha McGee, Violet Bennett, Penny Halyburton, Erika Ward, Patsy Collins, Thom Delcomyn, Mark Simpson, Theresa Farrow, Dawn Cardenas, Shon McNamee, Claudia Castro

- I. Penny Halyburton called the meeting to order at 10:02 a.m.
- II. Minutes of the February 17, 2011 summit were reviewed and approved.
- III. New Business

A. Pharmacy Benefit Management RFP Results

Debbie Weiner reviewed the Pharmacy Benefit Management RFP results, noting BCBSFL's offer of reducing the medical ASO fees over the next four years, in addition to a two year wellness grant. She also reviewed the prescription re-pricing, stating that all of the companies showed some savings over the current while BCBSFL showed additional savings due to the ASO reduction offer. Debbie also reviewed some additional advantages of moving to BCBSFL Prime Therapeutics. Thom asked about current prior authorizations in Caremark's system, to which Debbie responded that they could be transferred to whichever PBM was selected. It was also pointed out that a new mail-order prescription may be needed if a new PBM was selected. Thom pointed out that the \$150,000 required by BCBSFL if St. Johns County did not fulfill their 3 ½ year agreement would most likely be paid by another carrier if that carrier really wanted St. Johns County's business. After further discussion and agreement that the most savings would be derived from selecting BCBSFL Prime Therapeutics, Mark Simpson motioned to switch the Pharmacy Benefit Management program to BCBSFL Prime Therapeutics, Kim Dacosta seconded this motion, and it was unanimously approved. The recommendation will be presented to the Board for final approval.

B. BCBSFL Clinical Consultant Program Presentation

Claudia Castro, from BCBSFL, presented the Clinical Consultant Program to the committee, stating that the program included a group of clinical working to coordinate and maximize the County's benefits for both at risk members as well as wellness visits for all members. BCBSFL's clinicians mine through the clinical data to complete reporting and predictive modeling, which would include health fair data. Debbie

mentioned that at the next insurance committee meeting, Debbie and BCBSFL will present several performance based wellness incentive options. Claudia also pointed out an opportunity around diabetes management education, as only 30% of members with diabetes have not had a claim for HbA1c in the last 12 months, and it is recommended at least two times per year. Finally, Claudia reviewed the recommendations, such as promoting health fairs in order to identify the silent suspects and knowing your numbers.

IV. Old Business

V. Insurance Fund Review

A. Claims Analysis

Debbie Weiner reviewed the cost analysis through February 2011, noting that the overall trend was running at 7.97%, which was good.

VI. Adjournment

A. Schedule Next Committee Meeting

The next committee meeting was scheduled for 4/21/2011 at the Supervisor of Elections Office at 10 am. The meeting was adjourned at 11:30 a.m.

St. Johns County

Pharmacy Benefit Management Market Analysis

	Current Caremark	Renewal Caremark	Option 1 BCBSFL Prime Therapeutics <sup>4</sup>	Option 2 Envision <sup>5</sup>	Option 3 Express Scripts	Option 4 Medco
<b>FEES</b>						
Administrative Fees (Per Claim)	\$ -	\$ -	\$ -	\$ 1.85	\$ -	\$ -
Projected Annual Administration Fees	\$ -	\$ -	\$ -	\$ 96,275.85	\$ -	\$ -
Dispensing Fees						
Retail Generic	\$ 1.50	\$ 1.50	\$ 1.30	\$ 1.45	\$ 1.20	\$ 1.20
Retail Brand Name	\$ 1.50	\$ 1.50	\$ 1.22	\$ 1.35	\$ 1.20	\$ 1.20
Retail Specialty	\$ -	\$ -	\$ -	\$ -	\$ 2.00	\$ 1.20
Mail Generic	\$ -	\$ -	\$ -	\$ 9.50	\$ -	\$ -
Mail Brand	\$ -	\$ -	\$ -	\$ 9.50	\$ -	\$ -
Projected Annual Dispensing Fees	\$ 64,960.00	\$ 69,565.50	\$ 61,185.02	\$ 112,500.25	\$ 52,778.40	\$ 55,558.80
<b>Total Annual Estimated Rx Fees</b>	<b>\$ 64,960.00</b>	<b>\$ 69,565.50</b>	<b>\$ 61,185.02</b>	<b>\$ 208,776.10</b>	<b>\$ 52,778.40</b>	<b>\$ 55,558.80</b>
<b>DISCOUNTING</b>						
1/1/11 - 12/31/11 Medical ASO Fees	\$ 878,636.00	\$ 878,636.00	\$ 730,048.00	\$ 878,636.00	\$ 878,636.00	\$ 878,636.00
1/1/12 - 12/31/12 Medical ASO Fees	\$ 1,357,492.62	\$ 1,357,492.62	\$ 1,126,182.00	\$ 1,357,492.62	\$ 1,357,492.62	\$ 1,357,492.62
1/1/13 - 12/31/13 Medical ASO Fees	\$ 1,398,217.40	\$ 1,398,217.40	\$ 1,157,292.00	\$ 1,398,217.40	\$ 1,398,217.40	\$ 1,398,217.40
1/1/14 - 12/31/14 Medical ASO Fees	\$ 1,440,163.92	\$ 1,440,163.92	\$ 1,190,890.80	\$ 1,440,163.92	\$ 1,440,163.92	\$ 1,440,163.92
<b>Total Estimated 3-1/2 Year ASO Fees</b>	<b>\$ 5,074,509.94</b>	<b>\$ 5,074,509.94</b>	<b>\$ 4,204,412.80</b>	<b>\$ 5,074,509.94</b>	<b>\$ 5,074,509.94</b>	<b>\$ 5,074,509.94</b>
<b>RETAIL</b>						
Brand Name (Pre) <sup>1</sup>	AWP -17.50%	AWP -18.36%	AWP -17.44%	AWP -17.00%	AWP -20.00%	n/a
Brand Name (Post) <sup>1</sup>	n/a	AWP -15.40%	AWP -14.00%	n/a <sup>6</sup>	AWP -17.15%	AWP -15.50%
Generic Effective Rate Guarantee <sup>2</sup>	AWP -60.00%	AWP -66.00%	None	AWP -73.00%	None	AWP -73.00%
Generic	AWP -60.00%	AWP -66.00%	AWP -74.00%	AWP -73.00%	AWP -73.90%	AWP -73.00%
Non-MAC Generic (Pre) <sup>1</sup>	AWP -17.50%	AWP -27.63%	n/a	AWP -25.00%	n/a	n/a
Non-MAC Generic (Post) <sup>1</sup>	n/a	AWP -25.00%	AWP -18.50%	n/a <sup>6</sup>	n/a	n/a
Brand Name (Pre) <sup>1</sup>	AWP -25.00%	AWP -25.92%	AWP -23.20%	AWP -23.00%	AWP -26.50%	n/a
Brand Name (Post) <sup>1</sup>	n/a	AWP -23.00%	AWP -20.00%	n/a <sup>6</sup>	AWP -23.85%	AWP -23.50%
Generic Effective Rate Guarantee <sup>2</sup>	None	AWP -68.00%	None	None	None	AWP -78.00%
Generic	AWP -62.00%	AWP -68.00%	AWP -74.50%	AWP -86.00%	AWP -75.70%	AWP -78.00%
Non-MAC Generic (Pre) <sup>1</sup>	AWP -61.00%	AWP -32.66%	n/a	n/a	n/a	n/a
Non-MAC Generic (Post) <sup>1</sup>	n/a	AWP -30.00%	AWP -23.00%	n/a <sup>6</sup>	n/a	n/a
Brand	n/a	n/a	AWP -15.67%	n/a	n/a	n/a
Generic	n/a	n/a	AWP -79.20%	n/a	n/a	n/a
Retail (Pre) <sup>1</sup>	AWP -17.00%	n/a	AWP -19.59%	n/a <sup>6</sup>	AWP -15.00%	n/a
Retail (Post) <sup>1</sup>	n/a	AWP -14.75%	AWP -16.20%	n/a <sup>6</sup>	AWP -11.50%	AWP -11.58%
Mail-Order (Pre) <sup>1</sup>	AWP -17.00%	n/a	AWP -19.59%	n/a	AWP -15.00%	n/a
Mail-Order (Post) <sup>1</sup>	n/a	AWP -14.75%	AWP -16.20%	n/a <sup>6</sup>	AWP -11.50%	AWP -13.44%
<b>REBATES</b>	\$11.00 retail / \$42.00 mail	\$13.09 retail / \$46.13 mail	\$11.75 retail / \$39.50 mail	\$8.75 retail / \$35.00 mail	\$17.25 retail / \$45.75 mail	\$15.53 retail / \$48.93 mail

# St. Johns County

## Pharmacy Benefit Management Market Analysis

	Current Caremark	Renewal Caremark	Option 1 BCBSFL Prime Therapeutics <sup>4</sup>	Option 2 Envision <sup>5</sup>	Option 3 Express Scripts	Option 4 Medco
12-Mo. Claims Re-Pricing						
AWP	6,381,502	6,381,502	6,381,502	6,381,502	6,381,502	6,381,502
Ingredient Cost	3,896,063	3,756,263	3,754,534	3,235,757	3,524,544	3,762,111
Dispensing Fee	64,960	69,566	61,185	112,500	52,778	55,559
Administrative Fee				96,276		
Gross Cost	3,961,023	3,825,829	3,815,719	3,444,533	3,577,322	3,817,670
Member Cost Share	933,705	1,044,685	1,003,483	937,145	936,285	912,391
Rebates	239,514	275,916	239,667	190,724	271,397	313,042
Net Plan Cost	2,787,804	2,505,218	2,572,569	2,316,664	2,369,640	2,592,237
Claims Excluded from Repricing	n/a	0.20%	1.00%	0%	0.50%	0%
Total Estimated Rx Savings	\$	\$(282,586.50)	\$(215,234.79)	\$(471,140.11)	\$(418,164.39)	\$(195,567.03)
% Change Over Current	0.00%	-10.14%	-7.72%	-16.90%	-15.00%	-7.02%
Total Estimated 3-12 Year ASO Savings	\$	\$	\$(870,097.14)	\$	\$	\$
% Change Over Current	0.00%	0.00%	-17.15%	0.00%	0.00%	0.00%
Clinical Prior Authorization		\$30 each	No additional cost	\$8.00 each	\$0.05 PMPM	\$0.09 per claim
Step Therapy / Clinical		No additional cost	No additional cost	All programs included in Admin fee	Pricing Varies	
Rate Guarantee		5/1/2014	12/31/2014	5/1/2014	5/1/2014	5/1/2014

<sup>1</sup>"Pre" represents the Pre-AWP settlement discount and "Post" represents the Post-AWP settlement discount

<sup>2</sup>Generics at the retail and mail level are either on the vendor's MAC (maximum allowable cost) or not on their MAC list. There is a smaller discount for drugs not on the MAC list. At the end of the day, if the average generic effective rate is less than the difference between the non-MAC and MAC discounts, Caremark will make up the difference.

<sup>3</sup>Retail Generic rate is guaranteed at AWP -66.5% for 5/1/2012 and AWP -67% for 5/1/2013. Mail Generic rate is guaranteed at AWP -68.5% for 5/1/2012 and AWP -69% for 5/1/2013.

<sup>4</sup>BCBSFL will reduce the current ASO fee from \$52.15 to \$44.00 for Blue Options, and from \$ to \$ for Blue Choice, effective 5/1/11, if Prime Therapeutics is chosen as the PBM. The BO rate will increase to \$45.25 1/1/2012, \$46.50 1/1/2013 and \$47.85 1/1/2014. In the unfortunate event of an early contract termination prior to 12/31/2014, St Johns County agrees to pay BCBSF \$150,000.

<sup>5</sup>Transparent Model. Envision provided second and third year pricing, which basically guarantees first year pricing, with the exception of the retail brand discount increasing to AWP -17.5% by year three, and the dispensing fee per brand and generic Rx lowering by \$0.05 year two and year three. All brand discounts provided are pre-settlement AWP discount. Provided a 90-day at retail option with no dispensing fee. They also included the admin fee for year 2 and year 3, at \$1.90 and \$1.97.

