BENEFIT MANAGEMENT AGREEMENT

THIS BENEFIT MANAGEMENT AGREEMENT ("Agreement"), effective 12:01 a.m. July 1, 2019, and valid through June 30, 2020, with the ability to renew for four (4) one-year periods, is made by and between Anderson County Government, the Plan Sponsor and/or Plan Administrator (hereinafter referred to as the "Plan Administrator") and Medical Benefits Administrators, Inc. ("MEDBEN"), a third-party administrator ("TPA").

The Plan Administrator and/or Plan Sponsor has established one or more health benefit plans to provide health benefits to individuals deemed eligible under the plan(s) and to their eligible dependents. This Agreement provides only for the performance of services for each such health benefit plan(s) specifically listed on Exhibit A (Plan Listing), attached hereto. Such plans are hereinafter referred to collectively as "Plan." MEDBEN fees listed in Exhibit A are guaranteed for three (3) years, beginning July 1, 2019 through June 30, 2022. However, Vendor fees listed in Exhibit A are not guaranteed. This Agreement is the result of competitive solicitation, Request for Proposals #4930 for Health Benefit Program & Associated Services, which is incorporated as an exhibit.

Anderson County Government, as Plan Administrator and/or Plan Sponsor, has the authority to enter into and execute this Agreement. Unless otherwise specified in the applicable Plan or otherwise specified by the Plan Sponsor, the Plan Sponsor shall also be the Plan Administrator. MEDBEN is not the Plan Sponsor, Plan Administrator, Named Fiduciary, or trustee, as those terms are defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA") or any other applicable state or federal law and/or regulation. The parties intend that MEDBEN shall not be deemed a "fiduciary" for the Plan within the meaning of ERISA, COBRA or any other applicable state or federal law and/or regulation governing the Plan, and MEDBEN does not assume the Plan Administrator's, the Named Fiduciary's, or a fiduciary's discretionary authority. The parties intend that MEDBEN shall have no discretionary authority or final determinative capability. This Agreement assumes that the Plan Administrator has established the Plan for the exclusive benefit of the individuals eligible for coverage under the Plan.

MEDBEN has the authority to enter into and execute this Agreement with regards to services to be performed by MEDBEN, and also with regards to services, if any, to be performed by its parent company, Medical Benefits Mutual Life Insurance Co. ("MBM"), and such parent company's other subsidiaries, MedBen Marketing Services, Inc. ("MMS") and VisionPlus of America, Inc. ("VPA"). References to the rights and responsibilities of MEDBEN in this Agreement may also include these named entities as such references relate to the relationship, if any, between the Plan Administrator and such entities. Services to be provided by other entities named in this Agreement or its Exhibits are governed by separate agreements which have been entered into and between such entities and the Plan Administrator and/or Plan Sponsor, or between such entities and MEDBEN, and any rights and responsibilities of the parties referenced in this Agreement will be determined in accordance with such separate agreements.

The services to be performed by MEDBEN shall be limited to those set forth in this Agreement and the performance by MEDBEN of such services shall be subject in all respects to review by the Plan Administrator within the framework of policies, interpretations, rules, practices and procedures made or established by the Plan Administrator.

Plan Administrator and MEDBEN agree as follows:

ARTICLE I
PURPOSE OF AGREEMENT

Section 1.1 The purpose of this Agreement is to state the terms and conditions by which MEDBEN will provide independent administrative services to the Plan Administrator as it relates to administration of the Plan(s).

Section 1.2 The parties acknowledge that:

(a) This is a contract for administrative services only as specifically set forth herein;
(b) MEDBEN shall not be obligated to disburse more in payment under this Agreement than the Plan Administrator shall have secured and/or made available;

(c) This Agreement shall not be deemed to be a contract of insurance under any laws or regulations. MEDBEN does not insure, guarantee or underwrite liability. MEDBEN has no responsibility and the Plan Administrator has total responsibility for securing funding of claims arising under the Plan. MEDBEN has no responsibility for any expenses directly related or incidental to such Plan;

(d) MEDBEN is not the Plan Administrator, Plan Sponsor or a Plan fiduciary and will not be identified as such. The Plan Administrator acknowledges and agrees that it is the administrator and named fiduciary as such terms are defined by ERISA or any other state or federal law and/or regulation; and,

(e) The Plan Administrator acknowledges and agrees that MEDBEN will not be deemed to be a legal or tax advisor as a result of the performance of its duties under this Agreement. MEDBEN makes no representation concerning federal, state, or local laws, rules or regulations applicable to the Plan. Plan Administrator must seek its own counsel for legal advice and guidance. In no event shall MEDBEN be liable for special or consequential damages, even if MEDBEN was advised of the possibility of such damages;

(f) The Plan Administrator hereby grants its approval to MEDBEN for MEDBEN to retain entities, experts, and subcontractors to assist MEDBEN in the accomplishment of the tasks assigned to MEDBEN by this Agreement and the applicable Plan Document.

ARTICLE II
FUNDING

Section 2.1 The Plan Administrator, or any authorized representative of the Plan Administrator, shall establish an account at a bank of its choice to provide for the payment of benefits and the costs of operating each Plan. It is the Plan Administrator's sole responsibility to determine if more than one Plan has been created and if more than one bank account should be established by the Plan Administrator and is subject to this Agreement, separate banking accounts shall be established by the Plan Administrator. At the Plan Administrator's sole discretion, the Plan Administrator shall determine whether it shall authorize MEDBEN to have access to any such Plan bank account(s) and whether such is necessary to perform the tasks requested of MEDBEN by the Plan Administrator. The Plan Administrator hereby agrees that any tasks it requests MEDBEN to perform pertaining to the Plan bank account(s) shall be ministerial and not financial in nature. The Plan Administrator shall be solely responsible for authorizing payment of any Plan benefits and expenses from such account(s), including expenses for services provided for in this Agreement.

Section 2.2 It shall be the sole responsibility of the Plan Administrator to determine the amounts necessary, the frequency of payment and the method of payment of the costs of benefits and expenses associated with the Plan. The Plan Administrator agrees to make deposits to the Plan bank account(s) from which claims will be paid for each applicable Plan in compliance with Section 8.17 and Section 8.18 of the Agreement and with any other applicable federal or state law and/or regulation, including ERISA, if applicable.

Section 2.3 The Plan Administrator is required to forward any applicable participant contributions to the appropriate Plan bank account(s) within the time frames set forth under applicable laws and/or regulations, including ERISA, if applicable. It shall be the sole responsibility of the Plan Administrator to ensure that participant contributions are handled in compliance with all applicable laws and/or regulations, including ERISA, if applicable.

Section 2.4 The Plan Administrator shall be solely responsible for the method and amount deposited in the Plan bank account(s) necessary for the operation of the Plan, in accordance with any applicable laws and/or regulations, including ERISA, if applicable. MEDBEN shall prepare checks at the request of the Plan Administrator and draw on the Plan bank account(s) to effectuate the Plan Administrator's payment of claims and other applicable Plan operating expenses. MEDBEN shall issue such checks ("checkruns") based on a scheduled frequency determined by the Plan Administrator, but no more frequently than once per week. Any additional or special checkruns beyond the scheduled frequency initially requested by the Plan Administrator shall only be scheduled with the express approval of MEDBEN, including, but not limited to, any checkruns requested at the end of a stop-loss contract period or as a result of the termination of this Agreement.

Section 2.5 MEDBEN shall have no discretionary authority or control with regard to determining the need for managing or investing Plan assets. The Plan Administrator shall be solely responsible for segregating and maintaining the assets of any Plan in accordance with applicable state or federal laws and/or regulations, including ERISA, if applicable.

ARTICLE III
TPA SERVICES

Section 3.1 MEDBEN shall only be responsible for the proper exercise of its own duties as described herein and shall not be responsible for any act or failure to act on the part of any other party, including the Plan Administrator, and shall not be responsible to file any reports required under ERISA or any other state or federal law and/or regulation with respect to the Plan. MEDBEN shall not be responsible for maintaining the Plan in compliance with the provisions of ERISA or any other applicable state or federal law and/or regulation. MEDBEN shall provide the following non-discretionary services to the Plan Administrator during the term of this Agreement, as described in this Agreement, in accordance with the terms of the applicable Plan:

Section 3.2 In general, MEDBEN shall provide the following claims related services as more specifically set forth in this Article 3 and this Agreement:

a) Receive claims for benefits.

b) Review claims and/or charges of healthcare service providers ("Provider[s]") for eligibility in accordance with the terms of the Plan (as set forth by the Plan Administrator) and with assistance of the Plan Administrator, when requested by the Plan Administrator, certify eligibility of employees to receive payments under the Plan.

c) Obtain necessary additional medical information from Providers to process claims in strict accordance with the terms of the applicable Plan (as set forth by the Plan Administrator).

d) Adjudicate claims which appear to be clearly covered or clearly not eligible under the terms of the applicable Plan.

e) Refer to the Plan Administrator, with suggestions, any unresolved question regarding interpretation of the Plan's, policies, practices or procedures established by Plan Administrator, including any factual question(s) which may affect the benefits payable and adjudication of such claim(s) based upon the Plan Administrator's decision as expressed by the Plan Administrator directly or through its agent.

f) Provide information to the Plan Administrator on disputed claims, should such information be presented to MEDBEN.

g) Arrange for the investigation and/or review of claims by external sources, if applicable.

h) Provide notification to claimants or the Plan Administrator regarding claims determined under the terms of the Plan to be ineligible for payment. Appeals and final coverage decisions fall within the discretionary authority of the Plan Administrator. MEDBEN shall utilize its standard forms for such notification(s), if applicable. It is expressly understood that any such notification(s) prepared and/or produced by MEDBEN shall be reviewed, revised and approved by the Plan Administrator and any other party, including legal counsel, which the Plan Administrator deems appropriate. Regardless of whether the Plan Administrator chooses to obtain such approval of the notification document, the Plan Administrator shall be solely responsible for its content and any liability resulting from the use thereof.

i) Coordinate benefits with other known payers and pursue subrogation, reimbursement or other recovery in accordance with the Plan. MEDBEN shall have neither the responsibility nor the obligation to take any action, legal or otherwise, against any Plan participant or other person to enforce the provisions of the Plan. Such action is taken at the discretion of the Plan Administrator.

j) Issue checks or electronic funds in payment of claims on behalf of Plan Administrator and issue payment utilizing Plan funds as provided in this Agreement, at the instruction of the Plan Administrator, for amounts due per the applicable Plan, with respect to claims that qualify under the Plan. Such action is taken at the discretion of the Plan Administrator.

k) Provide a written explanation of benefits (EOB) to the Plan participant, claimants and Providers. It is expressly understood that MEDBEN shall utilize its standard EOB form and any such EOB document prepared and/or produced by MEDBEN shall be reviewed, revised and approved by the Plan Administrator and any other party, including legal counsel, which the Plan Administrator deems appropriate. Regardless of whether the Plan Administrator chooses to obtain such approval of the EOB document, the Plan Administrator shall be solely responsible for its content and any liability resulting from the use thereof.

Notwithstanding the foregoing, MEDBEN shall provide claim processing, claim issuance and other ministerial services necessary for the operation of the Plan, solely as described and contracted herein. MEDBEN will perform the contracted services, including those described in 3.2 in accordance with the policies, procedures and rules established by MEDBEN for such services. The Plan Administrator retains all authority to instruct MEDBEN on the processing of specific claims. MEDBEN shall not be liable for claims processing, claim issuance or other ministerial services on claims which have not been "completely processed during the term of this Agreement." "Completely processed during the term of this Agreement" means MEDBEN has released a claim check from its system. If a claim is not "completely processed during the term of this Agreement" it means that MEDBEN was unable to completely consider the claim for adjudication (by following MEDBEN's usual and customary claims processing procedures) before the end of the term of this Agreement.