<sup>6</sup>Adjusted AWP internally by a factor and therefore, does not disclose price based off of the current actual AWP.

DIG

ArmsRx  
Navitus

## Attachment C

To: Stacey Stanish  
From: Debbie Weiner – Senior Account Manager  
Subject: Summary of Rx RFP Analysis by Insurance Committee – 3/24/11

Each vendor was required to quote what administrative and dispensing fees they would charge and what discounts they would provide to the group for brandname and generic drugs. 5 vendors provided quotes, 2 declined to quote.

All vendors were provided an electronic file of claims processed through the current carrier system for the group in 2010.

The vendor then ran these claims through their system applying the discounts quoted on their RFP response. This is referred to as a Claims Repricing Report.

Quoted Discounts are applied to the Average Wholesale Price (AWP) of each drug. AWP is established by the First Data Bank System and all vendors start with the same AWP for each applicable drug. AWP can change on a daily basis. Because the vendors are not able to input historical AWP pricing in their Claims Repricing Report and can only use current AWP, the claims savings shown on the spreadsheet are not guaranteed. They are basically an estimate of what the claims cost would have been if the group had been with that vendor in 2010 using the discounts and fees quoted today and current AWP.

This spreadsheet of the outcomes was reviewed by the insurance committee at the 3/24/11 meeting. The committee unanimously agreed to recommend that the Rx coverage be moved to BCBSFL for the following reasons:

- Discounts are lower than current contract providing an estimated savings of \$215,000
- Dispensing fees are lower than current contract
- BCBSFL has also agreed to lower the medical administrative fee that the group pays each month per employee for the next 3 ½ years. The guaranteed savings is \$870,000 over the 3 ½ year period.
- BCBSFL has also offered to donate \$25,000 in 2011 and 2012 to SJC Wellness Program to help support programs that assist members in leading healthier lifestyles which can equate in the long run in lower claims. Proven actuarial data shows that for every \$1 invested in wellness, returns \$3 in claims savings.
- By having both the Medical and Rx together with BCBSFL, the chronic disease management care team can engage more members. For instance if a member goes to the doctor's office and is diagnosed as diabetic. The doctor's office files a code that indicates a diagnostic office visit but the code cannot tell BCBSFL what was diagnosed. But if the member files a Rx claim for medication, the care management team will know it was for a diabetic related reason. The Care Management team will reach out to the member to engage them in a diabetic management program. Based on actual 2010 claims data specific to SJC, an uncontrolled diabetic can cost the plan \$60,000 a year. If you can help to manage just 5 diabetics, estimated savings to a Plan is \$300,000.
- Members will not be issued new cards, they simply utilize their current card for both medical and rx.
- Moving to another PBM would be disruptive to the membership in addition another PBM cannot offer lower guaranteed ASO fees. They can offer lower discounts but because of the fluctuation of AWP, and because of the cost of drugs continue to trend upwards, claims savings is not guaranteed and will dissipate over time.

## Attachment D



## BlueCross BlueShield of Florida

An Independent Licensee of the  
Blue Cross and Blue Shield Association

March 11, 2011

Rachael Lando  
The Bailey Group  
1200 Plantation Island Drive, Suite 210  
St. Augustine, FL 32080

On behalf of Blue Cross and Blue Shield of Florida and Prime Therapeutics, we are pleased to acknowledge that we have attended to each of the requirements within the St. Johns County RFP to provide integrated pharmacy benefit management (PBM) services. We are committed to providing you with solutions that promote lower TOTAL net cost and improve overall satisfaction.

It is important to mention that we are sensitive to your strategic priorities including but not limited to local presence and market advantage, low net cost approach, medical and pharmacy data integration, and cost of services. We are pleased to summarize the value and importance of these key priorities on behalf of St Johns County.

### **Local Presence and Market Advantage**

Through our Florida Blue Retail locations, we are able to provide a retail health segment that affords us speed to market and the ability to better meet the needs of our members. We take pride in providing you with a pharmacy network that consists of over 3,900 local pharmacies and two mail service facilities to meet 90-day home delivery needs. For more sensitive specialty medication needs we provide services through 61 locations.

As the most recognizable brand in Florida our formulary is locally managed through a pharmacy and therapeutics committee, which is comprised of local physicians, pharmacists and allied health care professionals. This produces aligned incentives (low net cost access without conflicting interests) such as rebates for the right reasons and necessary brand medication access that limits waste and misuse/abuse. There is always a focus on the TOTAL cost and quality of managing a complete package of medical and pharmacy benefits.

We are an equity owner in our PBM, Prime Therapeutics, LLC (Prime), along with eleven other non-profit Blues plans. Prime owns PrimeMail, our mail order pharmacy vendor. Our vested interest in our PBM and our alignment of resources allows us to take a holistic (100% view) approach to the management of your employees versus only focusing on 20% as occurs with stand alone pharmacy benefit managers.

### **Low Net Cost and Integration**

Our pledge to provide affordable programs is paramount. Providing and having access to integrated health management programs at no additional cost is critical in managing TOTAL net cost. Our predictive modeling analytics and integrated health management programs increase the effectiveness of disease management, health coaching and wellness initiatives. It is important to recognize that these health management programs are coordinated by one integrated team helping to improve overall participation in disease management programs towards improved quality and savings. The reporting of such information is facilitated through a team comprised of BCBSF clinicians, pharmacists and representatives from Prime Therapeutics.

It is important to recognize the benefits and savings St Johns County can achieve through our integrated partnership:

- We estimate over \$200,000 in annual drug cost savings vs. current incumbent offer
- We estimate an average drug cost of \$72.81 vs. current incumbent average drug cost of \$76.89
- We recognize further opportunity to improve your current generic utilization rate of 71.2% through client-centric benefit modeling and forecasting tools

- We offer no additional RX fees such as administration fees, reporting, clinical prior authorizations, etc.

Most importantly we feel very strong about our total low net cost philosophy and the benefit of medical and pharmacy integration. As a result we are pleased to offer the following in support of medical and pharmacy integration under BCBSF/Prime:

- A reduction in the medical ASO fee from the current \$52.15 to \$44.00 effective 5/1/11 with BCBSF/Prime pharmacy benefit\*
- Medical ASO fee 1/1/12-12/31/12 = \$45.25 with BCBSF/Prime pharmacy benefit\*
- Medical ASO fee 1/1/13-12/31/13 = \$46.50 with BCBSF/Prime pharmacy benefit\*
- Medical ASO fee 1/1/14-12/31/14 = \$47.85 with BCBSF/Prime pharmacy benefit\*

\*Please recognize this as our commitment towards the continuation of our long term successful partnership. In the unfortunate event of an early contract termination, St Johns County agrees to pay BCBSF \$75,000. However, this early termination clause will be null if the contract is served through its full term.

#### **Summary**

We are confident that you will find our proposal to be the ideal combination of flexible benefits, network savings, network access, affordability and integrated services and look forward to working with you and your team as you proceed in reviewing the proposal.

## Reporting Capabilities

1. (PBM/RX) Attached is a report of the rx claims processed for the group in past 12 months. We would like for this to be run through your system to see what the cost would have been to the group and members with the discounts and fees that you would provide to this group.

Please refer to attached Claims History Document.

2. (PBM) List the clinical reports that are available (and at what intervals) to the Medical carrier, broker or client. Please provide sample reports, your ability to substantiate savings and associated costs.

Please refer to the attached Sample Reports document.

3. (PBM) Do you provide members with any type of monthly, quarterly, semi-annual or annual benefits cost statements showing total pharmacy spend specific to the member?

Yes, we do provide our members with a monthly and annual member health statement which provides total pharmacy spend specific to the member.

## Overview

4. (PBM) If the current PBM charges any implementation costs to switch PBMs, will you pay these costs? Refer to Jimmy

We are willing to discuss once the cost has been established.

5. (PBM) How do you facilitate/implement the conversion from a group's current PBM to yours?

We utilize a structured implementation process to facilitate the conversion from the outgoing PBM to ours. Upon notification of sale, an Implementation Specialist will be assigned to facilitate the implementation process. An implementation timeline will then be developed, identifying key activities and associated time frames. The timeline is then reviewed with the client for input and agreement. The Implementation Specialist subsequently facilitates a series of meetings or conference calls to include group structure, detailed review of benefits with client sign-off, open enrollment needs and materials, review of eligibility requirements, enrollment method and, if applicable, testing, enrollment time frames, transition of care, customer service contacts, etc. At the clients discretion, file transfers including Open Refill File for Mail Order, Open PA File, Specialty Utilization File, and Paid Claims File may be requested from the outbound PBM to alleviate disruption during conversion.

At least six weeks prior to the program effective date, we run a test file representing a variety of adjudication situations, particularly those atypical or more complex situations where special concerns arise. Approximately 150 test claim scenarios are run through the system to ensure benefits have been loaded correctly. These test claims cover the majority of benefit design issues and possible adjudication concerns. We will review test claims for such things as:

- Copay adjudication

- Pharmacy reimbursement
- Drug coverage
- Formulary design

During and after testing, we will obtain printouts of test claims, explaining what was processed and the results. If we find that a claim is adjudicating incorrectly, we can troubleshoot the problem. If there was an error in loading the benefit, a correction will be made in the system and the testing process will begin again. This testing is provided as part of the standard implementation plan to ensure quality.

Once we review the test claims and are confident with the accuracy of the group benefit setup, we sign off on the review form indicating we are in agreement on how claims will process in the system.

The test system is a unique service and an example of our desire to work with clients in meeting their needs and responding to their concerns.

Note: The outbound PBM may assess fees for these files.

6. (ALL PRODUCT LINES) Are customer service calls documented? (summarized or verbatim)?

Yes, we log and track member inquiries on either the Inquiry Control System or Siebel, depending on the product. Each of these systems creates a record with a tracking number, recording questions asked, and responses provided. Siebel empowers the member service associate with the ability to see all previous communications and triggers pre-set needs-based solutions in response to inquiries. Detailed monitoring of inquiries occurs daily.

7. (ALL PRODUCT LINES) Please describe, in detail, the billing options that are available to this client.

We offer a list bill method to report enrollment transactions or you can utilize our online capability to view monthly invoices.

8. (ALL PRODUCT LINES) How do you generally distribute SPD booklets to employees? (ie Mail to their homes, etc)

A Summary Plan Document includes sections for various types of benefits (i.e., vision, dental, long term disability, or any number of services) through companies other than BCBSF/HOI. Therefore, although we cannot agree to develop a Summary Plan Document, we are happy to provide member handbooks applicable to the benefit plan selected.

The preferred method for members to access materials, including the member handbook and applicable endorsements, is via their personal account available on MyBlueService, at [www.bcbsfl.com](http://www.bcbsfl.com). This account is the member's online gateway to everything about their health plan including access to the most up-to-date information whenever they need it, available 24/7.

9. (PBM) What do you consider your major advantage in this market and why?

As an industry leader in the Florida market, BCBSF insures more than 4 million members, providing an array of products and services to meet the needs of the diverse Florida marketplace. Through our Florida Blue Retail locations, we are able to provide a retail health segment, that affords us speed to market and the ability to better meet the needs of our members. We are an equity owner in our PBM, Prime Therapeutics, LLC (Prime), along with eleven other non-profit Blues plans. Prime owns PrimeMail, our mail order pharmacy vendor.

Our vested interest in our PBM and our alignment of resources allows us to take a holistic (100% view) approach to the management of your employees versus only focusing on 20% as occurs with stand alone pharmacy benefit managers. Our strategy is to maintain the lowest net cost formulary that also provides members the broadest access to medications.

We offer a full range of medical and pharmacy services and take pride in ensuring our services are of the highest quality. We continually seek ways to enhance services in response to market conditions and client needs. Our PBM's philosophy of aligned incentives, administrative efficiencies, and medical/pharmacy integration distinguish it from competitors in the marketplace.

Working with BCBSF, the administration of St. John's County's medical and pharmacy benefits program is simpler and more efficient, placing fewer burdens on resources. Value provided to employer groups includes both financial and administrative efficiencies.

***Financial value to employer groups includes:***

- Our retail and mail service benefits will deliver considerable financial savings without compromising the integrity of St. John's County's prescription drug program. We will work closely with St. John's County to determine opportunities to manage cost.
- Meeting cost management goals by providing expert advice and delivering innovative solutions. We are committed to aligning incentives and making recommendations that provide the most cost-effective therapy choices that continue to meet the medication needs of employees.
- Competitive pricing is on par with the largest PBMs in the industry and is forged from a partnership with Blue Cross and Blue Shield clients. Together, we drive market share to lower net-cost solutions that are applied to formulary development, benefit design, manufacturer contracts, and network reimbursement. Using this approach, we help our clients successfully decrease overall per member per month costs.

***Administrative value to employer groups include:***

- Ease of administration through fewer vendors to manage, shared eligibility and consolidated billing. In addition, employers can make one call to account management for all health plan and pharmacy questions.

- Pharmacy collaboration with BCBSF disease and case management initiatives. This integration allows for better management of the entire health care equation for plan participants.
  - Crossover for combined spending accounts, point-of-service prescription claim crossover, and combined accumulators, such as deductibles and benefit maximums.
10. (PBM) Describe the function of your Customer Service Department. (Please be sure to include times available, training, certified pharmacy techs, and contact info for head of department.)

All customer service representatives (CSRs) are highly qualified, dedicated professionals trained to assist with all types of inquiries and issues.

***Contact Center Functionality***

The Contact Center team's primary purpose is to assist members with general benefit plan and pharmacy questions. CSRs have on-line, real-time access to claims information to respond to member calls. CSRs are well positioned to handle all types of member and pharmacist inquiries for both retail and mail service, from eligibility and complex coverage issues to mail order status. For example, CSRs most often address the following topics:

- Prior authorization requests
- General claim inquiries
- Formulary questions
- Eligibility issues
- Deductible questions
- Invalid birthday clarification
- Dosage/days supply questions
- Broken, spilled, or lost medications
- Pharmacy locator requests
- Changes to formulary and/or new drugs available

***Times Available***

The Contact Center is available for service 24 hours a day, 7 days a week, including holidays. Members always have access to speak with a pharmacist for inquiries that are clinical in nature.

***Certified Pharmacy Technicians & Other Contact Center Staff***

The Contact Center employs nearly 60 certified pharmacy technicians to support the CSRs. Twenty-four hour access to licensed pharmacists is also provided for additional clinical assistance. In addition to the pharmacy technicians and pharmacists, the Contact Center employs supervisors, CSRs, quality analysts, trainers, and operations support.

## ***Training***

All members of the Contact Center team have extensive call center experience, are committed to customer service for members and clients, and have proven track records of success in running best in class call centers.

### ***Initial Training for CSRs***

The Contact Center has dedicated training staff for both initial and ongoing CSR training. Training specialists train new CSRs in both a classroom and on-the-job environment. Initial training lasts four weeks and includes study and practice of the following topics:

- Claims system
- Computer system
- Phone system
- Customer service skills
- Sensitivity training

Quizzes are administered daily to ensure comprehension of the material. All CSRs must pass a final exam before graduating. Periodically, the training staff interviews new CSRs shortly after graduating to identify any gaps in the training.

After passing the formal training, CSRs are paired with tenured CSRs during the "nesting" period. During this eight-day period, new CSRs are eased into handling member service calls. Supervisors closely monitor and track calls during the first 30 days after training to ensure CSRs are meeting service requirements.

### ***Ongoing Training for CSRs***

The Contact Center's training staff ensures all CSRs regularly refresh their skills to continue providing the highest quality of service.

Ongoing training activities and methods include the following:

- Weekly 60-minute refresher/new program training sessions
- Weekly quizzes to focus on new items or reinforce existing processes
- As-needed CSR alert publications
- Annual interpersonal skills training
- Weekly department newsletters with updates on training information
- Monthly department meetings with training activities
- Bi-monthly team lead meetings to identify training gaps and develop focused group training sessions
- Weekly coaching sessions between supervisors and CSRs

CSRs also receive individual performance statistics on a monthly scorecard. Using performance diagnostic tools, on a weekly basis or more frequently as needed, supervisors provide CSRs with feedback to improve their performance. Supervisors also review any CSR errors reported through the Prime Call Tracking (PCT) to identify trends for improvement. With one of the lowest supervisor to CSR ratio in the industry, at 1:15, the Contact Center ensures that CSRs are provided the guidance necessary to maintain superior customer service.

### ***Clinical Program Training***

Clinical program training for CSRs is developed with the oversight of the Pharmacy Manager supporting the Contact Center. CSRs receive training to include both support and execution of clinical programs, empowering them to the level consistent with pharmacy law.

All CSRs are empowered to resolve member issues, including "out of medicine" and interruption of therapy, to a level that is consistent with BCBSF and Prime's clinical programs.

### ***Contact Information***

Roger Cheek, Vice President, Contact Center Operations  
2901 Kinwest Pkwy, Building B  
Irving, TX 75063  
972-630-1175  
RCheek@primetherapeutics.com

11. (PBM) How do mail order and retail prescription claims processing systems integrate?

All data from mail, network retail, and manual retail claims is fully integrated into the same pharmacy claim system.

The key element in the integrated approach to claims management is our online, real-time eligibility verification and claim adjudication capabilities via electronic point-of-sale technology. This online, real-time link offers distinct advantages to participants.

The retail pharmacies function with the mail service as a single entity – all patient profile, eligibility, DUR, and plan design data reside in a single database. There is no need to submit additional eligibility data for members to use the mail service pharmacy portion of their prescription drug benefit. This seamless operation provides uniform and consistent DUR, reporting, and claim adjudication services. More importantly, this unified approach provides members with safe, comprehensive pharmaceutical care.

We believe that our integrated approach to mail service, combined with the benefits of working with our integrated PBM, offers a true carve-in opportunity. The value of a carve-in approach applies not only to medical and pharmacy, but also to retail and mail. Using PrimeMail means we have the ability to implement programs at mail as part of the overall group pharmacy management strategy. Mail service benefit designs and clinical programs are a key component in attaining mail service utilization goals and overall care and cost management goals.

12. (PBM) Can you support non-traditional dispensing units, i.e., home infusion companies?

PrimeMail's automation is standardized to drive efficiencies; therefore, PrimeMail does not dispense the majority of medications in packaging other than the prescription vials currently used.

Non-traditional dispensing units such as home infusion companies are administered under the health benefits.

13. (PBM) Do you have 24/7 member services? Is a live pharmacist available at a call center for members to call 24/7, or is a pharmacist pager / call back system in place?

Yes, the Contact Center provides 24/7 member service, including on holidays. Our Contact Center also includes dedicated, on-staff pharmacists who are available to assist CSRs with questions requiring clinical expertise.

Pharmacists and pharmacy technicians are available onsite at the Contact Center. These staffing numbers fluctuate throughout the day based on forecasted volume. Onsite hours are as follows:

- Monday – Friday: 7 am to 10 pm
- Saturday: 8 am to 6 pm
- Sunday: 9 am to 5:30 pm

Additionally, an on call pharmacist is available after hours, seven days a week.

14. (PBM) Mail order scripts: Please provide your average turnaround time from receipt of script to the time the member receives their medications for the following: New mail order script, Refill via phone or IVR, Refill via fax, Refill via web

Clean orders ship within an average of 0.27 business days and orders requiring intervention shipped within an average of 1.64 business days. PrimeMail's turnaround time standard for new and refill prescriptions that do not require intervention is two business days; for those prescriptions that require intervention, our standard is five business days. PrimeMail consistently meets our turnaround time goals.

Members can expect to receive their medications in as few as five to eight business days after PrimeMail receives orders. Prescription refills ordered through fax, internet, or by phone offer faster turnaround times.

According to a recent member survey conducted by Kenexa, PrimeMail delivers new prescriptions more than one day faster than other PBMs and delivers refills nearly one-half day faster.

Members can check and monitor the status of their refill order through links available on the MyBlueService member self-service portal via our website, [www.bcbsfl.com](http://www.bcbsfl.com).

15. (PBM) Do you provide Drug Information Service, and if so, how does it function?

Yes, BCBSF and Prime provide members and physicians with comprehensive drug information via the internet.

#### ***Member Access to Drug Information***

BCBSF and Prime provide both general and plan specific drug information through the pharmacy member website, [www.myprime.com](http://www.myprime.com), accessible via a link from [www.bcbsfl.com](http://www.bcbsfl.com).

#### ***Formulary Search***

The Formulary Search feature allows any website user to search on client-specific formularies. While logged on, members are able to search their formularies based on their specific coverage and benefits. When searching for brand drugs, the generic equivalent and similar drugs are provided in addition to the brand drug.

#### ***General Drug Information***

Members can select multiple drugs at a time to check for general drug information like adverse drug interactions, uses, and side effects. Members are also provided information on precautions, overdose warnings, food interactions, and medical alerts.

Prime uses MediSpan as the source of drug information for our website, including complete drug profiles with color photo illustrations of any drug listed in MediSpan. Illustrations may also show the specific dosage form for identification.

#### ***Drug Pricing***

The Drug Pricing feature allows members to search on any drug to calculate the costs at both retail and mail for generic and brand products. For a member who has logged onto the secure member area of our website, the Drug Pricing feature uses plan-specific cost information specifically based on the member's coverage and pharmacy benefit plan.

When a member enters a drug, form, quantity, strength, and package size (when applicable), the Drug Pricing feature returns the amount the member would typically expect to pay for the specified drug at that time, based on the member's copayment and other benefit design features.

Members can also price shop by location by selecting a pharmacy based on address or zip code. The feature automatically prices at the member's last used pharmacy but another pharmacy can be easily selected. Members can also view side-by-side retail versus mail savings opportunities.

#### ***Generic Alternatives and Therapeutic Equivalents***

When members enter the name of the prescription drug, form, and strength into the Drug Pricing feature, the website automatically identifies generic equivalents when available, presents a side-by-side cost comparison, and highlights potential savings.

Our website also provides a link to a special feature, which allows members to view brand and generic alternatives and therapeutic equivalent drugs as a way to save money by choosing similar drugs.

### *Physician Access to Drug Information*

Prime's website, [www.primetherapeutics.com](http://www.primetherapeutics.com), provides timely and relevant information to physicians including the following:

- Formularies and formulary updates
- Prime Drug Insights communications on new drug information, timely pharmaceutical and health care industry news, and drugs advancing through the pipeline

Prime updates the website on a continual basis to ensure physicians have the correct, accurate, and quality information in connection with the services we perform on behalf of clients.

Additionally, BCBSF supports electronic prescribing (e-prescribing) in conjunction with Prime, through Prime's established e-prescribing partnership with Surescripts. Prime has built the infrastructure required to support today's most common e-prescribing transaction standards (eligibility, formulary, medication history, new prescription, and refill/renew).

16. (PBM) Please explain your organizations philosophy in driving the lowest net cost within therapeutic classes, considering therapeutic efficacy, rebate comparison and physician education.

Our formulary strategy is to maintain the lowest net cost formulary that also provides members the broadest access to medications. Our PBM contracts with manufacturers that are generally structured to provide an access discount (i.e., a discount given for having a product on formulary) and volume discounts that are dependent on the market shares achieved by products on the formulary. Higher market shares will earn higher discounts on the overall utilization of a product.

Benefit design is still one of the most effective methods of containing cost. By implementing three- and four-tier copay or coinsurance benefit designs and/or adjusting brand/generic differentials, you can significantly reduce costs.

We focus on achieving specific cost management goals based on your business objectives and unique participant needs. We will work closely with you to determine where the opportunities lie to manage cost followed by recommendations for programs that achieve specific goals.

Additionally, we are committed to aligning incentives and making recommendations that provide the most cost-effective therapy choices that continue to meet the pharmacy needs of participants.

17. (PBM) Describe your organization's pharmacy approach to managing members with chronic and complex conditions.

We take an integrated approach in collaboration with our Care Team in managing members with chronic and complex conditions.