Section 3.3 Any request for modified or additional services by the Plan Administrator must be set forth in writing by the Plan Administrator and approved in writing by MEDBEN prior to the performance of said service. In the event such modified or additional services are requested, MEDBEN reserves the right to charge the Plan Administrator for such modified or additional services. The Plan Administrator shall have the sole responsibility for the interpretation of all Plan documents, except those expressly reserved to the Trustee(s) in the Trust, if such has been established. MEDBEN shall rely solely on the representations of the Plan Administrator with respect to the Plan, including, but not limited to, representations that the individuals covered under the Plan are eligible under the Plan and that benefits paid by the Plan are non-taxable.

Section 3.4 MEDBEN will outsource any and all Plan medical cost containment services, as applicable, including, but not limited to: pre-admission certification; continued stay review; discharge planning; second surgical opinion review/approval; individual benefit management; medical claim review; medical case management, to MEDBEN's preferred medical cost containment vendor(s) on behalf of the Plan and/or Plan Administrator, unless MEDBEN has, in writing, a request from the Plan Administrator to utilize a different medical cost containment vendor on behalf of the Plan. In no event, shall MEDBEN

provide medical cost containment services for the Plan nor make any medical decisions on behalf of the Plan. Any charges for services rendered, and/or billed, by a medical cost containment vendor on behalf of the Plan shall be the sole responsibility of the Plan Administrator.

Section 3.5 MEDBEN will process claims for benefits provided under the Plan, in accordance with the Plan, following MEDBEN's usual and customary business practices subject to and in accordance with this Agreement on behalf of persons entitled to receive benefits under the Plan. The Plan Administrator shall be solely responsible for the payment of all claims and all claims payment determinations (whether made directly by the Plan Administrator or through the Plan document(s)). In addition, the Plan Administrator shall be solely responsible for the payment of any claim monies or assessments that a state or federal agency determines the Plan owes, including, but not limited to, payment of claims and/or assessments under the Medicare Secondary Payer rules and surcharges imposed on health benefits by the State of New York, the State of Massachusetts or other states, as applicable.

Section 3.6 In the processing of claims under this Agreement, MEDBEN may utilize special agreements it has entered with third parties, including Providers, to secure additional discounts for the Plan which are not part of the Plan's contracted preferred provider arrangements. The use of such discounts may require the Plan to pay additional fees. The availability of any such discounts will be determined by MEDBEN. The Plan Administrator further authorizes MEDBEN, without any additional specific authorization, to take any actions necessary for the Plan Administrator to participate in any class action settlement offers relative to services and/or supplies provided through the Plan in which MEDBEN has chosen to participate in on behalf of its clients. MEDBEN shall be under no obligation to participate in any such settlement offers. Any proceeds obtained via such settlement offers, minus the costs assessed during, or associated with such participation, shall be returned to the Plan Administrator once the settlement process is resolved and the proceeds have been distributed.

Section 3.7 MEDBEN will outsource any and all Plan subrogation matters to its preferred subrogation vendor on behalf of the Plan and/or Plan Administrator, unless MEDBEN has, in writing, a request from the Plan Administrator not to utilize such vendor's services on behalf of the Plan. The fees for performing such subrogation services are set forth in Exhibit A (under Fee Schedule), however, such fee is subject to change and is not guaranteed by MEDBEN. In no event will MEDBEN perform any subrogation services for the Plan, the Plan Administrator or the Plan Sponsor.

Section 3.8 MEDBEN shall render its standard monthly claim and plan expense reports to the Plan Administrator, with respect to the services provided and performed for the Plan under this Agreement, in MEDBEN's standard fashion. Unless notified in writing to the contrary, such reports shall be deemed accepted by the Plan Administrator within thirty (30) days of the date such reports are sent or otherwise made available to the Plan Administrator.

Section 3.9 MEDBEN, at the request of the Plan Administrator or the Plan Administrator's agent or broker of record, shall secure proposals for excess stop-loss insurance on behalf of the Plan Administrator in relationship to its responsibility to the Plan. It shall be the sole responsibility of the Plan Administrator to contract for the services of such excess stop-loss carrier(s). If MEDBEN assists the Plan Administrator in purchasing excess stop-loss insurance, the Plan Administrator shall remain solely responsible for compliance with the provisions of the excess stop-loss insurance policy. MEDBEN shall assist the Plan Administrator with the submission of claims to the Plan Administrator's excess stop-loss carrier for consideration under the Plan Administrator's excess stop-loss policy, if applicable, by following MEDBEN's usual and customary excess stop-loss claims submission procedures. MEDBEN's usual and customary excess stop-loss claims submission procedures shall also be followed during the last month of the Plan Administrator's stop-loss policy contract period.

MEDBEN shall not be liable for determining the existence of, or pursuing, underlying Plan claims which may be potential claims under the Plan Administrator's excess stop-loss policy. "Underlying Plan claims" are those for which services and supplies are rendered prior to the end of the contract period but claims for which are either received for consideration after the end of the contract period or are received prior to the end of the contract period but have not been "completely processed during the contract period." "Completely processed during the contract period" means MEDBEN has released a claim check from its

system. If a claim is not "completely processed during the contract period" it means that MEDBEN was unable to completely consider the claim for adjudication (by following MEDBEN's usual and customary claims processing procedures) before the end of the period prior to the termination of the stop-loss contract period or this Agreement, whichever occurs first.

Section 3.10 MEDBEN shall assist the Plan Administrator in its responsibilities regarding Participant and health care provider complaints and appeals by acquiring data and information necessary for the Plan Administrator to render a decision regarding the complaint or appeal. Likewise, MEDBEN shall assist the Plan Administrator regarding the mandated external review of any claim, should such be imposed upon the Plan Administrator or required under the Plan. In either case, it shall be the sole responsibility of the Plan Administrator to determine if it has enough information to make a decision as well as to render a final decision under the Plan. MEDBEN shall not assume the discretionary authority of the Plan Administrator for decisions rendered on behalf of the Plan.

Section 3.11 MEDBEN shall honor any valid Participant or beneficiary assignment of benefits to any person qualified to be an assignee under the terms of the Plan. Any assignment of benefits for which the Participant or beneficiary is not legally liable shall not be honored.

Section 3.12 Other than the forms or materials printed specifically for the Plan, MEDBEN shall keep and maintain all records pertaining to its services under this Agreement for the Plan using its standard forms and databases. Claims and eligibility records and information shall be maintained by MEDBEN in accordance with its standard systems. MEDBEN will, if requested by the Plan Administrator, provide information in other, mutually agreed upon, formats upon the Plan Administrator's payment of any additional costs incurred in providing the information in such a format.

Section 3.13 MEDBEN shall, at the request of the Plan Administrator and within ninety (90) days after the end of the Plan Year, provide the Plan Administrator with information in its possession which is required to be furnished under ERISA and any other applicable state or federal law or regulation.

Section 3.14 In the performance of its duties hereunder, MEDBEN shall not be required to perform any function or act which MEDBEN has notified the Plan Administrator constitutes a violation of ERISA, or any other applicable law or regulation. In addition, MEDBEN reserves the right to unilaterally terminate this Agreement if the Plan Administrator, the Plan Sponsor, or any Trustee, violates ERISA or any other applicable law or regulation.

Section 3.15 MEDBEN shall, at the request of the Plan Administrator, provide other services to the Plan Administrator at costs to be agreed to in writing prior to the commencement of such services. In its duties under this Agreement, MEDBEN shall rely expressly on the representation of the Plan Administrator with respect to the Plan and the performance of services hereunder. This Agreement does not provide the Plan Administrator with any services, administrative or otherwise, which are not expressly set forth herein.

This Agreement does not provide services relating to the Plan's or Plan Administrator's reporting and disclosure requirements, as set forth by ERISA as amended, the Consolidated Omnibus Budget Reconciliation Act of 1982, as amended ("COBRA") (except as may be specifically set forth in any COBRA Addendum or Exhibit to this Agreement, the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), (including but not limited to the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and the requirements of the final modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013, the Internal Revenue Service, the U. S. Department of Labor, the Affordable Care Act, or other applicable state or federal law and/or regulation, unless and except as specifically set forth in this Agreement. For example, MEDBEN does not provide services pertaining to the Plan's Summary Annual Report nor does MEDBEN perform discrimination testing on behalf of the Plan.

This Agreement does not relieve the Plan Administrator or Plan Sponsor of any of their responsibilities to the Plan under state and/or federal law and/or regulation whether express or implied, including, but not limited to, reporting and disclosure requirements, funding issues, and matters affecting privacy and confidentiality. MEDBEN will provide the Plan Administrator with Plan information maintained for the Plan Administrator in conjunction with this Agreement in order for the Plan Administrator to comply with the Plan's reporting and disclosure requirements under state or federal law and/or regulation.

ARTICLE IV
MEDBEN SERVICE FEES

Section 4.1 The Plan Administrator shall remit to MEDBEN the fees set forth in Exhibit A (under Management Services Fee Schedule, including both MEDBEN service fees and Vendor Fees (as defined in Section 4.3). The fees listed on Exhibit A must be remitted to MEDBEN within the time frame set forth on the billing statement presented to the Plan Administrator monthly. Any other vendor fee which is not payable to MEDBEN, but which MEDBEN has agreed to collect and remit on behalf of the Plan Administrator, shall be remitted by MEDBEN to such vendor, provided the Plan Administrator remits total payment to MEDBEN within the time frame set forth on the applicable billing statement. MEDBEN shall not be liable for the consequences resulting from payments remitted to MEDBEN after the due date set forth on the applicable billing statement.

Section 4.2 MEDBEN fees listed in Exhibit A are guaranteed for three (3) years, beginning July 1, 2019 through June 30, 2022. However, Vendor fees listed in Exhibit A are not guaranteed. Any change in such service fees shall be subject to change provided that notice of said change is given by MEDBEN to the Plan Administrator not less than thirty (30) days prior to the date of any such change. In addition, MEDBEN shall have the right to adjust any fee to reflect increased expenses incurred by reason of changes to the Plan and/or a change in duties required of MEDBEN as a result of legislative or regulatory changes. MEDBEN has the right to adjust any fee as of the date such changes in the Plan, legislation or regulation become effective.

MEDBEN's service fees may also be adjusted on any date that increased expenses are incurred by MEDBEN due to a change in the charges imposed by public bodies, such adjustment being limited to a rate sufficient to reflect the increase in expenses.

In addition to payment of MEDBEN's service fees, the Plan Administrator shall reimburse MEDBEN for investigation expenses and the cost of special supplies, forms, and/or all other services not listed herein but required to be performed by MEDBEN to accomplish its duties as set forth herein, after notification of same. However, no such investigative fees or expenses shall be incurred without the prior approval of the Plan Administrator.

Section 4.3 Vendor Fees (defined below) are also set forth in Exhibit A but are not guaranteed by MEDBEN. Vendor Fees are those fees collected from the Plan Administrator (at the Plan Administrator's request) and remitted by MEDBEN on behalf of the Plan Administrator which are either:

a) established by the vendor pursuant to an agreement between the vendor and the Plan Administrator; or

b) established by the vendor pursuant to an agreement between the vendor and MEDBEN, which are applicable and necessary to MEDBEN's fulfillment of its obligations under this Agreement.