As the health care industry evolves, we believe the need for innovative integration of medical and pharmacy data increases. A long time belief is that integrating pharmacy and medical data produces better health outcomes and reduces overall

cost. Specifically, we believe that medical and pharmacy data integration provide the following benefits:

- Clinically superior and more cost-effective health care;
- Improved participant health and quality of life, while using fewer expensive health care resources;
- Improved predictions of drug utilization and identification of groups and individuals at risk for catastrophic events, so proper interventions can be targeted and implemented;
- Lower overall trend due to more successful programs and intervention strategies;
- Early identification of potential case, disease and/or disability management for participants; enhanced quality care due to ability to identify participants at risk based on diagnosis;
- Greater ability to identify over-utilization and under-utilization of medications based on medical diagnosis offering greater opportunity for effective interventions;
- Increased opportunities to support enrollment in medical and pharmacy specialty programs; and
- Increased ability to identify and close gaps in care related to patient noncompliance with the refilling of prescribed medications.

18. (PBM) Describe your approach regarding the emerging area of personalized medicine and genetic testing.

We require genetic testing for coverage of certain medications (e.g., Erbitux; Vectibix for KRAS testing and Herceptin for HER2 analysis, etc.). These tests are performed to assure the patients will respond to treatment. As other tests are identified we will certainly incorporate them into our medical coverage guidelines.

19. (PBM) Are you willing to and capable of providing routine external claims feeds to the client's medical carrier for purposes of disease management, case management etc.? Do you charge an additional fee for this service?

We are proposing an integrated medical/pharmacy program, which we feel, is essential for superb medical management and cost effective health care. Our pharmacy strategy is to promote the management of pharmacy programs in conjunction with health care management of members in order to obtain the best medical outcomes possible. Integrating pharmacy claims and medical data is at the cornerstone of our ability to offer groups value for their health care investment. We clearly understand that to optimize value from pharmaceuticals, the drug benefit must be integrated into a comprehensive medical plan as opposed to simply a drug spend component management.

20. (PBM) Describe your approach to leveraging the internet to engage members to identify and select more cost effective drugs, including generic equivalents, generic alternatives, and lower cost brands.

We provide an online self-service center, MyBlueService (MBS), which enables members to get information around-the-clock, whenever they need it most. This center provides access to helpful information on prescription drugs and their cost, pharmacy benefit information as well as general health topics. Designed for use by participants, our tools encourage cost-conscious purchasing behavior by promoting generic utilization, formulary compliance, and healthy lifestyles. MBS can be accessed through the Member Login at [www.bcbsfl.com](http://www.bcbsfl.com). Once signed in members may easily access pharmacy information by selecting My Benefits, Pharmacy, and then selecting Information & Resources, Compare Drug Prices, Pharmacy Claims, or Find a Pharmacy. The following is a brief description of those selections:

### **Pharmacy Information & Resources**

#### ***Mail Order.***

Members may learn more about mail order, handled through PrimeMail.

#### ***Find a Participating Pharmacy.***

Filling prescriptions at a participating pharmacy saves members money and eliminates the need to file claims. Members can check the provider directory for a list of participating pharmacies in their area.

#### ***Compare Drug Prices from Selected Pharmacies.***

This tool allows members to compare prescription drug prices from selected pharmacies and find generic alternatives online. Comparison shopping can help members save significantly on prescription drugs as pharmacy charges can sometimes vary greatly for the same drug.

#### ***Generic Drugs.***

Generic drugs have the same active ingredients, strength, dosage form, safety, quality and performance as their brand counterparts. Members can learn more about generics here.

#### ***Responsible Rx.***

To help keep members drug costs down, pharmacy plans may: require members to try certain drugs before another drug is covered; limit the quantity of a drug covered within a certain time period; or provide dosing recommendations approved by the FDA. Members can learn more about Responsible Rx here.

#### ***Helpful Links.***

Links to additional sites providing more information on prescription drug choices for consumers.

Includes link to member video: Shop for the Lowest Rx Price.

### *Approved Drug Lists.*

The Medication Guide includes covered medications, indicates available generics, and if there are any special requirements or limits.

Pharmacy and Prescription Drug Frequently Asked Questions. Includes a wide range of pharmacy questions and answers.

Rx Drug Forms. PDF files of all prescription forms.

### *Pharmacy Claims*

Here members are linked to MyRxHealth, providing easy access to information on prescription drugs, including drug safety information. Members have access to targeted, useful information on the formulary, generic alternatives to brand medications, cost information, cautions and side effects, drug interaction information, and drug topic articles. The website was designed to educate members, promote generic drug utilization, provide formulary information, and encourage healthy lifestyles.

*Available features include:*

- Drug pricing feature;
- Formulary search and listing capability;
- Generic utilization;
- Mail service refills, order status verification, and account access.
- Ways to save; and
- Drug News & Perspectives

This site is an ideal complement to today's rapidly emerging consumer-directed health plan initiatives, where members assume greater responsibility for making health care purchasing decisions.

21. (PBM) As a PBM do you have any type of wellness offering? If so, are there any additional costs associated with it?

We have partnered with some of the best online health and wellness resources to provide our members value-added interactive tools and features. We want members to get more out of their health care plan, differentiate among the cost and quality of health care alternatives, and ultimately make better-informed health care decisions. Our tools provide information to help members choose the most qualified doctor and hospital for their needs, estimate their costs before a health care visit, and much more.

22. (PBM) Do you offer an HRA and biometric testing? Refer to Jimmy

Yes, through our Better You from Blue wellness program.

23. (PBM) Does your program have a specific element for smoking cessation, if so, please describe in detail, including outcomes.

We offer the following smoking cessation programs to help members assess their readiness for change and deliver support and tools for improved success rates.

#### *Next Steps*

Our Lifestyle Management program, Next Steps, delivers an array of health education services to members. Nurses offer onsite and/or telephonic tobacco cessation classes. Two classes are available, chosen based on the needs of the employer group. Freedom from Smoking, developed by the American Lung Association, offers an eight session class with class time of one hour. The Area Health Education Centers (AHEC) offers Quit Now™ with six session program with class time of one hour. Success rates of 25%-30% are reported by both programs. Next Steps provides members with specialized education based on their health risk, personal needs, and ethnicity and language preferences. Members are identified, stratified, and triaged by risk and then contacted via phone and mail. Members receive clinical assessments, goals, plans, schedule, and follow-up support. High-risk members are referred to appropriate care resources.

#### *Health Coaching*

Our disease management program, powered by Health Dialog, provides members with experienced health professionals, including certified smoking cessation specialists that use all interactions with members to positively impact their health, including motivational interviewing and assessment of individuals' readiness to change. These professionals may direct members to web based modules available on MyBlueService via [www.bcbsfl.com](http://www.bcbsfl.com).

#### *Health Management Centers – Tobacco Use*

Through our arrangement with WebMD our members have access to online Health Management Centers that provide support in their efforts to improve and maintain their health. The Centers provide tools that can help members tackle important health challenges and information to achieve a healthy future. The resources provided are tailored to the member based on the answers provided in the WebMD Personal Health Assessment and include a center on **Tobacco Use**. Here members can learn more about how to be and stay a non-tobacco user. No matter how long they have used tobacco, there's hope for better health. Members also have access to topic specific online communities provided by WebMD. Integrated in relevant Health Management Centers, they provide a forum for members to communicate with others who have similar concerns.

#### *Lifestyle Improvement Programs – Smoking Cessation Program*

In addition to the Health Management Centers, members will also have access to WebMD Lifestyle Improvement Programs which address the practical and educational aspects of behavior change. The online change program for **smoking** provides a personalized, engaging, and highly interactive way for members to address and improve their risk factor at their own pace. A healthy lifestyle is the key to continued well-being. Changing one's lifestyle for the better takes time and real effort. But,

with the help of this program, members can do it. And it's worth it: Quitting tobacco can reduce the risk of heart disease and stroke and improve self-esteem.

The Smoking Cessation Lifestyle Improvement Program has two equally important parts: the Readings and the Planner. Together, they take about 30 minutes per day to complete. It is recommended that participants read one step of the Readings per day and check their Planner daily.

The Readings take participants through 70 steps, divided into 10 phases. Each step provides practical tips and information for planning and achieving a successful quit attempt. Participants will also find Journaling Activities. Keeping a journal is a powerful tool for lasting change. It helps participants identify their personal obstacles, plan ways to overcome them and record their successes. The Planner provides a place to track the number of cigarettes smoked each day. Like the Journaling Activities, the Planner is a great way for participants to record their progress.

### ***National Discount Program***

Our national discount program, Blue365, offers members special access to resources that make it easier and more affordable to make healthier choices. This program delivers health and wellness tools and services, information, and discounts to help our members manage their health care experience and make healthy choices. They can take advantage of exclusive discounts at select local companies and leading, national brands for everyday health and wellness or family care. This program provides members access to various smoking cessation products and services.

It's easy for members to find out all the details for these exclusive savings – the information is available online 24/7. Members can visit [www.bcbsfl.com](http://www.bcbsfl.com) and log on to MyBlueService, our member self-service center. Under discounts and rewards, members can select discount programs for members to begin taking advantage of specific offers. New products and services are being added to the member discount program all the time – so members should check back often for new savings opportunities.

24. (ALL PRODUCT LINES) Do you provide one main contact for the daily administrative needs of this plan?

You will continue to have Shon McNamee as your point of contact for any administrative needs.

25. (PBM) Please include performance guarantees in the areas of plan implementation, claims payment customer service, and account management. (Please include rate guarantee).

No specific pharmacy performance guarantees are provided at this time. Please refer to the special ASO fee concessions included in the cover letter.

### **Claim Facility and Personnel**

26. (ALL PRODUCT LINES) What are the hours of operation for customer service?

Our member service representatives can be reached through our toll-free number, (877) 352-2583 from 8 a.m. to 9 p.m., Monday through Thursday, and 9 a.m. to 9

p.m. EST on Friday. The mailing address for claims is P.O. Box 1798, Jacksonville, Florida 32231.

Members may also access our member self-service center, MyBlueService, via the web 24/7, 365 days a year at [www.bcbsfl.com](http://www.bcbsfl.com).

27. (ALL PRODUCT LINES) Do customer service representatives have authority to adjust a claim during a call?

You will continue to receive a dedicated service unit that will handle all of your claim issues.

28. (ALL PRODUCT LINES) Provide the address of the locations that would be processing claims/providing customer service for our client.

Our primary claims administration and customer service location that will be providing service to St. John's County members is located at our home office in Jacksonville, Florida.

29. (PBM) How many claims processing platforms do you support? Explain the integration of systems and how to ensure a smooth member experience.

We support our internal common claims processing system which fully integrates with our PBM's pharmacy claims processing system. As such, we have excellent capabilities for integrating pharmacy claims and medical data to enhance drug utilization review and comprehensive pharmacy benefit program initiatives. Integrating pharmacy claims and medical data is at the cornerstone of our ability to offer groups value for their health care investment. We clearly understand that to optimize value from pharmaceuticals, the drug benefit must be integrated into a comprehensive medical care plan as opposed to simply a drug spend component management.

#### ***Traditional Pharmacy Management and the Evolving Health Care Industry***

Traditionally, employers and health plans have isolated pharmacy management from medical management. Cost containment strategies are primarily determined by reviewing pharmacy data with little or no consideration of how pharmacy decisions will impact medical costs, or how the strategy could be significantly more successful by understanding the medical rationale behind the prescribing of certain medications.

We believe as the health care industry evolves, the need for innovative integration of medical and pharmacy data increases. A long time belief is that integrating pharmacy and medical data produces better health outcomes and reduces overall cost. Specifically, we believe that medical and pharmacy data integration provide the following benefits:

- Clinically superior and more cost-effective health care;
- Improved participant health and quality of life, while using fewer expensive health care resources;
- Improved predictions of drug utilization and identification of groups and individuals at risk for catastrophic events, so proper interventions can be targeted and implemented;

- Lower overall trend due to more successful programs and intervention strategies;
- Early identification of potential case, disease and/or disability management for participants; enhanced quality care due to ability to identify participants at risk based on diagnosis;
- Greater ability to identify over-utilization and under-utilization of medications based on medical diagnosis offering greater opportunity for effective interventions;
- Increased opportunities to support enrollment in medical and pharmacy specialty programs; and
- Increased ability to identify and close gaps in care related to patient noncompliance with the refilling of prescribed medications.

### *Data Integration Strategy*

To provide groups with significant and long-term value, data integration is incorporated into many of our programs.

- Trend management – Integrated claims data can establish relationships between current pharmacy use patterns and future health expenditures.
- Utilization management and clinical programs – UM programs (e.g., retrospective DUR, prior authorization, step therapy) are more effective when medical data is incorporated. The integration of medical data into these programs allows for more accurate targeting, better quality of care outcomes, provider and member satisfaction.
- Specialty drug management – Currently, half the time spent on specialty drugs is going through the medical adjudication process. Management of these high-cost medications is more effective when we have an understanding of the medical diagnosis.
- Proactive clinical program development and validation – Our medical and pharmacy integration initiative utilizes a database of pharmacy and medical data to conduct investigations that focus on the proper use of drug therapy to maximize quality of patient care and total health care cost-effectiveness.

### *Integration Experience*

We can integrate medical and prescription claims data to enhance drug utilization review and disease management initiatives. We have significant experience using an integrated approach to link medical data and pharmacy utilization to leverage better solutions to pharmacy management challenges.

30. (PBM) Do you charge an additional fee for allowing & processing claims as part of coordination of benefits for members with secondary coverage?

Currently, we do not offer coordination of benefits capabilities at point of sale, as this is not a standard industry practice. However, COB recoveries are done on a pay and pursue basis as is the standard with most other PBM's.

## **Claims Administration and Adjudication**

31. (PBM) Do you cover or exclude FDA approved drugs utilized for off-label drug indications?

BCBSF excludes pharmacy coverage of selected non-FDA approved drugs. Our pharmacy endorsements support exclusion of coverage for drugs that are not approved by the FDA for any indication. Our pharmacy endorsements also exclude coverage for products that were approved by the FDA as a medical device or a medical food.

32. (PBM) Please address the following pricing items in detail: Dispensing Fee, AWP Discount, Administration Fee, Clinical Fee, Mail Order Program, Specialty Pharmacy Pricing- include a list of products covered and associated prices off of AWP, Rebates, Prior Authorization, Any other fees not mentioned in this RFP.

The estimated pass thru retail dispensing fees are brand \$1.22 and generic \$1.30.

The estimated pass thru AWP discounts are brand retail 14.0%, generic retail 74%, brand mail 20%, generic mail 74.5%, and specialty 16.2%.

There is no administration fee, no clinical fee, no prior authorization fee.

Please refer to the attached Specialty List document.

The rebates estimate is brand retail \$11.75 per brand script and brand mail \$39 per brand script.

33. (PBM) Do you utilize multiple MAC lists? Please explain in detail how and when these lists are utilized.

One Maximum Allowable Cost list (MAC) is utilized for the Florida based network.

Our mail order vendor Prime mail utilizes their own MAC list for the mail order pharmacy.

34. (PBM) Please provide your mail & retail service discounts and fees for the following:  
Mail Order: Brand Discount off of AWP, Generic Discount (MAC & Non-MAC) off of AWP, Dispensing Fee per Rx, Admin Fee per Rx  
Retail: Brand Discount off of AWP, Generic Discount (MAC & Non-MAC) off of AWP, Dispensing Fee per Rx, Admin Fee per Rx

Estimated pass thru retail dispensing fees are brand \$1.22 and generic \$1.30.

Estimated pass thru AWP discounts are brand retail 14.0%, generic retail 74% (76% MAC and 18.5% non MAC), brand mail 20%, generic mail 74.5% (78% MAC and 23% non MAC), and specialty 16.2%.

35. (PBM) Are your mail and retail discounts and fees a pass-through of your organization's contracted rate or is there margin between your billable and payable rates?

Our pharmacy management model fosters transparency. We do not utilize spread pricing. Groups receive the discounts that we have actually negotiated with network pharmacies. There is 100% pass through of pharmacy payable discounts and dispensing fees on a claim-by-claim basis.

36. (PBM) Are any claims excluded from your retail and mail discount guarantees? If so, please describe in detail. Confirm that your generic guarantee includes all generic products (MAC and Non-MAC) when at least two competitors exist for a general product.

We are providing 100% pass thru pricing no pharmacy specific guarantees. Please refer to the special ASO fee concessions included in the cover letter.

37. (PBM) Please provide a formulary rebate guarantee either on a per total Rx basis or per contract per month basis. If a per total Rx basis is offered, confirm your guarantee is measured across all claims, brand and generic, formulary and non-formulary, and that no claims are excluded or pro-rated in the guarantee calculation.

We are providing 100% of earned rebates no pharmacy specific rebate guarantees. Please refer to the special ASO fee concessions included in the cover letter.

38. (PBM) For retail and mail order: Is the actual package size dispensed to the patient the same as the actual package bought by the dispensing pharmacy? If not, what criteria/formula is used to determine final cost to the patient? (i.e. Is the pharmacy supplier buying in bulk and then re-packaging solely to obtain profit?)

Yes, for both retail and mail, the AWP is priced off the actual package size. The claims system uses the full 11-digit National Drug Code (NDC) number for claims processing. For retail, drug price is determined according to the NDC submitted by the pharmacy.

PrimeMail service pricing is based on the actual package size dispensed. PrimeMail does not engage in repackaging or relabeling practices that artificially raise prescription drug prices for clients and members. Each prescription's NDC code is the same as the original packaged NDC code.

## **Auditing Practices**

39. (PBM) How much paid history do you retain for reporting, clinical editing, and for audit purposes?

BCBSF's PBM, Prime, maintains claims history online and in archived format to ensure ongoing, consistent access to data. Our standard is to retain pharmacy claims history files, eligibility information, and all other system data online for the current year plus the previous three years of data. Data older than four years is archived and stored following Prime's corporate retention policy of ten years.

## **Network Administration**

40. (PBM) Describe your pharmacy network in terms of size and nationwide coverage. What major chains (20 or more locations) do not participate in your offered retail network?

We contract with the following retail pharmacy chains, which are included in our comprehensive network of over 4,000 pharmacies in the state of Florida: Albertsons, CVS, Kmart, Publix, Walgreens, Wal-Mart, Target and Winn-Dixie.

For members traveling outside the state of Florida, we use the National Pharmacy Network comprised of over 61,000 pharmacies nationwide administered by Prime Therapeutics, which includes most of the major chains within each state.

41. (PBM) What is the source of AWP used in your billing formula? Do you use more than one source of AWP? what references are used and what criteria are used to select a specific AWP among sources? (i.e. If utilizing drug info from one source with multiple AWP options, do you consistently utilize the same AWP amount for the same prescription?) What NDC is used to price the transaction?

Medispan is the AWP source utilized, as is an 11-digit National Drug Code for pricing transactions, and is updated weekly.

42. (PBM) Are there any system limits to calculating lesser prices between AWP discount and dispensing fee, Usual and Customary Pricing, and Maximum Allowable Cost (MAC) and dispensing fee?

No, there are no system limits to calculating lesser of prices; lower-of logic is used to process claims. As such, members pay the lower of the standard copay amount, the contracted rate, or the U&C charge of the retail pharmacy, whichever is the lowest.

43. (PBM) What options do you have for pricing prescriptions less than the member's copay?

Prescriptions that are less than the members copay adjudicate at lesser of pricing logic.

44. (PBM) Do you provide clients with assistance in devising new pharmacy benefit programs and evaluating cost savings achieved by changes in benefit language?

Yes, we can provide consultative assistance with regards to pharmacy benefit programs and the evaluation of costs savings .

45. (PBM) Please describe how you handle rebates and a process in which the client can verify the distribution of the rebate share. In addition, please confirm that your mail and retail service discounts are guaranteed on an annual basis and that any shortfall below the guarantee will be credited dollar for dollar by your organization.

For ASO groups with first quarter enrollments, the rebate reporting is 180 days later or approximately October 1 and the rebate check is ready no more than 60 days after that or about the end of December. We typically send rebates out in less than 30 days; however, if we have to make changes to the programming that drives rebates, it can take 60 days. We engage the services of a national accounting agency to conduct rebate audits on our behalf - Price Waterhouse

46. (PBM) How do you educate your network concerning a new plan sponsor or group?

We provide education to our participating pharmacies via Provider Education materials, Fax Blasts and Prime Perspectives.

## **Utilization Review Services**

47. (PBM) Provide a description of your Drug Utilization Review (DUR) programs to include retrospective, concurrent, and prospective programs. Provide sample reports, your ability to substantiate savings and associated costs. How quickly is retrospective DUR performed?

We strive to reduce prescription drug costs through several comprehensive programs and benefit designs. These important programs provide cost-savings, but also help ensure members are receiving high-quality care and cost-effective drug therapy.

### ***Drug Utilization Review***

We offer a suite of concurrent and retrospective drug utilization review programs. The utilization management programs control claims utilization by applying established clinical criteria and best practices to the management of these drug therapies. The clinical criteria are based upon peer reviewed literature and claims data. The programs are highly targeted, and in some cases utilize both pharmacy and medical data to enhance the programs' effectiveness.

### ***Retrospective Drug Utilization Review***

Retrospective drug utilization review (DUR) programs are designed to manage drug utilization and identify potential misuse and abuse. Potential intervention opportunities are identified by reviewing medical and pharmacy claims history for specific aberrant prescribing patterns in targeted diseases such as asthma, depression, and hypertension. Physicians and/or members are then targeted for an intervention to encourage more appropriate utilization.

Historically, DUR programs have centered around edits (e.g., drug to pregnancy) that focus on appropriate therapy according to manufacturer labeling information as provided by drug database sources, such as MediSpan. However, studies have demonstrated that for the majority of the time, these edits provide alerts that do not result in improved member outcomes. As a result, second generation DUR programs have appeared in the marketplace.

As such, we offer second generation retrospective drug utilization protocols based on national prescribing guidelines. In contrast to the traditional DUR offering, these programs focus on appropriate therapy according to national guidelines and are traditionally stand-alone programs. Our retrospective DUR program, rooted in evidence-based medicine and national guidelines, provide more value to clients and our ultimate customer, the member.

### ***Frequency***

The intervention method for retrospective DUR is typically a physician mailing on a quarterly basis. Retrospective DUR program letters are sent to physicians immediately after the drug utilization review. Information sent to physicians may include:

- Letter explaining the clinical issue;
- Drug utilization profile for each identified member; or
- Feedback-response survey.

Retrospective DUR programs provide informative and actionable information to the physician, with the expectation that the physician will address drug therapy changes directly with the member. Changes in therapy are measured at defined intervals, and retrospective DUR initiatives can be repeated to address persistent medication use problems.

### *Savings*

The success of retrospective DUR programs is measured by the percentage of changes in utilization, not per member. Savings are dependent upon program selection, as some programs are quality initiatives that are expected to result in increased adherence and pharmacy costs, some are safety messages and others are generic programs but all savings are provided on a program by program basis.

Typically, one in ten retrospective DUR interventions achieves a positive outcome; cost savings will vary by specific program and member population.

### *Concurrent Drug Utilization Review*

The concurrent DUR program screens prescriptions at the point of sale for potential drug problems. If a DUR edit flags a claim in the claims system, a message is displayed online for the pharmacist to identify the potential conflict before the member receives the medication. This is particularly effective for member interventions. The pharmacist then explains the message to the member and, if applicable to the benefit design, denies the prescription for coverage. Most concurrent DUR edits, however, are set as informational only in which pharmacists use their professional judgment in dispensing medication.

We comply with the National Council for Prescription Drug Programs (NCPDP) specifications for online DUR and support all available MediSpan modules. Our claims system can store multiple messages for reporting purposes. Receipt of the message is based on capabilities of the pharmacy software.

Standard concurrent DUR edits include:

- Drug-to-drug interaction;
- Drug-to-gender caution;
- Duplicate therapy;
- Duplicate prescription;
- Drug-to-age caution;
- Dosage/duration;
- Drug regimen compliance; and
- Drug-inferred health state.