MEDBEN reviews all vendors on an annual basis to confirm that the services offered are still relevant, that each vendor is still performing services as described, and that the fees for such services are commensurate with those findings and industry standards. A brief description of each MEDBEN and Vendor service provided for under this Agreement is set forth in Exhibit A (under Management Services Fee Schedule) or in this Agreement itself. MEDBEN shall not be responsible for disclosing in this Agreement or elsewhere any fees of which it has no knowledge.

ARTICLE V
PLAN ADMINISTRATOR REQUIREMENTS

Section 5.1 As detailed further in this Article V and this Agreement, the Plan Administrator shall:

a) Establish the Plan as described in Section 5.2 and Section 5.3, which shall be the basis for MEDBEN's performance of its duties under this Agreement.

b) Maintain current and accurate Plan eligibility and coverage records, verify participant, dependent and beneficiary eligibility and submit eligibility and coverage information monthly, or more often if requested by MEDBEN, to MEDBEN at its designated electronic or postal address. This information shall be provided in a format acceptable to MEDBEN and shall include the following for each participant, dependent and beneficiary: name and address, Social Security number, Medicare ID number if applicable, Medicaid number if applicable, date of birth, type of coverage, gender, relationship to participant, other insurance or health plan coverage information, changes in coverage, date coverage begins/ends, and any other information as necessary to determine eligibility and coverage under the Plan.

c) Assume the responsibility for and hold MEDBEN harmless from the erroneous disbursement of benefits by MEDBEN in the event of error or neglect by the Plan Administrator in providing eligibility and coverage information to MEDBEN, including, but not limited to, failure to give timely notification of ineligibility or termination of a former participant, dependent or beneficiary, or fraudulent enrollment and/or continuation of coverage.

d) Not request or require MEDBEN, under any circumstances, to issue claims drafts for claims, stop loss or excess loss insurance premiums, or any other costs arising out of the subject matter of this Agreement, unless the Plan Administrator has so authorized and has previously deposited sufficient funds to cover such claims or other expense obligations and payment(s).

e) Acknowledge that it is the Plan Administrator and named fiduciary. As such, the Plan Administrator retains full discretionary control and authority and discretionary responsibility in the operation and administration of the Plan.

f) Provide timely, accurate and complete information required by MEDBEN to provide the services that MEDBEN has agreed to perform under this Agreement. MEDBEN shall have the right to rely on such information. Such information shall include but not be limited to all necessary eligibility, enrollment and participant data; and copies of all governing documents of the Plan and any amendments thereto, including any written policies, interpretations, rules, practices or procedure concerning same. Such information shall be provided upon execution of this Agreement and immediately following modification or amendment. MEDBEN shall have the right to assume that all such information is accurate and complete and MEDBEN shall be under no duty to question such information. Plan Administrator shall reimburse MEDBEN, if requested by MEDBEN, at its standard hourly rates for MEDBEN's costs incurred for efforts expended to assist in the remedy of such data or information inaccuracies as were provided by the Plan Administrator and assist MEDBEN by providing MEDBEN with a detailed description of the Plan to be administered.

g) Determine Plan procedures and practices, which are not self-evident based upon this Agreement and/or the Plan Document and advise MEDBEN of same in writing within thirty (30) days of signing this Agreement.

h) Assist when necessary in determining eligibility of persons to receive benefits and advise MEDBEN in writing within thirty (30) days of any changes in eligibility of Plan participants and beneficiaries.

i) Designate an employee with whom MEDBEN can implement, coordinate and administer the services to be performed under this Agreement. Such employee shall handle all transactions and communications with MEDBEN, and all questions that arise will be channeled through such employee.

j) File all reports with all governmental agencies and make all disclosures to Plan participants and beneficiaries as may be required by applicable state or federal laws and/or regulations, including ERISA, if applicable, unless MEDBEN has explicitly agreed to make such disclosures in this Agreement.

k) Approve, adopt and distribute Plan Documents, Plan Amendments, Summary Plan Descriptions, Summaries of Material Modifications, and Summaries of Benefits and Coverage and any other required documentation, in a timely fashion.

l) Provide all necessary and available information as requested by MEDBEN, for MEDBEN to perform its services. Misinformation will be promptly reported to MEDBEN upon discovery. Any enrollment correction that may result in a refund adjustment of the monthly administration fee or MEDBEN service fees shall only be considered retrospectively ninety (90) days. Vendor Fee reimbursement shall be made as set forth in each applicable Vendor contract.

m) Promptly provide funds for claims and expenses. Except as specifically otherwise provided in this Agreement, the Plan Administrator shall be solely responsible for the costs and expenses incurred in operation of the Plan including all costs attributable to professional services contracted for and provided in connection with the administration of the Plan by MEDBEN at the direction of the Plan Administrator. MEDBEN shall be responsible for paying the costs and expenses incurred in connection with the maintenance and operation of its facilities.

n) Provide funds necessary to be used to make payments of the Plan to participants, beneficiaries and health care providers as funds are needed to cover such payments. It shall be the sole responsibility of the Plan Administrator to provide funds sufficient to cover drafts issued by MEDBEN as payment for the benefits provided in the Plan, if applicable.

o) MEDBEN shall have the right to terminate this Agreement in the event the Plan Administrator fails to provide necessary funds to meet payments required by the Plan as well as all other financial obligations of the Plan Administrator in accordance with Section 8.17 and Section 8.18 of this Agreement.

p) Unless otherwise stated elsewhere, the term "notice," as contemplated in this section, shall be sufficient if made by telephone, mail, e-mail or personal delivery. Termination notice or notice of amendment to this Agreement must be provided in writing.

q) Authorize MEDBEN to pursue all applicable health care provider and health care facility discounts on behalf of the Plan.

r) Notify MEDBEN at least thirty (30) days prior to the expiration of a stop loss insurance contract of claims which Plan Administrator has knowledge of, and which may result in a claim (specific or aggregate), prior to the contract's expiration date. After such notice, Plan Administrator and MEDBEN shall handle such claims as described in Article III and elsewhere in this Agreement. In the event MEDBEN is able to process such claims in accordance with Article III, it shall be the Plan Administrator's sole responsibility to fund such claims and payments in a timely manner prior to the expiration of the stop loss insurance contract.

s) Pay all invoices from MEDBEN in accordance with Section 8.17 and in compliance with the invoice deadlines set forth by vendors selected by Plan Administrator and managed by MEDBEN on behalf of the Plan.

t) Be responsible for all duties required of an employer or Plan Administrator under COBRA, except as otherwise specified in this Agreement as a duty of MEDBEN, if any. Such COBRA duties of the Plan Administrator shall include, but not be limited to, providing the initial COBRA notice to each covered employee and/or dependent spouse of his or her continuation of coverage rights under the Plan and notifying MEDBEN, in writing, of the date of a qualifying event if the Plan Administrator has purchased COBRA services from MEDBEN as delineated in Exhibit A (Management Services Fee Schedule).

u) Be responsible for all duties required of an employer or Plan Administrator under HIPAA and HITECH, except as otherwise specified in this Agreement as a duty of MEDBEN, if any. Such HIPAA and HITECH duties of the Plan Administrator shall include, but not be limited to, creating and maintaining privacy and security policies and procedures for the Plan. In addition, Plan Administrator shall submit complete and accurate employment health coverage data to MEDBEN in a timely manner.

Section 5.2 MEDBEN shall prepare draft documents, in its standard formats, for the Plan's use, including the Plan document, the Summary Plan Description ("SPD"), any Plan amendment, any Summary of Material Modification ("SMM"), any other notices or documents agreed to under this Agreement, for the Plan Administrator's review. The Plan Administrator understands that MEDBEN's assistance in preparing plan documents is ministerial only and further agrees that MEDBEN's assistance does not impart or convey fiduciary responsibility upon MEDBEN. The initial set-up fee set forth on Exhibit A includes the preparation of the initial Plan document, its amendments, the initial Summary Plan Description and any Summary of Material Modifications at the Plan Administrator's instruction. The Plan Administrator shall be responsible for paying to have the initial supply of SPDs and other forms printed, unless Exhibit A indicates that the initial printing charge is included in the set-up fee. The fee for any additional document preparation, and any additional printing costs, shall be negotiated at the time such documentation is requested by the Plan Administrator. In addition, MEDBEN reserves the right to charge additional fees in the event a request is made to re-write the Plan document and SPD or if re-writing the Plan and SPD is required for compliance with any applicable state or federal laws and/or regulations, including ERISA, if applicable. The cost of such Plan and SPD re-write shall be determined at the time such is requested or required. Other than as indicated, the Plan Administrator shall be responsible for all costs of materials printed or purchased for use by the Plan.

It is expressly understood that any such draft documents prepared and/or produced by MEDBEN shall be reviewed, revised and approved by the Plan Administrator and any other party, including legal counsel, which the Plan Administrator deems appropriate. Regardless of whether the Plan Administrator chooses to obtain such approval of this Agreement, the Plan documents, or any other documents drafted in accordance with this Agreement, the Plan Administrator shall have final approval of all Plan documents, including Plan amendments, SPDs, SMMs and notices, and shall be solely responsible for their content and any liability resulting from the use thereof. MEDBEN shall prepare the documents at the instruction of the Plan Administrator who shall be solely responsible for their content. MEDBEN is not responsible for the content of any documents drafted by MEDBEN for use by the Plan, including, but not limited to, the Plan document and SPD. The Plan Administrator is solely responsible for maintaining compliance of all Plan documents, Plan amendments, SPDs and SMMs with applicable law and regulation.

MEDBEN shall not be liable for any Plan documents, Plan amendments, SPDs or SMMs which include retroactive effective dates, when such effective dates have been included by MEDBEN at the Plan Administrator's instruction.

Section 5.3 The Plan Administrator shall timely execute and adopt, in accordance with its established procedures, the Plan, the SPD, each amendment and each SMM, in the time frames allowed by applicable state or federal law and/or regulation, including ERISA, if applicable. It is the sole responsibility of the Plan Administrator to disclose and distribute all documents used by the Plan, including, but not limited to, each SPD and each SMM in accordance with any applicable state or federal law and/or regulation, including ERISA, if applicable.

Section 5.4 The Plan Administrator shall be solely responsible for disclosing, upon the request of a Participant or otherwise eligible beneficiary, certain documents and information as required by ERISA, if applicable and any other applicable state or federal law or regulation, including, but not limited to, the Plan's document(s), annual report(s), summary annual report(s), trust agreement(s), contract(s), and other instruments under which the Plan is established and/or operated.

Section 5.5 The Plan Administrator shall provide MEDBEN with a list of all eligible individuals, indicating those eligible for Participant or Dependent coverage and the applicable effective date for each such individual. The Plan Administrator shall provide MEDBEN with monthly updated eligibility and participation information. The Plan Administrator shall be solely responsible for, and bear the ultimate liability of, determining and maintaining eligibility under the Plan.

The Plan Administrator shall be solely responsible for obtaining each Participant's and each applicable Dependent's authorization allowing and authorizing MEDBEN, and MEDBEN's vendor's, as applicable, to process claims and handle protected health and individually identifiable information. Unless Participants and Dependents are enrolled on MEDBEN approved enrollment forms, MEDBEN shall assume that the Plan Administrator has obtained such authorization.