All participating network pharmacies, including PrimeMail, access the claims system, online and in real time, for concurrent DUR. Whichever pharmacy a member uses, that transaction becomes a part of his or her complete profile. Claims are checked against the current and comprehensive profile for each member.

### *Frequency*

Concurrent DUR edits automatically check all claims at the point of sale for potential problems. All prescriptions are subjected to concurrent DUR edits.

### *Savings*

In general, savings through the effective use of concurrent DUR edits will vary from one to two percent.

#### 48. (PBM) How do you monitor Controlled Substance drug usage?

The Controlled Substance DUR identifies members whose utilization of controlled substances appears to be excessive based on a combination of measured parameters. These parameters include the number of controlled substance claims filled during a three-month time period, the number of different prescribers, and the number of different dispensing pharmacies associated with those claims. These three measures are used to compute an "usage score" that serves as the benchmark for identifying members. Physicians identified as the prescriber for one or more claims receive a letter and controlled substance medication profile for each of their identified patients. The physician is asked to review the profile and communicate any necessary changes in drug therapy to the patient and/or the patient's pharmacy.

This report assesses the impact of a single targeted prescriber mailing by comparing controlled substance utilization in intervened-upon members during a three-month post-DUR time period to the three-month pre-mailing DUR period. Members who disenroll from the plan following the mailing are excluded from analysis.

#### *DUR Inclusion Thresholds*

- Members with an usage score of 12 or higher and at least 14 controlled substance claims were identified.
- Regardless of score, members with concomitant claims for cancer or HIV drugs were excluded.

#### *DUR Statistics*

DUR Pre-Period	11/01/2009 – 01/31/2010
# Prescribers Identified	2,107
# Unique Members Identified	948
Mail Date	03/01/2010
DUR Post-Period	3/20/2010 – 6/18/2010
# Members Disenrolled	104
# Members Eligible for Measurement	844

#### *Results (n = 844 Eligible Members)*

	Pre	Post
Average Usage Score	19.6	14.8
# Members with Decrease in Score	N/A	624
# Members with No Change or Increase in Score	N/A	220
# Controlled Substance Claims	13,899	10,771
Controlled Substance Costs	\$1,929,336	\$1,624,170
Reduction in Controlled Substance Costs (per measured member)	N/A	\$305,166 (\$362)

The Controlled Substance DUR resulted in a reduction of the controlled substance usage score in 74% of the members measured. The average usage score decreased from 19.6 to 14.8 indicating an overall reduction in the members' use of controlled substances, multiple prescribers, multiple pharmacies, or a combination of these parameters. Total controlled substance claims decreased 22.5% in the measured members and the reduction in utilization was associated with an approximate 16% reduction in controlled substance costs.

49. (PBM) How do you monitor Therapeutic duplications?

Therapeutic interactions are actively monitored for intervention through the concurrent and retrospective drug utilization review (DUR) programs. The concurrent DUR program monitors claims for duplicate therapy at point of sale for immediate intervention.

50. (PBM) How do you monitor Drug to Drug interactions?

Drug interactions are actively monitored for intervention through the concurrent and retrospective drug utilization review (DUR) programs. The concurrent DUR program monitors claims for drug interactions at point of sale for immediate intervention if deemed appropriate. Our retrospective DUR program affords BCBSF the opportunity to be a liaison to facilitate the communication of potential drug interactions, as evidenced through reports that are able to evaluate pharmacy claims of pharmacies that are not of the same chain or franchise.

51. (PBM) How do you track the effectiveness of your DUR interventions?

The success of retrospective DUR programs is measured by the percentage of changes in utilization, not per member. Savings are dependent upon program selection, as some programs are quality initiatives that are expected to result in increased adherence and pharmacy costs, some are safety messages and others are generic programs but all savings are provided on a program by program basis.

Typically, one in ten retrospective DUR interventions achieves a positive outcome; cost savings will vary by specific program and member population. Savings through the effective use of concurrent DUR edits will typically vary from one to two percent.

52. (PBM) What are your parameters for fraud/abuse edits at the member, pharmacy, and physician levels?

We can identify members that are possible drug abusers through our high drug utilization review program and poly-pharmacy program.

The Drug Utilization Review (DUR) program is comprised of three components, Concurrent DUR, Retrospective DUR and High Utilization DUR interventions. Components target the promotion of medication safety and appropriate medication utilization. The High Utilization DUR program evaluates the utilization patterns of members relative to the frequency of drug refills and the frequency and use of pharmacies. As aberrancies are identified providers are informed for action as deemed appropriate.

A voluntary Commercial Polypharmacy Program is in place to encourage members with multiple chronic medications to have their medications and supplements reviewed with their doctor. The program targets members who are taking five or more chronic medications for three consecutive months, prescribed by more than

one physician. Members matching the criteria, identified by claims data, are at higher risk for adverse effects, drug interactions and non-compliance.

53. (PBM) What other programs do you have that promote cost-effectiveness? Please provide sample reports, your ability to substantiate savings and associated costs.

We are committed to aligning incentives and making recommendations that provide the most cost-effective therapy choices that continue to meet the pharmacy needs of participants. Our current programs include:

#### ***Reducing Costs Beyond Discounts***

Carved-out PBMs have migrated toward revenue streams focused on manufacturer rebates and other manufacturer sources. Despite market rhetoric around "low net cost strategy," most PBMs are not truly focused or committed to a low net cost model. This is evidenced by misaligned formulary strategies driven by rebates at the expense of low net cost. Another example is the drug therapy promotional campaigns financed by pharmaceutical manufacturers and executed by PBMs that are not necessarily in a plan sponsor's best interests. We focus on achieving specific cost management goals based on your business objectives and unique participant needs. We will work closely with you to determine where the opportunities lie to manage cost followed by recommendations for programs that achieve specific goals.

The following are several utilization management programs we use to manage pharmacy costs:

- Benefit Design/OTC products;
- Prior Authorization;
- Step Therapy/Responsible Steps;
- Quantity Limits/Responsible Quantity;
- Mandatory Generic Substitution.
- Generic Incentive Programs.

#### ***Benefit Design / Move to Over the Counter Products***

Benefit design is still one of the most effective methods of containing cost. By implementing three- and four-tier copay or coinsurance benefit designs and/or adjusting brand/generic differentials, you can significantly reduce costs.

In addition, with several prescription products moving to over the counter (OTC) status within the last two years, we have an opportunity to encourage use of OTC alternatives rather than the more expensive prescription medications.

BCBSF implemented a program for coverage of OTC products July 1, 2007. This program allows for the coverage of select OTC medications when a member's physician prescribes an over the counter drug. Initially, this program allowed for coverage of Prilosec OTC. We plan to continuously evaluate and add to the OTC coverage as deemed appropriate.

Over the counter products will be covered on a group's first tier or at the generic cost share amount which is one in the same for most accounts.

Coverage of OTC products are identified in our Medication Guide. Members may access the Medication Guide via our website, [www.bcbsfl.com](http://www.bcbsfl.com), to determine if and when additional OTC drugs have been added.

### ***Prior Authorization***

Prior authorization (PA) effectively manages high-cost medications that have a significant potential for inappropriate utilization. The tool encourages safe and appropriate drug use based on FDA-approved labeling, scientific literature and nationally recognized guidelines. A clinical team of doctors and pharmacists reviews the FDA-approved manufacturer labeling and nationally accepted treatment guidelines to identify medications for the PA list. Medications are only selected if they meet the criteria – high-cost, high-use with clinical rationale that supports the ability to change utilization. This ensures that the PA tool helps to improve patient care while managing costs.

The PA process requires that specific criteria be met before the medication is covered under the patient's current prescription benefit. If the patient does not meet the PA criteria, the claim is rejected and a message is returned to the pharmacy stating that prior authorization is necessary. Prescribing physicians request a PA exception to override the edit. Specific PA guidelines were established to determine which exception requests should be approved. All approved PA exceptions are recorded into the claim system for up to one year.

### ***Step Therapy / Responsible Steps***

Step therapy helps ensure patient safety while managing the cost of specific drugs. It is used for pre-selected, high-cost drugs or drugs that have a high potential for misuse or inappropriate prescribing. This means that specific high-cost medications, based on clinical criteria, are considered for patients after a more appropriate, cost-effective medication has been tried.

Step therapy utilizes an automated, electronic prior authorization process by applying online clinical algorithms in the form of online edits at the pharmacy point-of-service. If the patient meets the requirements in the initial step therapy criteria, the requested medication will be covered automatically under their current prescription benefit.

When a prescription is filled without the necessary prerequisite medications in the patient's claim history, the claim will be rejected at the point-of-sale with a message stating PA is necessary. The prescribing physician requests a PA exception to override the edit. If approved, an authorization record will be entered into the claim system for up to one year. Step therapy criteria are updated annually or when new or additional information that may impact the existing criteria becomes available.

### ***Quantity Limits / Responsible Quantity***

Setting proper quantity limits provides significant pharmacy savings without increasing medical costs such as those from office and ER visits. The tool encourages appropriate drug utilization management to enhance participant outcomes and reduce drug benefit costs. The quantity limit program utilizes the recommended quantity limit list and targets certain drugs for quality and safety reasons supported by FDA-approved labeling, scientific literature and nationally recognized guidelines. Benefit coverage for these drugs is approved up to the pre-set maximum amount

recommended in this program. Prescription quantities that exceed the program limits will not be paid under the pharmacy benefit.

Quantity limits work at the pharmacy point-of-sale. When a prescription exceeds the pre-defined limits, the claim will be rejected with a message indicating the prescription quantity limit was exceeded for that medication. Prescribing physicians request a prior authorization exception to override the edit. Established criteria are reviewed to determine whether the patient will be granted additional quantities per month for the medication. If the prior authorization request is approved, an authorization record will be entered into the claim system for up to one year.

If patient's prescriptions exceed the quantity limit, they should contact their physicians to review medical records and determine whether to write a new prescription or to submit an exception request. Additional features include an annual update of criteria, standard reporting capabilities on program impact, savings and impact PMPM, and potential for integrated medical and pharmacy data for savings and outcome evaluation.

### ***Mandatory Generic Substitution***

Our pharmacy benefit includes mandatory generic substitution encouraging members to choose lower cost generic drugs in place of high cost brand medications. When a member chooses to fill a brand name prescription when a lower cost generic equivalent is available, the member will pay the brand deductible, copayment and/or coinsurance, and the cost difference between the brand and generic drug. Mandatory generic substitution does not apply if the prescriber requests the brand drug. In order for the member to fill the brand name prescription without paying the cost difference, the prescribing physician must indicate "Medically Necessary" on the prescription.

### ***Increasing Generic Use***

We strongly encourage the use of generic medications to manage overall drug spend. The opportunity to increase generic utilization will continue in the next few years as more generic medications come to market. There is opportunity to move to generics in the categories of depression, hypertension and epilepsy. We will work closely with you to take advantage of generic opportunities.

Use of the BCBSF MAC program is the first step to taking advantage of generic cost savings. Our MAC list is one of the most comprehensive and aggressive in the industry, providing an average discount of 60 percent off AWP.

In addition to the MAC program, we encourage the use of generic drugs through several integrated strategies and including physician-, pharmacist- and plan participant-directed initiatives designed to build awareness and educate pharmacists, physicians and participants about the safety, effectiveness and cost savings attributed to generic drugs.

## References

54. (ALL PRODUCT LINES) Please provide three references of current clients and two references of clients you have lost in the past two years. Ideally, these references would be similar in size and demographics to our client.

### Active Accounts:

Diocese of St. Augustine

Attn: Ron Ginder or Twink Wilson

11625 Old St. Augustine Rd

Jacksonville, FL 32258

904-262-3200

St. Johns County Employees (Board of County Commissioners)

Attn: Theresa Marcum

500 San Sebastian View

St. Augustine, FL 32084

904-209-0642

St. Johns County School Board

Attn: Michelle Price

40 Orange St

St. Augustine, FL 32084

904-819-7549

### Cancelled Accounts

Jax Port

Attn: Monique Smith

2831 Talleyrand Ave

Jacksonville, FL 32206

904-357-3005

55. (ALL PRODUCT LINES) What are your client retention statistics for each of the last three years?