Section 5.6 MEDBEN shall maintain all records necessary for the operation of the Plan functions consistent with services performed under this Agreement by MEDBEN. During the term of this Agreement, the Plan Administrator has the right of continuing access to such records and may request these records at any time allowing reasonable access time so as not to interfere with the benefit management processes of MEDBEN. The Plan Administrator shall abide by the privacy and confidentiality provisions of this Agreement when accessing and/or obtaining such records, information or data. The Plan Administrator is required, under applicable law, to maintain all records of the Plan for a period of at least six (6) years, if not longer. Upon termination of this Agreement, and at the request of the Plan Administrator, MEDBEN shall provide such records to the Plan Administrator for the Plan Administrator's maintenance thereof. Once this transfer has been made, or if no request is made within sixty (60) days of the termination of this Agreement, MEDBEN reserves the right to require payment of additional processing fees for any reports, documents or data requested by the Plan Administrator thereafter. MEDBEN will maintain any such records that remain in its possession for a duration of eight (8) years and, at the termination of such period, destroy such records. In the event MEDBEN determines that destroying such records is not feasible, MEDBEN shall extend the protections of this Agreement to such records.

Section 5.7 The Plan Administrator shall be solely responsible for all decisions regarding the determination of Plan benefits and eligibility and regarding claims payments, including, but not limited to, external review processes and the claims appeal processes set forth in the Plan.

Section 5.8 The Plan Administrator shall provide MEDBEN with copies of any complaints, filed in any and all jurisdictions, against the Plan Administrator, the Plan Sponsor, and/or the Plan, which pertain to the Plan or its administration or operation. Copies of such documents shall be provided to the Plan Administrator if received by MEDBEN.

Section 5.9 The Plan Administrator shall promptly provide MEDBEN with accurate data necessary for MEDBEN to perform the services set forth under this Agreement. The Plan Administrator shall cooperate with all reasonable requests for information from MEDBEN.

Section 5.10 It shall be the Plan Administrator's and/or Plan Sponsor's sole responsibility to ensure that any and all payments made by, or on behalf of, the Plan, the Plan Sponsor or the Plan Administrator, including those to agents, brokers, consultants, vendors, health care providers, etc., are not in excess of reasonable compensation, and that payment of such fees and expenses are reasonable expenses of, and allowable under, the Plan. MEDBEN shall disclose, under this Agreement, and Exhibit A, the fees, commissions and broker fees which are being paid in conjunction with products and services provided for under this Agreement about which MEDBEN has been notified. MEDBEN bears no responsibility for disclosing fee and/or commission information about which it has no knowledge of for services purchased from vendors or providers directly by the Plan Administrator and/or Plan Sponsor.

ARTICLE VI
TERM OF AGREEMENT - TERMINATION

Section 6.1 The fees in this Agreement shall be effective beginning July 1, 2019, unless otherwise indicated in association with a specific fee set forth on Exhibit A. Any fee revisions or other modifications made to this Agreement shall be set forth on amended Exhibits to this Agreement and, upon execution and acceptance of same, shall be made a part hereof as of the effective date(s) shown thereon.

Section 6.2 The Plan Administrator may terminate this Agreement at any time, with or without cause, provided that advance written notice is given to MEDBEN sixty (60) calendar days prior to the requested effective date of the termination. In the event the Plan Administrator terminates this Agreement with less than sixty (60) calendar days' notice, MEDBEN shall charge, and the Plan Administrator hereby agrees to pay MEDBEN, a termination fee equal to six (6) months of MEDBEN's average monthly administrative fee multiplied by the Plan's current census, as determined by MEDBEN. Upon termination, MEDBEN shall provide the Plan Administrator with information in its possession which is required to be furnished, under ERISA or any other applicable state or federal law and/or regulation, within ninety (90) days of the date of such written request for such information.

Upon notice of termination of this Agreement, MEDBEN shall provide notice to the Plan Administrator's vendors listed on Exhibit A. MEDBEN will attempt to secure the requested termination date with such vendors but may not be able to do so. MEDBEN shall notify the Plan Administrator of the effective date of termination of each such vendor. However, despite the requested termination date, the Plan Administrator shall remain liable for any and all payments due to all vendors, even those incurred beyond the requested termination date.

Section 6.3 MEDBEN may terminate this Agreement at any time, with or without cause, provided that written notice is given to the Plan Administrator sixty (60) days prior to the requested effective date of termination. MEDBEN may terminate this Agreement at any time in the event the Plan Administrator ever acts, or requests MEDBEN to act, in what MEDBEN determines to be a violation of ERISA or any other applicable law or regulation. Such termination shall not be affected without MEDBEN providing the Plan Administrator with thirty (30) days written notice of its intent to terminate this Agreement. In addition, MEDBEN reserves the right to terminate this Agreement immediately and at any time, for non-payment of fees and/or premiums.

Section 6.4 In the event of termination of this Agreement for whatever reason, MEDBEN shall cease its services under this Agreement, including claims processing, if applicable, and any and all other services set forth in this Agreement, as of the date of termination, unless and until the Plan Administrator has executed a Run-Out Agreement with MEDBEN. The Plan Administrator shall remain liable for all MEDBEN fees and premiums incurred and due as of the date of termination.

Section 6.5 All rights and obligations specified in this Agreement in Sections 3.1, 3.2, 3.9, 3.14, 3.15, 5.1, 5.6, 6.5, Article VII, Article VIII and the Business Associate Agreement Exhibit, to the extent applicable shall survive the termination of this Agreement.

Section 6.6 The termination of any additional contracts between the Plan Administrator and MEDBEN, if any, shall be subject to the requirements set forth in each separate contract, if any, for the termination of same.

ARTICLE VII
PRIVACY AND CONFIDENTIALITY

Section 7.1 MEDBEN and the Plan Administrator acknowledge that the Plan(s) listed in Exhibit A are subject to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), including but not limited to the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and the requirements of the final modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013. The parties recognize that the Plan(s) listed on Exhibit A are each Covered Entities, as defined by HIPAA and HITECH. MEDBEN recognizes that in its capacity as third-party administrator contracting with the Plan Administrator for Plan(s) specified management services, MEDBEN may be considered a Business Associate, as defined by the HIPAA and/or HITECH privacy and security standards. In addition, the parties to this Agreement recognize that certain other state and federal privacy laws and regulations may govern their relationship. The Business Associate Agreement between the Plan Administrator and MEDBEN governing these agreements is attached as the "BAA" Exhibit. If no agreement is attached, such an agreement has been previously signed by the Plan Administrator and MEDBEN and remains in effect.

Section 7.2 Direct electronic access by the Plan Administrator to existing MEDBEN databases will be granted at the sole discretion of MEDBEN and can be revoked or limited by MEDBEN at any time for any reason. Such access may require the installation of software on the Plan Administrator's systems, some of for which MEDBEN claims a proprietary interest, and other for which the use by MEDBEN and the Plan Administrator may be limited under agreements MEDBEN holds with third parties. If MEDBEN does provide such access, the Plan Administrator agrees that it will protect the software, and the information contained in the MEDBEN databases, as it protects its own confidential information and will not, directly or indirectly, allow access to or the use of the software, information or any portion thereof, on any computer, server, or network, by any person, corporation, or business entity other than the Plan Administrator without the express written approval of MEDBEN. The Plan Administrator is not permitted to use the software for any purpose other than for transactions with, or approved by, MEDBEN. The Plan Administrator agrees that, upon termination of this Agreement, any such software will be deleted, in its entirety, from its systems.

Section 7.3 Each of the parties to this Agreement reserves the right to control the use of any of its symbols, trademarks and service marks presently existing or hereafter established. Each party agrees that it will not use such words, symbols, trademarks, service marks or other devices in advertising, promotional materials or otherwise, and that it will not advertise or display such devices without the prior written consent of the other party and will cease any and all such usage immediately upon termination of this Agreement, except that MEDBEN may use, at the Plan Administrator's verbal request, the Plan Administrator's logo on benefit materials produced in accordance with the services performed by MEDBEN under this Agreement, including, but not limited to, use of the Plan Administrator's logo on its identification (ID) card and other plan related documents. In addition, each party agrees that any such signs, displays, literature or material furnished by the other party remains the property of the other party and shall be returned to it upon demand or the termination of the Agreement.

ARTICLE VIII
MISCELLANEOUS PROVISIONS

Section 8.1 If the Plan is subject to ERISA, then, as required under Section 412 of ERISA, the Plan Administrator and every person who handles Plan funds shall each be insured under a fidelity bond in an amount equal to ten percent (10%) of each Plan's (and if applicable, the Trust's) assets handled during the Plan Year. In no case shall such bond be less than $1,000.00 or exceed $500,000.00, except in the latter case when required by the United States Secretary of Labor. The amount of such bond shall be fixed at the beginning of each Plan Year, within the meaning of the applicable law.

MEDBEN, on behalf of itself and its applicable personnel, shall also maintain sufficient insurance under a fidelity bond in amounts equal to the requirements set forth under the law.

Section 8.2 This Agreement shall be binding upon the successors and assigns of the parties hereto but may not be assigned by either party without the prior written consent of a duly appointed officer of the other.

Section 8.3 The rights and obligations of the parties to this Agreement shall be governed by the laws of the State of Ohio, unless preempted by ERISA.

Section 8.4 In the event that the Plan Administrator, or the Plan, or any Plan related entity, are investigated, audited or reviewed by a state or federal agency, the costs of such investigation, audit or review, including those charged to MEDBEN, shall be borne by the Plan Administrator.

Upon thirty (30) days prior written request, the Plan Administrator shall have the right to audit the records pertaining to the Plan Administrator and the Plan(s) which are associated with the services performed by MEDBEN under this Agreement. Such audit shall be at the sole cost of the Plan Administrator and shall be performed in accordance with the procedures established by MEDBEN for such audits. MedBen reserves the right to charge the Plan Administrator for time spent in preparation for such audits and for reasonable expenses incurred by MedBen pertinent to such audits. Audits of the records of vendors associated with MEDBEN and listed in Exhibit A shall be performed in accordance with audit requirements of said vendor.

Section 8.5 MEDBEN shall use reasonable care and due diligence in the performance of its duties under this Agreement. MEDBEN shall not be liable for any mistake of judgment or other action(s) taken in good faith. No lawsuit or legal action may be brought under this Agreement later than three (3) years from the date of its termination.

Section 8.6 In no event shall the provisions of this Agreement, taken singly or jointly, nor any information or documentation, verbal, written or otherwise conveyed, be deemed legal or tax advice, regarding the Plan, the operation of the Plan, or the Plan Administrator's responsibility regarding the Plan. MEDBEN is not responsible for the tax and legal consequences resulting from the adoption and operation of the Plan.

Section 8.7 In the event MEDBEN makes an error or incorrect payment pursuant to this Agreement, which is a result of the failure of MEDBEN to exercise reasonable care in making the payment, for instance, a clerical error in the issuance of a draft, MEDBEN will be liable for its mistake. However, if the error or incorrect payment is the result of incorrect information provided directly or indirectly to MEDBEN by the Plan Administrator, a Covered Person, a provider, a Plan Administrator's vendor, a MEDBEN vendor, or any other source outside of MEDBEN, MEDBEN will not be liable for the error or incorrect payment. The Plan Administrator and MEDBEN will together make a diligent effort to remedy the error or recover any incorrect excess payment made. MEDBEN is not, however, required to institute court proceedings regarding such matters.

Section 8.8 Plan Administrator agrees to defend, indemnify and hold harmless MEDBEN and its employees from any and all losses, damages, liabilities, judgments, claims and expenses arising out of the Plan Administrator's performance, or lack thereof, of its duties and obligations under the Plan or this Agreement, the good faith performance by MEDBEN of its duties to the Plan Administrator under this Agreement, or action taken by MEDBEN at the direction of the Plan Administrator.

Section 8.9 MEDBEN does not insure or underwrite the liability of the Plan Administrator or the Plan. The Plan Administrator retains the ultimate and final responsibility for claims paid pursuant to the Plan and for the Plan's, and any related documents, compliance with all applicable laws, statutes, regulations, etc. The Plan Administrator is responsible for all expenses, including incidental expenses, of the Plan, except expenses specifically assumed by MEDBEN in this Agreement. MEDBEN assumes no discretionary authority of the Plan Administrator for decisions rendered on behalf of the Plan.

Section 8.10 MEDBEN shall be responsible to the Plan Administrator for loss of money resulting directly from fraudulent or dishonest acts by MEDBEN's employees. The remedy for payments made in error will be to seek recovery from the participant, dependent or provider of services.

Section 8.11 MEDBEN shall have no responsibility, risk, liability or obligation for the funding of the Plan or for any extended liabilities of the Plan whether resulting from the termination of the Plan or from a change to fully or partially insured funding methods. Such responsibility, risk, liability or obligation shall reside solely with the Plan Administrator, Plan participants, dependents and/or beneficiaries, and such other entities as designated in and by the Plan. It is the Plan Administrator's responsibility to secure funding of the applicable benefit Plan and/or trust, to provide funds to MEDBEN as needed to administer services provided to the Plan, and to do so as set forth in Section 8.17 and Section 8.18. MEDBEN will not be liable for failure by MEDBEN to process claims and/or advance funds due to a lack of funding arising from a failure by the Plan Administrator to secure funding of the Plan.

Section 8.12 It is understood and agreed by the parties hereto that MEDBEN is engaged to perform services under this Agreement as an independent contractor. Except as otherwise specifically provided in this Agreement or entered into by the parties at a later date, MEDBEN shall not provide any legal services to the Plan nor shall it be responsible for providing the services of an independent accountant or auditor.

Section 8.13 MEDBEN shall be entitled to conclusively rely on any written communication (including e-mail) received from the Plan Administrator which is reasonably believed to be genuine. MEDBEN shall be under no duty to investigate or inquire as to the trust, accuracy or completeness of such communications.

Section 8.14 Notwithstanding any provision in this Agreement to the contrary, neither MEDBEN nor the Plan Administrator shall have any liability to the other for failure of performance resulting from any cause beyond its control.

Section 8.15 The Plan Administrator shall have the sole responsibility of maintaining the Plan, and all Plan related documents and accounts in compliance with all applicable state or federal laws and/or regulations, including ERISA, if applicable. The Plan Administrator shall hold MEDBEN harmless against all loss, liability, damage, expense or other obligation resulting from or arising out of the operation of the Plan.

Section 8.16 The Plan Administrator bears all responsibility for ensuring that all of the Plan Administrator's employees and agents performing duties for the Plan are properly trained under all applicable laws and regulations, including, but not limited to ERISA, and that each Plan has established written instructions for Plan administration, where appropriate. MEDBEN will not provide any services relating to training or instructing any persons who are not employees of MEDBEN in the responsibilities imposed under any applicable laws or regulations, including ERISA, if applicable. MEDBEN will ensure that all MEDBEN employees performing Plan functions are properly trained in procedures relating to such functions in accordance with applicable laws and regulations.

Section 8.17 The Plan Administrator shall pay MEDBEN the charges as set forth in this Agreement in accordance with the time frames set forth on MEDBEN's billing statement. Failure to pay the costs and expenses specified herein shall result in the cessation of claim processing, and other services performed by MEDBEN, and termination of the Agreement.

Section 8.18 The Plan Administrator shall provide funds for the payment of benefits and claims provided under the Plan as set forth in this Agreement and evidenced by the Plan's periodic checkruns. If the Plan Administrator fails to fund for such benefits for a period exceeding twenty (20) days or does not authorize MEDBEN to release pending claim checks in a timely fashion, MEDBEN shall follow its standard procedures when speaking with the Plan's Participants, health care providers, and vendors, as described below. It shall be the Plan Administrator's responsibility and obligation to inform Plan Participants of their rights under ERISA, if applicable, or any other applicable state or federal law and/or regulation (or any

contract under which such benefits are provided). In the event the Plan's inability or unwillingness to fund is not immediately remedied, MEDBEN will follow its established procedures instead of those procedures set forth in this Agreement. In general, and in addition to the notification described herein, this includes, but is not limited to, the following: (1) terminating this Agreement immediately, as described in Section 6.3; (2) returning those checks to the Plan Administrator which have been issued on behalf of the Plan, but not yet released due to lack of funding; (3) notifying Participants that MEDBEN is no longer able to verify benefits or answer claims questions regarding the Plan; and (4) forwarding all calls regarding the Plan, benefits, claims, etc., to the Plan Administrator directly.

Section 8.19 If MEDBEN has agreed to collect excess stop-loss insurance premium from the Plan Administrator in order to remit same to the excess stop-loss carrier on the Plan Administrator's behalf, payment of the excess stop-loss insurance premium must be made to MEDBEN no later than five (5) days prior to the beginning of the excess stop-loss insurance carrier's grace period. Collection of excess stop-loss insurance premium by MEDBEN on behalf of the Plan Administrator does not constitute payment to the excess stop-loss insurance carrier unless the total excess stop-loss insurance premium due is received prior to the excess stop-loss insurance carrier's grace period as described above.

Section 8.20 Physicians, hospitals, preferred provider networks, vendors, and any other provider of services or supplies to the Plan and/or the Plan Administrator are considered independent contractors and are not the responsibility of MEDBEN. Nothing contained herein, or in the Plan, shall confer upon any Covered Person any claim, right or cause of action, either at law or in equity against MEDBEN for the acts or omissions of any Physician, health care provider, vendor, or other provider of services or supplies, including networks of providers or pharmacy benefit managers for whom a Covered Person receives or received services, supplies, care, and/or treatment whether or not covered by the Plan.

Section 8.21 It is the sole responsibility of the Plan Administrator to obtain and provide information which is required to be supplied by the Plan to Participants and other individuals under applicable state or federal law and/or regulation, including ERISA, if applicable. In the event such information is requested of MEDBEN and the information is protected under separate contract between MEDBEN and one of MEDBEN's vendors or suppliers, MEDBEN will assist the Plan Administrator in negotiating with such vendor or supplier for the necessary information but shall not take action which it believes may jeopardize MEDBEN's contract with such vendor.

Section 8.22 Neither MEDBEN or the Plan Administrator shall be liable for any failure or delay in performance under this Agreement (other than for delay in the payment of money due and payable hereunder, including, but not limited to, claims payments) to the extent said failures or delays are proximately caused by causes beyond that party's reasonable control and occurring without its fault or negligence, including, without limitation, natural disasters (earthquakes, hurricanes, floods), wars, riots or other major upheaval, power failures, destruction or damage of necessary systems or facilities, governmental restrictions or performance failures of parties outside the control of the contracting party, provided that, as a condition to the claim of non-liability, the party experiencing the difficulty shall give the other prompt written notice, with full details following the occurrence of the cause relied upon. Dates by which performance obligations are scheduled to be met will be extended for a period of time equal to the time lost due to any delay so caused.

Section 8.23 In those instances where a responsibility or performance obligation of MEDBEN or the Plan Administrator under this Agreement is dependent on a precedent performance activity of the other party, and the other party ("delaying party") does not perform its precedent performance activity or responsibility as of the scheduled date or in accordance with the specifications for such precedent performance activity or responsibility, then the performance activity or responsibility of the other party ("the non-delaying party") may be delayed by a reasonable period of time, but no less than a corresponding amount of time. MEDBEN and the Plan Administrator both understand that there may be instances where such corresponding delay may reduce the amount of time for the non-delaying party to perform its performance activity or its responsibility such that the non-delaying party does not have adequate or sufficient time to fulfill its obligations in a commercially reasonable manner and stay within the agreed upon schedule as set forth herein, in which case the non-delaying party shall be entitled to take a reasonably

necessary amount of time to complete its performance activity or obligation. MEDBEN and the Plan Administrator agree that a delay, other than a minimal delay, may require a negotiation between the parties to address the effect of such delay upon performance, schedule and/or price or costs.

Section 8.24 Any amendments or modifications to this Agreement, except for the rights reserved by MEDBEN in this Agreement, must be in writing and executed by all parties to this Agreement. All notices and communications required by this Agreement shall be sent to the contact person designated by the Plan Administrator at the most recent address supplied to MEDBEN by the Plan Administrator. However, any notices or information given by MEDBEN to a Plan Administrator's agent or broker of record shall be deemed notices or information given directly to the Plan Administrator.

Section 8.25 The captions and headings in this Agreement are for convenience and reference only and will in no way be held or deemed to define, describe, explain, modify or limit the meaning of any provision or the scope or intent of this Agreement. This Agreement may be executed in one or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

Section 8.26 The failure of either MEDBEN or the Plan Administrator at any time to enforce any of the provisions of this Agreement or any right under the Agreement, or to exercise any option provided, will in no way be construed as a waiver of the provisions, rights or options, or in any way to affect the validity of this Agreement. The failure of either party to exercise any rights or options under the terms or conditions of this Agreement shall not preclude or prejudice the exercising of the same or any other right under this Agreement. If any provision of this Agreement is declared invalid or unenforceable for any reason, the validity of the other provisions of this Agreement shall not be affected by the invalid or unenforceable provision.

Section 8.27 This Agreement, including all of its Exhibits, constitutes the entire understanding and agreement between Medical Benefits Administrators, Inc. and Anderson County Government regarding the nature and performance of services described in this Agreement. Any prior communication, agreement, advertisement or representation (whether written or verbal) is hereby superseded.

Section 8.28 Certain services performed under this Agreement may be subject to state specific laws and/or regulations. In some cases, the provisions of those requirements will be set forth in Exhibit B to this Agreement.

IN WITNESS WHEREOF, Medical Benefits Administrators, Inc. and Anderson County Government hereby agree to the provisions of the Benefit Management Agreement and all attached Exhibits by the authorized representative's signatures below, effective as of July 1, 2019.

PLAN ADMINISTRATOR
Anderson County Government
100 North Main Street
Suite 214
Clinton, Tennessee 37716

By: _____
Authorized Representative of Plan Administrator

Kim Jeffers Whitaker, HR Director
Printed Name

Approved By
Natalie Erb 5.17.2019
Natalie Erb, CPA, CTP
Anderson County Finance Director

MEDICAL BENEFITS ADMINISTRATORS, INC.
1975 Tamarack Road
Newark, OH 43055

By: _____
CAROLINE F. R. FRAKER
Senior Vice President, Compliance
Chief Privacy Officer

APPROVED AS TO LEGAL FORM
N. Jay Yeager
Anderson County Law Director

Anderson County Government
EXHIBIT A

PLAN LISTING

In accordance with the terms of the Benefit Management Agreement, of which this Exhibit A is made a part thereof, MEDBEN shall perform the management services and functions set forth in the Plan Administrator's Benefit Management Agreement, including the Exhibits attached thereto, solely on behalf of the following employee welfare benefit plans, referred to collectively in this Agreement as "Plan":

Anderson County Government Employee Health Benefit Plan

MANAGEMENT SERVICES FEE SCHEDULE

Effective July 1, 2019 through June 30, 2022 and remaining effective until modified or amended by mutual agreement of the parties* (unless otherwise specifically indicated herein), Anderson County Government, as Plan Administrator of the Plan(s) listed above, hereby agrees to the following management and service fees. Any fee marked with an asterisk (*) is a fee not guaranteed by MEDBEN and is subject to change prior to June 30, 2022.