This information is not currently available.

## Attachment E

SUM

APR 16 1993

ADMINISTRATIVE SERVICES AGREEMENT

between

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

and

ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS

This Administrative Services Agreement (hereinafter referred to as the "Agreement"), made this \_\_\_\_ day of \_\_\_\_\_, 1992, is by and between Blue Cross and Blue Shield of Florida, Inc., a Florida corporation having its principle place of business at 532 Riverside Avenue, Jacksonville, Florida 32231 (hereinafter referred to as the "Administrator") and St. Johns County Board of County Commissioners, located at P. O. Drawer 349, St. Augustine, Florida 32089 (hereinafter referred to as the "Employer").

WHEREAS, the Employer has established and currently sponsors a self-insured Employee Welfare Benefit Plan, to provide certain benefits (attached hereto as Exhibit "A" and hereinafter called the "Group Health and Dental Plan") for covered group members and their covered dependents; and

WHEREAS, the Employer desires that the Administrator furnish certain claims processing and administrative services with respect to the Group Health and Dental Plan.

NOW, therefore, in consideration of the mutual promises contained herein, and other good and valuable consideration, the parties agree as follows:

SECTION I

TERM

1.1 Initial Term.

The initial term of this Agreement shall be from October 1, 1992 (the effective date) and shall end on September 30, 1992 (the termination date), unless the Agreement is terminated earlier in accordance with the provisions of this Agreement.

1.2 Renewal Terms.

This Agreement will automatically renew each anniversary date for successive one year terms at the renewal rates



then in effect, unless either party notifies the other party of its intent not to extend this Agreement at least 30 days prior to the applicable anniversary date.

## SECTION II

### DUTIES AND RESPONSIBILITIES OF THE EMPLOYER

#### 2.1 Final Authority.

The Employer retains all final authority and responsibility for the Group Health and Dental Plan including, but not limited to, the benefits structure of the Group Health and Dental Plan, claims payment decisions, cost containment program decisions, utilization benefits management, compliance with the requirements of COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended), compliance with the requirements of ERISA (Employee Retirement Income Security Act of 1974, as amended), compliance with reporting and remitting abandoned property funds, and compliance with any other state and federal law or regulation applicable to the Employer or the administration of the Group Health and Dental Plan.

The Employer agrees to provide the Administrator with any information the Administrator reasonably requires in order to perform the administrative services set forth herein.

#### 2.2 Eligibility and Enrollment.

As of the first day of the term of this Agreement, the Employer will have delivered to the Administrator enrollment information regarding eligible and properly enrolled members, as defined by the Group Health and Dental Plan. The Employer shall deliver to the Administrator all employee and dependent eligibility status changes on a monthly basis, or more frequently as mutually agreed by the parties.

The Employer shall be responsible for providing each covered employee with a copy of the plan document which shall include the Group Health and Dental Plan.

#### 2.3 Financial Obligations.

##### A. Claims Payment; Reserve Requirement

The Employer is financially responsible for the payment of all claims properly submitted and paid in



accordance with the Group Health and Dental Plan. Financial arrangements regarding the payment of such claims are set forth in Exhibits "B" and "C". Additionally, the Employer shall maintain a reserve amount with the Administrator or its designee bank as set forth in Exhibits "B" and "C". This reserve amount must be maintained at all times by the Employer and the Employer is immediately required to submit funds to the Administrator or its designee bank whenever the reserve falls below the minimum level.

B. Administrative Fees; Late Charge

The Employer agrees to promptly pay all administrative fees as set forth in Exhibits "B" and "C". Administrative fees are not subject to change during the initial term of this Agreement, except as set forth below. The administrative fees shall be payable to the Administrator within 10 days of written notification to the Employer of the amount owed. In the event the Employer fails to pay the amount owed in full within said 10 day period, the Employer shall pay the Administrator, in addition to the amount due, a late charge as set forth in Exhibits "B" and "C".

C. Modifications

The Administrator may modify the administrative fees or reserve requirement contained in Exhibits "B" and "C" at any time on or after the first anniversary of this Agreement's effective date, upon giving forty-five (45) days prior written notice to the Employer. Additionally, the Administrator, at any time, may modify the administrative fee or the reserve requirement, if the Employer substantially modifies the Group Health and Dental Plan or changes enrollment.

2.4 Use of Names and Logos.

The Employer agrees to allow the Administrator to use the Employer's name and logo on I.D. cards and other forms necessary to effectuate this Agreement, and to promote the Employer's relationship with the Administrator to potential or existing providers. The Administrator shall not use the Employer's name or logo for any other purpose without the prior written consent of the Employer.



The Employer agrees that the names, logos, symbols, trademarks, tradenames, and service marks of the Administrator, whether presently existing or hereafter established, are the sole property of the Administrator and the Administrator retains the right to the use and control thereof. The Employer shall not use the Administrator's name, logos, symbols, trademarks or service marks in advertising or promotional materials or otherwise without the prior written consent of the Administrator and shall cease any such usage immediately upon written notice by the Administrator or upon termination of this Agreement, whichever is sooner.

### SECTION III

#### DUTIES AND RESPONSIBILITIES OF THE ADMINISTRATOR

##### 3.1 Generally.

It is understood and agreed that the Administrator is empowered and required to act with respect to the Group Health and Dental Plan only as expressly stated herein.

The Employer and the Administrator agree that the Administrator's role shall be limited to that of claims processor under the the Group Health and Dental Plan, that the services rendered by the Administrator under this Agreement shall not include the power to exercise control over the Group Health and Dental Plan's assets, if any, or discretionary authority over the Health Care Plan's operations, and that the Administrator will not for any purpose, under ERISA or otherwise, be deemed to be the "Plan Administrator" of the Group Health and Dental Plan or a "fiduciary" with respect to the Group Health and Dental Plan. The Administrator's services hereunder are intended to and shall consist only of ministerial functions. The Group Health and Dental Plan's "Administrator" for purposes of ERISA is the Employer.

##### 3.2 Enrollment; Forms and I.D. Cards.

The Administrator shall enroll those individuals who have completed an application and are identified by the Employer as eligible for benefits under the Group Health and Dental Plan on the effective date of the Group Health and Dental Plan, and subsequently during the continuance of this Agreement. The Administrator shall be entitled to rely on the information furnished to it by the Employer, and the Employer shall hold the



Administrator harmless for any inaccuracy or failure to provide such information in a timely manner.

The Administrator shall furnish to the Employer, for distribution to persons participating in the Group Health and Dental Plan, a supply of identification cards, benefit plan descriptions, forms to be used for submission of claims and enrollment, and any other forms necessary for the administration of the Group Health and Dental Plan, as determined by the Administrator.

3.3 Claims Processing.

The Administrator shall provide claims processing services on behalf of the Employer for all properly submitted claims, in accordance with the benefits set forth in Exhibit "A", using funds solely supplied by the Employer, as set forth in Exhibits "B" and "C". The Administrator shall furnish each claimant with an explanation of each claim that is paid, rejected or suspended.

For purposes of this Agreement, the term "claim(s)" shall be defined as the amount paid or payable by the Administrator to providers of services and/or covered group members under this Agreement and the Group Health and Dental Plan, and in conformity with any agreements the Administrator enters into with such providers of services.

3.4 Program Administration.

The Administrator shall administer its established Cost Containment Program and Utilization Benefits Management Programs, as selected by the Employer and outlined in the Group Health and Dental Plan.

The Administrator shall make available its Preferred Provider Organization Program(s) to covered group members and their covered dependents, as set forth in the Group Health and Dental Plan. Any agreements between providers of services and the Administrator are the sole property of the Administrator and the Administrator retains the right to the use and control thereof.

3.5 Whenever the Administrator becomes aware of an overpayment under the Group Health and Dental Plan, the Administrator shall make a diligent attempt to recover such overpayment. In the event any part of an overpayment is recovered, the Employer will receive a



refund from the Administrator. The Administrator shall notify the Employer whenever attempted recovery is unsuccessful and the Administrator shall not be required to institute any legal proceeding to recover such overpayment.

3.6 Records and Reports.

The Administrator agrees to establish, maintain and provide to the Employer, records and reports generated as a result of the administration of the Group Health and Dental Plan for the purposes of reporting claims experience and conducting audits of operations. However, the Administrator will not provide any report which contains individual group member identifiable medical information, nor will the Administrator provide any information with regard to providing pricing agreements or any other information which is of a confidential or proprietary nature, as determined by the Administrator.

3.7 Claims Payments

The source or sources of payment under the Group Health and Dental Plan are to be only the assets of the Employer, and the Administrator will have no liability whatsoever for providing a source from which payments will be made under the Health Care Plan.

SECTION IV

TERMINATION

4.1 Administration After Termination.

The Employer is solely liable and responsible for all claims incurred under the Group Health and Dental Plan by its covered group members and their dependents during the term of this Agreement, including those incurred claims which are not presented to the Employer or the Administrator during the term of this Agreement. The Administrator will adjudicate all claims incurred during the term of this Agreement. For purposes of this Agreement, the date of an incurred claim is the date the particular service was rendered or the supply was furnished. After the effective date of termination of this Agreement, the Employer will continue to provide the Administrator with funds to pay claims incurred prior to the termination date and will continue to pay



the applicable administrative fees as set forth in Exhibits "B" and "C".

4.2 Unilateral Termination

The Employer or the Administrator may unilaterally terminate this Agreement upon 90 days prior written notice to the other after the initial term of this Agreement.

4.3 Termination On Anniversary Date.

This Agreement shall automatically terminate as of the date of any anniversary of the effective date of this Agreement, if either the Employer or the Administrator has given at least 30 days prior written notice to the other of its intention not to renew this Agreement as of that anniversary date.

4.4 Termination Upon Default.

Upon the occurrence of any of the following events, as determined by the Administrator, this Agreement will automatically terminate at the end of the 8th business day following the day upon which the Employer is notified of any of the events of default set forth hereunder, and then only in the event that the Employer has not cured the incident of default:

1. The Employer's failure to provide adequate funds, as set in Exhibits "B" and "C", as necessary for the payment of claims pursuant to the Group Health and Dental Plan;
2. The Employer's failure to pay any administrative fees or late penalty as set forth in Exhibits "B" and "C" of this Agreement;
3. The Employer's failure to maintain the reserve requirement as set forth in Exhibits "B" and "C";
4. The Employer ceases to maintain a Group Health and Dental Plan;
5. The Employer modifies the Group Health and Dental Plan without the prior written consent of the Administrator;
6. At any time the Administrator has reasonable grounds for insecurity with respect to the Employer's financial ability to adequately fund the Group Health and Dental Plan, and the



Employer has failed to immediately provide adequate assurances of financial soundness to the Administrator;

7. At any time any judicial or regulatory body determines that this Agreement, or any provision of this Agreement, is invalid or illegal, or that this arrangement constitutes an insurance policy or program which is subject to state and/or federal insurance regulations and/or taxation;
8. At any time the Employer otherwise materially breaches this Agreement.

4.5 Rights and Responsibilities Upon Termination.

In the event of termination of this Agreement, the Employer will immediately notify each covered group member of the termination date.

Termination of this Agreement for any reason shall not affect the rights or obligations of either party which arise prior to the date of termination.

SECTION V

LEGAL ACTION; INDEMNIFICATION

5.1 Standard of Care.

The Administrator and the Employer shall each use the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims in the performance of its duties hereunder.

5.2 Liability; Indemnification.

The Administrator shall not be liable to the Employer or any other person for any mistake of judgement or other action taken in good faith, or for any loss or damage occasioned thereby, unless the loss or damage is due to the Administrator's gross negligence, criminal conduct or fraudulent acts.