Medical Benefits Administrators, Inc. (MEDBEN)

Claims and benefit management and processing services as described more fully in the Agreement.

Initial set-up fee (one-time fee)	$2,050.00
For medical claims management services	$22.05 per Participant per month.
For management of the prescription drug program(s) listed below	$2.50 per Participant per month.
One-time set-up fee for COBRA services (as described in the "COBRA" Exhibit)	$380.00 (MEDBEN will remit this entire fee to Medical Benefits Mutual Life Insurance Co.)
For COBRA management services (as described in the "COBRA" Exhibit) and for HIPAA Certificate of Creditable Coverage services	$1.95 per Participant per month. (MEDBEN will remit this entire fee to Medical Benefits Mutual Life Insurance Co.) A 2% administrative fee is added to current plan year rates and billed to COBRA Participants. This fee is not billed to the Plan Administrator. Medical Benefits Mutual Life Insurance Co. retains the 2% administration fee for the processing of COBRA premium.
For network maintenance costs	$0.75 per Participant per month.

Pharmacy, Network, Disease Management & Other Vendors*

Average Dispensing Fee by Prescription regardless of day supply (Retail and Mail Order)	$7.70 for brand and $6.70 for generic drugs charged by Ventegra*. *These are average dispensing fees – actual fees will vary based on utilization and pharmacy used.**
Mail Order Dispensing Fee	$0.00*
RxEOB On-line Services	$0.10 PEPM is remitted to Ventegra for RxEOB*
For processing of prescription drug card electronic claims regardless of day supply (Retail and Mail Order)	$2.95 per adjudicated electronic claim to Ventegra*. (Ventegra retains $2.45 of this fee and $0.50 per adjudicated claim is retained by Pharmaceutical Horizons for drug program reporting and analysis, plan design consultation, group and customer service support and prior authorization services.)*
For processing of prescription drug card program paper claims	No additional charge for the first fifty (50) DMRs each month (but the $2.95 per electronic claim fee will apply.) Each claim received above the 50 per month threshold shall incur an additional $5.00 processing fee per claim (for a total of $7.95 per claim).*
For processing of mail order pharmacy electronic claims	$2.95 per adjudicated electronic claim to Ventegra*. (Ventegra retains $2.45 of this fee and $0.50 per adjudicated claim is retained by Pharmaceutical Horizons for drug program reporting and analysis, plan design consultation, group and customer service support and prior authorization services.)*
Pharmacy Rebates and charges for managing and maintaining the prescription drug program pharmaceutical contracts and, if applicable, the prescription drug program formulary	Pharmacy rebates are paid by Ventegra* to the Plan Administrator by remitting same to MedBen who then forwards the rebates to the Plan Administrator. 100% of the pharmacy rebates available to the Plan Administrator are paid and remitted to the Plan Administrator.*
For access to the preferred provider network	$4.90 per Participant per month in the PHCS network to be remitted by MEDBEN to PHCS.*

For access to the preferred provider network	16% of facilities/providers contract savings to be remitted by MEDBEN to Multiplan Wrap.*
HealthCare Bluebook	$1.75 per Participant per month*.
Language Translation Services	Fees vary according to the type of translation services* requested by Participants or Plan Administrator in effect at the time translation is requested and completed. All costs are on a pass-through basis from MedBen's contracted translation service provider.*

***Vendor fees are not guaranteed by MedBen to remain constant during the term of this Agreement.**

Utilization Review Vendor*

1. Plan Administrator hereby authorizes MEDBEN to electronically transfer its Plan(s) medical claims data, prescription claims data and utilization review data to its designated utilization review vendor in order for that vendor to provide the services requested by Plan Administrator.
2. The Plan Administrator authorizes MEDBEN to pay for services rendered in accordance with such utilization review vendor's fee schedule set forth below and as modified from time to time.

For utilization review (pre-certification) management services performed by Hines & Associates	$3.05 per Participant per month. (Hines & Associates* retains $1.85 of this and MEDBEN receives $1.20). Additional amounts may be charged to the Plan Administrator by Hines & Associates for physician and nurse reviews, including, but not limited to case management and medical necessity reviews.*
Case management services performed by Hines & Associates	$125.00 per hour.*

***Vendor fees are not guaranteed by MedBen to remain constant during the term of this Agreement.**

The Phia Group (Phia)*

MEDBEN will outsource any and all Plan subrogation matters to The Phia Group on behalf of the Plan and Plan Administrator, unless MEDBEN has, in writing, a request from the Plan Administrator not to utilize The Phia Group's services on behalf of the Plan. The Phia Group charges the amount set forth in the fee schedule below for performing subrogation services. The fees below are subject to change and are not guaranteed by MEDBEN. In no event and under no circumstances will MEDBEN perform any subrogation services for the Plan or the Plan Administrator. If the Plan Administrator decides not to use The Phia Group's services, the Plan Administrator acknowledges and understands that it will be responsible for managing and handling all subrogation matters outside of this Agreement and without the assistance of MEDBEN.

Subrogation services performed by The Phia Group	20% of amounts recovered.*

Litigation services associated with subrogation cases (on a case by case basis and as approved by the Plan Administrator)	Hourly rate in effect at the time such services are requested.*

***Vendor fees are not guaranteed by MedBen to remain constant during the term of this Agreement.**

DISCLOSURE/APPROVAL STATEMENT

This statement is designed to comply with the conditions of disclosure, acknowledgment and approval required by the U.S. Department of Labor, the Internal Revenue Service, and any other applicable state or federal law and/or regulation, applicable to the Plan(s) in connection with the purchase of group insurance by employee benefit plans. Sherrill D. Morgan & Associates, the stop-loss carrier's Managing General Agent, if applicable, and MedBen Marketing Services, Inc., the agent(s) and/or broker(s) who assisted the Plan Administrator in purchasing the following group insurance product(s) from the insurance carriers listed below, may collectively and/or individually receive commissions, if and as set forth below:

Group Insurance Product(s)
1) To be determined.

Insurance Carrier(s)
1) To be determined.

By agreeing to submit claims on behalf of the Plan Administrator and by accepting commission, if applicable, MEDBEN does not endorse any particular excess stop-loss carrier or its policies. Although MEDBEN has made every effort to review such policies in consideration of the Plan Administrator's purpose for purchasing same, the Plan Administrator remains solely responsible for meeting the terms of the stop-loss policy, including any conditions which must be met in order to receive reimbursement or other claims payment under the stop-loss policy.

COMMISSION SCHEDULE

This Commission Schedule is attached and made part of this Agreement effective as of July 1, 2019, unless otherwise noted. In addition, MedBen Marketing Services, Inc. may receive additional commissions or bonus amounts based upon contractual relationships MedBen Marketing Services, Inc. has with various excess insurance carriers and vendors.

The Commission Schedule is as follows:

MedBen Marketing Services, Inc. (for stop-loss coordination fee)	0% of the stop-loss premium.
Sherrill D. Morgan & Associates (for stop-loss coordination fee)	0% of the stop-loss premium.

MedBen Marketing Services, Inc. and certain MedBen Marketing Services, Inc. employees may also receive certain commissions. Some commissions may be based on the volume of business with certain vendors, including life insurance carriers. The actual percentage and amount of commissions paid in these circumstances will vary based on the specifics of the product(s) purchased and sold. Fees and commission amounts disclosed herein for services and/or products not performed by MEDBEN are not guaranteed by MEDBEN during the term of this Agreement.

In some instances, MEDBEN is compensated for work it does to assist vendors in providing services to the Plan and the Plan Administrator. In particular, some medical cost containment vendors share a portion of their fees with MEDBEN to compensate MEDBEN for the work and extra personnel MEDBEN provides to the vendors in collecting necessary documentation and information for such vendors.

The Plan Administrator is authorized to purchase insurance and management services for the Plan and acknowledges that the information herein is correct and reflects the actions taken and requested by the Plan Administrator. The Plan Administrator hereby authorizes the purchase of such insurance and management services and acknowledges the fees described herein. In addition, by executing this Agreement, the Plan Administrator acknowledges that neither the Plan Administrator nor any representative of the Plan Administrator has or will receive, directly or indirectly, any compensation, for his or her own personal account, in connection with the purchase of the recommended insurance and management services.

PLAN ADMINISTRATOR
Anderson County Government
100 North Main Street
Suite 214
Clinton, Tennessee 37716

By: _____
Authorized Representative of Plan Administrator

Kim Jeffers-Whitaker, HR Director
Printed Name

Approved By
Natalie Erb 5.17.19
Natalie Erb, CPA, CTP
Anderson County Finance Director

MEDICAL BENEFITS ADMINISTRATORS, INC.
1975 Tamarack Road
Newark, OH 43055

By: _____
CAROLINE F. R. FRAKER
Senior Vice President, Compliance
Chief Privacy Officer

APPROVED AS TO LEGAL FORM
N. Jay Yeager
Anderson County Law Director

Anderson County Government

"BAA" EXHIBIT

BUSINESS ASSOCIATE ADDENDUM

This Amendment ("Addendum") is made to the most recent Benefit Management Agreement ("Agreement") made by and between Medical Benefits Administrators, Inc., including its parent and affiliated companies, (hereinafter individually "MedBen" or "Business Associate"), an Ohio corporation, and Anderson County Government ("hereinafter "Plan Sponsor" or "Covered Entity"). This Addendum is effective as of the effective date of the Agreement.

WHEREAS, MedBen and Plan Sponsor acknowledge that Plan Sponsor sponsors and maintains the employee welfare benefit plan or plans set forth on Exhibit A of the Benefit Management Agreement (hereinafter collectively referred to as the "Covered Entity" or the "Plan") for which MedBen provides specific services; and

WHEREAS, MedBen and Plan Sponsor acknowledge that MedBen is a Business Associate of the Covered Entity; and

WHEREAS, MedBen and Plan Sponsor acknowledge that MedBen has contractual relationships with other service providers which provide services for the Plan and who are considered Business Associate Subcontractors of Plan Sponsor; and

WHEREAS, MedBen and Plan Sponsor desire to ensure that, with respect to the duties and obligations of the parties under the Benefit Management Agreement, the standards of privacy and security for each Individual utilizing or obtaining Services are adhered to pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended, (referred to herein as "HIPAA") and all applicable federal and state laws, including but not limited to the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and the requirements of the final modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013 ("the Final Regulations") collectively referred to as the "HIPAA Requirements"; and

WHEREAS, by executing this Addendum, the parties agree to abide by the terms and conditions of the Addendum and the Benefit Management Agreement, as amended.

In consideration of the promises and the mutual covenants and undertakings set forth in this Addendum, the parties have executed this Addendum through their duly authorized representatives as of the date noted above.

1. **Definitions**:

   All capitalized terms contained in this Addendum shall have the meaning ascribed to them in the Benefit Management Agreement unless otherwise defined herein. In the event of any conflict between a definition as contained in the Benefit Management Agreement and a definition contained in 45 CFR Parts 160 and 164, the definition contained in 45 CFR Parts 160 and 164 shall govern.

   (a) Breach: "Breach" shall mean, as defined in 45 C.F.R. 164.402, the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted by the HIPAA Requirements that compromises the security or privacy of that Protected Health Information.

   (b) Business Associate: "Business Associate" shall have the same meaning as the term "Business Associate" in 45 CFR 160.103 and shall mean MedBen in this Addendum.

   (c) Business Associate Subcontractor: "Business Associate Subcontractor" shall mean, as defined in 45 C.F.R. 160.103, any entity (including an agent) that creates, receives, maintains or transmits Protected Health Information on behalf of Business Associate, including, but not limited to: (a) a function or activity involving the use or disclosure of individually identifiable health information, including, but not limited to, utilization review, case management, subrogation, medical management, quality assurance, and data analysis. "Business Associate Subcontractor" shall not include any person or entity with whom Covered Entity has entered into a contract with directly, even if MedBen has also contracted with such person or entity.

(d) Covered Entity: "Covered Entity" shall have the same meaning as the term "Covered Entity" in 45 CFR 160.103 and shall mean the employee welfare benefit plan or plans set forth on Exhibit A in the Benefit Management Agreement for whom MedBen provides Services.

(e) Designated Record Set: "Designated Record Set" shall have the same meaning as the term "Designated Record Set" in 45 CFR 164.501.

(f) Electronic PHI: "Electronic PHI" shall mean, as defined in 45 C.F.R. 160.103, Protected Health Information that is transmitted or maintained in any Electronic Media.

(g) Individual: "Individual"' shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

(h) Plan Sponsor: "Plan Sponsor" shall mean any client of MedBen which is a corporation, partnership, labor union, association, employer, governmental entity, or any other group that provides self-funded health benefits to its employees or members pursuant to the terms of a plan. It is at the request of the Plan Sponsor that MedBen is performing administrative and management functions.

(i) Privacy Rule: "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164

(j) Protected Health Information: "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR 164.103, limited to the information created or received by Business Associate from or on behalf of the Covered Entity. The use of the term "Protected Health Information" in this Addendum shall include both Electronic PHI and non-Electronic PHI, unless another meaning is clearly specified.

(k) Required By Law: "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.

(l) Secretary: "Secretary" shall mean the Secretary of the Department of Health and Human Services or his or her designee.

(m) Security Incident: "Security Incident" shall mean, as defined in 45 C.F.R. 164.304, the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(n) Services: "Services" shall mean: 1) the services performed by MedBen and described in the Benefit Management Agreement to which this Addendum is made a part; and 2) the services performed by a Trading Partner on behalf of the Covered Entity.

(o) Unsecured Protected Health Information: "Unsecured Protected Health Information" shall mean, as defined in 45 C.F.R. 164.402, Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by DHHS.

2. **Business Associate Services**: Pursuant to the Benefit Management Agreement, MedBen provides Services for Covered Entity that may involve the use and disclosure of Protected Health Information.

3. **Flow-Down of Obligations to Business Associate Subcontractors**: Business Associate agrees that as required by the HIPAA Requirements, Business Associate will enter into a written agreement with all Business Associate Subcontractors that: (i) requires them to comply with the Privacy and Security Rule provisions of the Addendum in the same manner as required of Business Associate, and (ii) notifies such Business Associate Subcontractors that they will incur liability under the HIPAA Requirements for non-compliance with such provisions. Accordingly, Business Associate shall ensure that all Business Associate Subcontractors agree in writing to the same privacy and security restrictions, conditions and requirements that apply to Business Associate with respect to PHI.

However, if Covered Entity directs MedBen to forward or receive PHI from any other person or entity (whether the Covered Entity has directly contracted with such person or entity), Covered Entity agrees that it is the Covered Entity's responsibility to enter into a Business Associate agreement with such person or entity. MedBen shall not be responsible for determining if such an agreement exists before complying with Covered Entity's instruction as to the delivery or receipt of PHI by the person or entity on Covered Entity's

behalf. Such persons or entities described in this paragraph are not Business Associate Subcontractors under this Addendum.

4. Obligations and Activities of MedBen:

(a) MedBen shall not use or disclose PHI in any manner that would constitute a violation of 45 C.F.R. Parts 160 and 164 if used or disclosed by MedBen. MedBen further agrees that to the extent it is carrying out one or more of the obligations under the HIPAA Requirements, it shall comply with such requirements that apply to the Covered Entity in the performance of such obligations.

(b) MedBen shall not use or further disclose PHI other than as permitted or required by this Addendum or as Required By Law.

(c) MedBen shall use appropriate safeguards to prevent any unauthorized access, use, disclosure, modification or destruction of PHI other than as provided for by this Addendum and the Agreement.

(d) MedBen shall mitigate, to the extent practicable, any harmful effect that is known to MedBen resulting from any unauthorized access, use, disclosure, modification or destruction of PHI by MedBen in violation of the requirements of this Addendum.

(e) MedBen shall provide notice to Covered Entity as required by and in accordance with Section 5 of this Addendum.

(f) In accordance with Section 3 of this Addendum, MedBen shall disclose PHI to those Business Associate Subcontractors that may be assisting MedBen in carrying out MedBen's, the Plan Sponsor's, or the Plan's functions.

(g) MedBen shall provide access, at the request of the Covered Entity, to PHI in a Designated Record Set during MedBen's normal business hours to the Covered Entity or to an Individual in order to meet the requirements under 45 CFR 164.524. If the Covered Entity determines that access to the Individual's PHI can only be accommodated through MedBen, MedBen shall accommodate the request in accordance with its internal procedures for handling such a request. In the event an Individual contacts MedBen directly about accessing PHI, MedBen shall follow its internal procedures for handling such a request. In the event MedBen is asked to provide copies of an Individual's PHI, MedBen shall provide such access by mailing a copy of the PHI in a Designated Record Set to the address given by the Individual, unless otherwise directed by the Covered Entity.

(h) MedBen agrees to make any amendment to PHI in a Designated Record Set as directed by the Covered Entity, in accordance with 45 CFR 164.526. In the event an Individual contacts MedBen directly about making amendments to PHI, MedBen shall follow its internal procedures for handling such a request.

(i) MedBen agrees to make internal practices, books, and records, including policies and procedures and PHI relating to the use and disclosure of PHI received from, or created or received by the Covered Entity or on behalf of the Covered Entity, or at the request of the Secretary or designated by the Secretary, during MedBen's normal business hours for purposes of the Secretary determining the Covered Entity's compliance with the Privacy Rule.

(j) MedBen shall document such disclosures of PHI and information related to such disclosures as would be required for the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. MedBen shall, at the request of the Covered Entity, provide to the Covered Entity information collected in accordance with this provision of the Addendum, to permit the Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. In the event an Individual contacts MedBen directly about obtaining an accounting of disclosures of PHI in accordance with 45 CFR 164.528, MedBen shall follow its internal procedures for handling such a request.

(k) MedBen, including its Business Associate Subcontractors, shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity, as required by 45 CFR 164.314, as amended from time to time.

5. **Breach Notification**:

(a) MedBen agrees to notify Covered Entity without delay and in any event no later than thirty (30) calendar days following the discovery of any Breach, including the unauthorized acquisition, access, use, disclosure or destruction of unsecured PHI, including any successful Security Incident, which compromises the security or privacy of PHI and poses a significant risk of financial, reputational or other harm to the Individual, and that is not permitted by this addendum, by law, or permitted in writing by the Covered Entity, whether such Breach is by Business Associate or Business Associate Subcontractor. Upon notification by MedBen, Covered Entity shall perform a risk assessment to determine whether the Potential Breach constitutes a Breach as defined in 45 C.F.R. 164.402. For purposes of this Section 5, "Potential Breach" shall not include:

i. any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of MedBen, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under subpart E of HIPAA;

ii. any inadvertent disclosure by a person who is authorized to access PHI at MedBen to another person authorized to access PHI at MedBen; or

iii. a disclosure of PHI in which MedBen has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) MedBen agrees to cooperate fully with Covered Entity in any investigation and risk assessment of any Potential Breach.

(c) A Breach or successful Security Incident is considered discovered as of the first day on which the unauthorized acquisition, access, use or disclosure of the Unsecured Protected Health Information was known by MedBen, or by exercising reasonable diligence, would have been known by MedBen, or the first day MedBen is notified by any Business Associate Subcontractor of a Breach or Security Incident.

(d) The notice to Covered Entity shall include, to the extent possible:

i. the identification of each Individual whose unsecured PHI has been, or is reasonably believed by MedBen to have been, accessed, acquired, or disclosed during the Breach or successful Security Incident;

ii. a description of the types of unsecured PHI that MedBen believes may have been involved in the Breach or successful Security Incident (such as whether the Individuals' full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved); and

iii. a brief description of what happened; including the date of the Breach or successful Security Incident, and the date the Breach or successful Security Incident was discovered.

(e) To the extent the following information is available to MedBen, MedBen shall also provide Covered Entity with the following information in the notification to Covered Entity, or as it becomes available:

i. any steps MedBen believes that Individuals should take to protect themselves from potential harm resulting from the Breach or successful Security Incident; and

ii. a brief description of what MedBen and any Business Associate Subcontractor is doing to investigate the Breach, to mitigate harm to the Individuals, and to protect against any further Breaches or successful Security Incidents.

At the request of the Covered Entity, MedBen will consider providing contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

(f) For Unsuccessful Security Incidents, Business Associate shall provide Covered Entity, upon its written request, a report that: (i) identifies the categories of Unsuccessful Security Incidents as described in Section 4(c)(iii)(4); and (ii) indicates whether Business Associate believes its (or its Business Associate Subcontractor's) current defensive security measures are not adequate, the measures Business Associate (or Business Associate Subcontractor) will implement to address the security inadequacies.

(g) In the event that a Law Enforcement Official (as defined in 45 C.F.R. 164.103) states to MedBen that notification to Covered Entity would impede a criminal investigation or cause damage to national security, MedBen shall delay the notification to Covered Entity as specified by the Law Enforcement Official. MedBen shall provide Covered Entity with a written statement from the Law Enforcement Official or, if the statement was oral, documentation of the statement made by the Law Enforcement Official, as soon as possible after the statement was made to MedBen.

(h) In the event that MedBen fails to notify Covered Entity of a Breach or successful Security Incident, as defined in 45 C.F.R. 164.402, MedBen shall indemnify and hold Covered Entity harmless from any and all liability, damages, costs (including reasonable attorneys' fees and costs) and expenses imposed upon or asserted against Covered Entity arising out of MedBen's failure to timely notify Covered Entity of any Breach. This Section shall survive termination of this Addendum.

(i) MedBen shall educate its employees, directors and officers as necessary and appropriate, regarding compliance with its internal HIPAA Requirements and procedures and the importance of the notification requirements of this Section 5 of the Addendum.

6. **Permitted Uses by MedBen**: MedBen shall use and disclose PHI only to the extent necessary to perform the Services and to assist Business Associate Subcontractors in performing their services, and in a manner that such use and disclosure would not violate the Privacy Rule if done by MedBen, provided, however, that:

(a) MedBen may use PHI in its possession for the proper management and administration of MedBen's operations or to carry out the legal responsibilities of MedBen.

(b) MedBen may disclose PHI in its possession for the proper management and administration of MedBen, provided that disclosures are required by law or addressed in this Addendum.

(c) MedBen may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR 164.504(e)(2)(I)(B).

7. **Obligations of the Covered Entity**:

(a) Covered Entity shall allow MedBen access to PHI of Individuals utilizing the Services through the Covered Entity.