The Employer hereby agrees to indemnify and hold harmless the Administrator, its directors, officers,



employees and agents against any and all actions, claims, lawsuits, settlements, judgements, costs, interest, penalties, expenses and taxes, including but not limited to, attorneys fees and courts costs, resulting from or arising directly or indirectly out of or in connection with any function of the Administrator under this Agreement, including the administration of any Cost Containment or Utilization Benefit Management Programs, or payments made pursuant to the direction of the Employer, unless it is determined that the direct and sole cause of such liability was the result of gross negligence, criminal conduct or fraudulent acts on the part of the Administrator or any of its directors, officers, employees or agents. Further, the Employer agrees to indemnify and hold harmless the Administrator for any taxes or assessments, including penalties and interest, or any other amounts legally levied based on the terms of this Agreement. This provision applies to any amounts imposed, now or later, under the authority of any federal, state, or local taxing jurisdiction. This provision will continue in effect after termination of this Agreement for any reason.

5.3 Legal Actions.

In the event the Administrator is served with process in any lawsuit or is made a party to any arbitration proceeding or other legal action relating to any matter for which indemnification is required under the preceding paragraph, the Employer shall, upon written request by the Administrator, immediately furnish a defense to and indemnify and hold harmless the Administrator in any such lawsuit, proceeding or other action and shall use its best efforts to secure, by motion or otherwise, the dismissal of the Administrator from such lawsuit, proceeding or other action. The Administrator will provide the Employer with available data and materials that are reasonably necessary for the preparation of the defense of such lawsuit, proceeding or other action.

SECTION VI

MISCELLANEOUS PROVISIONS

6.1 Amendment.

Except as otherwise provided for herein, this Agreement may be modified, amended, renewed, or extended only upon



mutual agreement, in writing, signed by the duly authorized representatives of the Employer and the Administrator.

6.2 Subsidiaries and Affiliates.

Any of the functions to be performed by the Administrator under this Agreement may be performed by the Administrator or any of its subsidiaries, affiliates, or designees.

6.3 Governing Law.

This Agreement is subject to and shall be governed by the laws of the State of Florida, except where those laws are preempted by the laws of the United States.

6.4 Venue.

All actions or proceedings instituted by the Employer or the Administrator hereunder shall be brought in a court of competent jurisdiction in Duval County, Florida.

6.5 Waiver of Breach.

Waiver of a breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.

6.6 Inconsistencies.

If the provisions of this Agreement are in any way inconsistent with the provisions of the Group Health and Dental Plan, then the provisions of this Agreement shall prevail and the other provisions shall be deemed modified, but only to the extent necessary to implement the intent of the parties expressed herein.

6.7 Notices.

Any notice required to be given pursuant to this Agreement shall be in writing, postage pre-paid, and shall be sent by certified or registered mail, return receipt requested, or by Federal Express or other overnight mail delivery for which evidence of delivery is obtained by the sender, to the Administrator or the Employer at the addresses indicated on the first page of this Agreement, or such other addresses that the parties may hereafter designate. The notice shall be effective on the date the notice was posted.

6.8 Entire Agreement.



This Agreement, including the attachments hereto, contains the entire agreement between the Administrator and the Employer with respect to the specific subject matter hereof. Any prior agreements, promises, negotiations or representations, either verbal or written, relating to the subject matter of this Agreement and not expressly set forth in this Agreement are of no force and effect.

6.9 Severability.

In the event any provision of this Agreement is deemed to be invalid or unenforceable, all other provisions shall remain in full force and effect.

6.10 Binding Effect of Agreement.

The Agreement shall be binding upon and inure to the benefit of the parties, their agents, servants, employees, successors, and assigns unless otherwise set forth herein or agreed to by the parties.

6.11 Survival.

The rights and obligations of the parties as set forth herein shall survive the termination of this Agreement to the extent necessary to effectuate the intent of the parties as expressed herein.

6.12 Independent Relationship.

Notwithstanding any other provision of this Agreement, in the performance of the obligations of this Agreement, each party is at all times acting and performing as an independent contractor with respect to the other party. It is further expressly agreed that no work, act, commission or omission of either party (or any of its agents or employees) pursuant to the terms and conditions of this Agreement, shall be construed to make or render such party (or any of its agents or employees) an agent, servant, representative, or employee of, or joint venturer with, such other party.

6.13 Execution of Agreement.

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and such counterparts shall constitute one and the same instrument.



IN WITNESS WHEREOF, on the date first written above, the parties have caused this Agreement to be executed by their duly authorized representatives.

ADMINISTRATOR

BLUE CROSS AND BLUE SHIELD  
FLORIDA, INC.

J. Discenza  
Signature

Judith A. Discenza, F.S.A.  
Name (Printed)

V.P. & Actuary  
Title

4/8/93  
Date

EMPLOYER

ST. JOHNS COUNTY BOARD OF  
COUNTY COMMISSIONERS

Nicholas M. Meiszer  
Signature

Nicholas M. Meiszer  
Name (Printed)

County Administrator  
Title

October 21, 1992  
Date



EXHIBIT "A"

to the  
ADMINISTRATIVE SERVICES AGREEMENT  
between

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

and

ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS

GROUP HEALTH PLAN

The entire Group Health Plan is attached hereto and made a part of this Agreement.



EXHIBIT "B"

to the  
ADMINISTRATIVE SERVICES AGREEMENT  
between

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

and

ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS

FINANCIAL ARRANGEMENTS  
Banking Arrangement  
(Medical Only)

I. Effective Date.

The effective date of this Exhibit is October 1, 1992.

II. Bank Account.

The Employer agrees to establish a bank account prior to the effective date of this Agreement, in its own name, at the bank designated by the Administrator. The Employer authorizes the Administrator to write checks on the bank account in order to pay claims pursuant to this Agreement. The Employer agrees to maintain the bank account and the reserve amount as set forth below. The Employer shall be responsible for the reconciliation of its bank account, based on information and reports provided by the Administrator and the bank.

III. Special Banking Information.

- A. Name of Employer (as it is to appear on the checks) - no more than 25 characters: St. Johns County BOCC
- B. Employer Bank Account Reference Number - 5 characters: 10021
- C. Reserve Requirement: \$62,953.
- D. Funding Frequency: Weekly
- E. Method of Funding: ACH



IV. Administrative Fees:

- A. Administrative fees during the term of the Agreement:  
[\$18.54 per enrolled employee per month]
- B. Administrative fees after the termination of the Agreement: 9.7% of claims paid.

V. Late Payment Penalty

- A. A daily charge of .00038 times the amount of overdue administrative fees.

VI. Expected Enrollment

- A. The administrative fees and reserve requirement referenced above are based on an expected enrollment of: Single - 417; Family - 357.
- B. If the actual enrollment is materially different from this expected enrollment, the Administrator reserves the right to adjust the administrative fees and the reserve requirement as set forth in the Agreement. Actual administrative fees will be charged based on actual enrollment.



EXHIBIT "C"

to the  
ADMINISTRATIVE SERVICES AGREEMENT  
between

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

and

ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS

FINANCIAL ARRANGEMENTS  
Prospective Funding  
(Dental Only)

I. Effective Date.

The effective date of this Exhibit is October 1, 1992.

II. Monthly Estimated Payments.

- A. Approximately 15 days before the first date of each month, the Administrator will submit to the Employer a bill for the amount of expected claims to be paid during the forthcoming month. The bill will also include the estimated monthly administrative fee. The Employer agrees to pay the full amount of the bill by the first of each month. If the payment is not received by the Administrator by the first of the month, the payment will be considered past due and subject to a late payment charge, as set forth below. Additionally, the Administrator will immediately suspend claims until payment is received by the Administrator.
- B. At the end of each month, the Administrator will provide the Employer with a detailed printout of the previous month's claims payments. In the event the actual claims and actual administrative fee are in excess of the estimated amount received on the first of the month, the Employer will be notified by the Administrator of the amount due the Administrator. The Employer agrees to pay the total amount due to the Administrator within 15 days of the written notification.
- C. In the event the actual claims and actual administrative fee are less than the estimated claims and estimated administrative fee, the Administrator shall reimburse the Employer the difference or offset a future month's estimated payment.

ASO/PFC  
920608.4B1

C  
8-1



Administrative Services Agreement  
Exhibit B  
Page 2

III. Funding Information

A. Method of Funding Transfer: Check

IV. Administrative Fees:

A. Administrative fees during the term of the Agreement:

[\$3.79 per enrolled employee per month]

B. Administrative fees after the termination of the Agreement: 9.7% of claims paid.

V. Reserve Requirement

A. N/A

VI. Late Payment Penalty

A. A daily charge of .00038 times the amount of overdue administrative fees.

VII. Expected Enrollment

A. The administrative fees and reserve requirement referenced above are based on an expected enrollment of: Single 417; Family 357.

B. If the actual enrollment is materially different from this expected enrollment, the Administrator reserves the right to adjust the administrative fees and the reserve requirement as set forth in the Agreement. Actual administrative fees will be charged based on actual enrollment.



EXHIBIT "D"

to the  
ADMINISTRATIVE SERVICES AGREEMENT  
between

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.  
and

ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS  
AGGREGATE EXCESS LIABILITY COVERAGE (STOP-LOSS)

- A. Blue Cross and Blue Shield of Florida ("BCBSF") agrees to provide Aggregate Excess Liability Coverage, whereby the maximum claims chargeable to the Employer is limited to a fixed amount for all individuals covered under the Group Health Plan. Since the enrollment of the group may fluctuate, thereby affecting maximum payout liability, this fixed amount (stop-loss attachment point) is expressed as an average amount of all claims dollars paid per employee contract per year. The attachment point per contract is \$2,948.00.
- B. BCBSF will be responsible for any claim(s) incurred by such member in excess of the stop-loss attachment point, provided that the claim: is covered under the terms of the Group Health Plan; and is actually paid during the term of this Agreement.
- C. The Employer shall pay to BCBSF, each month, an Aggregate Excess Liability Coverage charge. Such charge shall be equal to the Aggregate Excess Liability Coverage rate multiplied by the number of contracts covered at the beginning of each month. The number of contracts covered shall be determined by the Administrator and such number will not be prorated. This charge is due and the Employer shall pay this charge to BCBSF by the first day of the month following the invoice date. The rate for Aggregate Excess Liability Coverage is: \$4.50 per contract per month.
- D. Upon termination of this Agreement, the Aggregate Excess Liability Coverage shall immediately terminate. The Administrator has no liability under this Excess Liability Coverage Section for any claims paid after such termination dated regardless of when the claim was incurred, even if the claim was incurred during the term of this Agreement.

ASO/PPC  
921012.2C

D  
9-1



## Attachment F

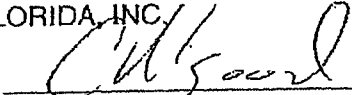
AMENDMENT TO ADMINISTRATIVE SERVICES AGREEMENT

THIS AMENDMENT, entered into on 12/27/2008, 2008 is by and between Blue Cross and Blue Shield of Florida, Inc. (hereinafter called the "Administrator") and St. Johns County Board of County Commissioners. In consideration of the mutual and reciprocal promises herein contained, the Administrative Services Agreement between the Administrator and the Employer (hereinafter "Agreement") effective October 1, 1992 is amended as follows:

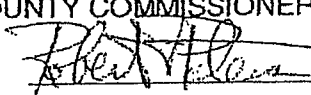
1. Section I, Initial term, is hereby amended to extend the term of the Agreement until December 31, 2011 unless the Agreement is terminated earlier in accordance with the terms of the Agreement.
2. Exhibit B to the Agreement is hereby amended, effective January 1, 2009. The revised Exhibit B is attached to this Amendment and replaces the Exhibit B previously attached to the Agreement.
3. Except as otherwise specifically noted in this Amendment, all other terms and conditions of the Agreement shall remain unchanged and in full force and effect.

IN WITNESS WHEREOF, this Amendment has been executed by the duly authorized representatives of the parties.

BLUE CROSS AND BLUE SHIELD  
OF FLORIDA, INC.

By:   
Title: VP, MAJOR ACCTS  
Date: 12/29/08

ST. JOHNS COUNTY BOARD OF  
COUNTY COMMISSIONERS

By:   
Title: DIRECTOR/H.R.  
Date: 12/12/08

SIGN  
HERE