(b) Covered Entity shall provide MedBen with the Notice of Privacy Practices that the Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes or modifications to such notice.

(c) Covered Entity shall provide MedBen with any changes in, or revocation of, permission by an Individual to use or disclose such Individual's PHI, if such changes affect MedBen's permitted or required uses and disclosures.

(d) Covered Entity shall notify MedBen of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 CFR 164.522.

(e) Covered Entity shall not request MedBen to use or disclose PHI in any manner that would not be permissible under HIPAA Requirements if done by the Covered Entity, provided however, that the Covered Entity may request that MedBen use or disclose PHI for data aggregation or management and the administrative activities of MedBen.

8. **Return of Protected Health Information**: At termination of the Benefit Management Agreement, if feasible, MedBen shall return or destroy all PHI created or received by MedBen on behalf of the Covered Entity. In the event that MedBen determines that returning or destroying the PHI is not feasible, MedBen shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction of the information infeasible.

9. **Termination**:

(a) This Addendum shall terminate when the then current Benefit Management Agreement between the parties terminates, unless terminated earlier in accordance with paragraph (b) of this Section 9.

(b) Covered Entity and Business Associate each will have the right to terminate this Addendum if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of Business Associate's or the Covered Entity's respective obligations regarding PHI under

this Addendum and, on notice of such material breach or violation from the Covered Entity or Business Associate, fails to take reasonable steps to cure the material breach or end the violation.

If Business Associate or the Covered Entity fail to cure the material breach or end the violation after the other party's notice, the Covered Entity or Business Associate (as applicable) may terminate this Addendum by providing Business Associate or the Covered Entity written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. Such termination shall be effective 60 days from this termination notice.

10. Miscellaneous:

(a) This Addendum may be executed in one or more counterparts. Each counterpart shall be deemed an original. In addition, an executed copy of this Addendum shall be as valid as the original.

(b) Except as provided in Section 5 of this Addendum, this Addendum shall be subject to the indemnification provisions of the Benefit Management Agreement.

(c) To the extent that any provision of this Addendum is in conflict with any law, regulation, rule or administrative policy of any government entity, this Addendum will have been deemed to have been amended in order to bring it into conformity with these provisions. In addition, the parties agree to amend this Addendum, as appropriate, to conform with any new or revised law or regulation to which either party becomes subject, including, but not limited to, the Standards for Electronic Transactions, 45 CFR Parts 160 and 162 and the Health Insurance Reform: Security Standards 45 CFR Parts 160, 162 and 164.

(d) Except as stated in paragraph (c) of this Section 10, this Addendum may be amended only in a written document signed by the duly authorized officers of both parties.

(e) This Addendum will be executed, delivered, integrated, construed and enforced pursuant to and in accordance with the laws of the State of Ohio.

(f) This Addendum may not be assigned by either party without the prior written consent of the other party. Except for the prohibition on assignment contained in the preceding sentence, this Addendum shall be binding upon and inure to the benefits of the heirs, successors, and assigns of the parties hereto.

(g) The waiver by either party of a breach or a violation of this Addendum shall not operate as, or be construed to be, a waiver of any subsequent breach of same or other provisions hereof. No waiver shall be effective against any party hereto unless in writing signed by that party.

(h) All notices, requests, demands, approvals, and other communications required or permitted by this Addendum shall be in writing and sent by either certified mail or by personal delivery. Such notice shall be deemed given on any date of delivery by the United States Postal Service. Any notice shall be sent to the addresses set forth in the Benefit Management Agreement.

(i) If any provision of this Addendum is held invalid, the remainder of this Addendum shall not be affected unless the invalid provision substantially impairs the benefits of the remaining provisions of this Addendum.

(j) The responsibilities of the parties under this Addendum shall survive the termination of this Addendum and the termination of the Benefit Management Agreement indefinitely.

(k) The Covered Entity and MedBen each ratify and confirm the terms and conditions of the Benefit Management Agreement as modified by this Addendum herein and agree that both shall remain in full force and effect unless otherwise terminated or amended at a later date, as specified in the Benefit Management Agreement. All other provisions of the Benefit Management Agreement not amended by this Addendum remain valid and effective.

(l) In the event of a conflict between the terms of the Benefit Management Agreement and this Addendum, this Addendum shall control.

PLAN ADMINISTRATOR
Anderson County Government
100 North Main Street
Suite 214
Clinton, Tennessee 37716

By: _____
Authorized Representative of Plan Administrator

Kim Jeffers-Whitaker, HR Director
Printed Name

Approved By
Natalie Erb 5.17.19
Natalie Erb, CPA, CTP
Anderson County Finance Director

MEDICAL BENEFITS ADMINISTRATORS, INC.
1975 Tamarack Road
Newark, OH 43055

By: _____
CAROLINE F. R. FRAKER
Senior Vice President, Compliance
Chief Privacy Officer

APPROVED AS TO LEGAL FORM
N. Jay Yeager
Anderson County Law Director

Anderson County Government

"COBRA" EXHIBIT

COBRA SERVICES AGREEMENT

THIS AGREEMENT is effective between the Plan Administrator and Medical Benefits Mutual Life Insurance Co. (hereinafter referred to as "MBM"), a mutual life insurance company organized under the laws of the State of Ohio, during the term of the Benefit Management Agreement between the Plan Administrator and MEDBEN, except as otherwise specified in Exhibit A.

The Plan Administrator sponsors and is responsible for the administration of the employee health benefit plan(s) (hereinafter referred to as the "Plans") set forth on Exhibit A. The Plan Administrator wishes to retain MBM to provide certain administrative services for the Plans and to assist the Plan Sponsor in complying with the Internal Revenue Code of 1986, as amended, and the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), if applicable, solely as both relate to COBRA continuation benefits.

The provisions of the Benefit Management Agreement which are applicable to MEDBEN, as such provisions apply to the administration of the Plan Administrator's COBRA coverage, shall also be applicable to MBM in reference to such administration. This agreement only applies to the Plan Administrator's COBRA administration for the Plans listed in Exhibit A. MBM shall not be responsible for providing any COBRA administrative services for any employee benefit plans which are not set forth in Exhibit A.

Medical Benefits Mutual Life Insurance Co. agrees to provide the following services for the implementation and administration of COBRA for the employee benefit plans listed in Exhibit A:

A. MBM shall provide drafts of all notices and other documents to be utilized in accordance with the COBRA administrative services set forth in Exhibit "A". It is expressly understood that the draft notices and documents prepared by MBM shall be reviewed, revised and approved by the Plan Administrator and any other party, including legal counsel, which the Plan Administrator deems appropriate. Regardless of whether the Plan Administrator chooses to obtain such approval, the Plan Administrator shall be fully responsible for determining whether any notice and/or document provided pursuant to this Agreement is legally sufficient, and in conformity with the applicable law. The responsibility for the text of such notices and other documents, whether or not modified by the Plan Administrator, is that of the Plan Administrator and the Plan Administrator shall be solely responsible for any liability resulting from the use thereof.

B. At the time MBM enrolls an individual in one of the Plans, MBM shall provide written notice to such individual and, if applicable, such individual's spouse and covered dependents, if any, of his or her rights under COBRA.

C. MBM shall provide timely written notice, in accordance with COBRA, to all those qualified beneficiaries that the Plan Administrator has determined are eligible under COBRA, of such individuals' rights under COBRA. The Plan Administrator is solely responsible for any additional liability or increased risk which is incurred by the Plan Administrator due to failure to provide timely notice to a qualified beneficiary of such beneficiary's rights under COBRA.

D. To the extent possible, MBM shall ensure that all persons qualifying for continuation coverage, as determined by the Plan Administrator, are afforded such coverage for the period for which they are entitled, and for which such persons have submitted the applicable premiums. MBM shall make factual determinations which are necessary to perform duties hereunder in strict accordance with the guidelines set forth in COBRA and any other applicable laws and regulations, and within any other guidelines established by the Plan Administrator which are not in violation of any applicable law. The Plan Administrator shall bear the final responsibility for ensuring that the Plans comply with these laws and regulations and shall have all discretionary and final authority for providing such continuation coverage under COBRA.

E. MBM shall directly bill all qualified beneficiaries electing COBRA coverage under the Plans.

F. In the event that this Agreement is terminated, MBM shall provide to the Plan, Plan Administrator, or to any other entity as designated in writing by the Plan Administrator, sufficient records and information on current COBRA participants to enable the Plan Administrator to continue such

persons in the Plan Administrator's Plans, or any successors to such Plans, as required by law. Upon tender of this information, all responsibility of MBM to the Plan Administrator for COBRA administrative services under this Agreement shall cease. In addition, MBM agrees to provide the following specific services for the Plan(s)

G. COBRA administration:
   1. to generate the Initial Notice to New Enrollees;
   2. to generate the specific Qualifying Event Notice to all qualified beneficiaries;
   3. to generate the required conversion notice within the proper time frames, if applicable;
   4. to generate a COBRA Expiration Notice prior to the end of the 18, 29 or 36 months, as applicable;
   5. billing and collection of premium payments along with distribution to the Plan Administrator;
   6. supplying necessary forms to qualified beneficiaries and enrollees;
   7. tracking the 12 standard dates required for proper compliance;
   8. maintaining proper documentation of COBRA activity, including maintenance of a certificate of mailing log for all qualifying event notifications;
   9. monitoring COBRA's requirements for changes, and update notices and procedures;
   10. sending the Plan Administrator hard copies of notifications along with a packet of documentation reports;
   11. producing management reports for the Plan Administrator. The reports are broken down into 4 different categories, including:
      a. Employer Reports;
      b. Benefit Reports;
      c. Qualified Beneficiary Reports; and
      d. Premium Reports; and
   12. providing a Toll-Free 1-800 number for the Plan Administrator, related employers participating in the Plan(s), qualified beneficiaries and enrollees with questions about COBRA.

In the event of a dispute between MBM and the Plan Administrator with regards to the interpretation of any applicable law, or with regards to the Plan Administrator's responsibilities or duties under COBRA, the Plan Administrator shall be the final authority. MBM reserves the right to terminate this agreement at any time if the Plan Administrator takes, authorizes or directs any action which MBM believes is a violation of COBRA or any other applicable law or regulation.

The Plan Administrator shall be solely responsible for determining whether a "qualifying event," as defined by COBRA, has occurred relating to a covered employee or a qualified beneficiary under the Plans and shall make timely notification of such qualifying event to MBM. Further, the Plan Administrator agrees to notify MEDBEN of the occurrence of any of the following events as it relates to the Plan Administrator's COBRA coverage or any individual who the Plan Administrator knows or believes is currently a Plan participant under one of the Plan(s) listed in Exhibit A:

A. the death of a covered employee;
B. the termination or reduction of hours, of a covered employee's employment;
C. the divorce or legal separation of the covered employee from the employee's spouse;
D. the covered employee's becoming entitled to benefits under Title XVIII of the Social Security Act;
E. a dependent child ceasing to be a dependent child under the generally applicable requirements of the Plan;
F. bankruptcy reorganization under Title 11 for persons with retiree coverage if it causes a "substantial" loss of coverage within one year before or after filing;
G. new enrollees covered by the plan(s);
H. notification of receipt or non-receipt of premium payments from qualified beneficiaries;
I. COBRA rate changes and/or carrier changes;

J. any change in circumstance justifying a change in COBRA eligibility of any individual who the Plan Administrator knows or believes is currently a COBRA participant under the Plans; and

K. any other information, as requested by MBM, that is relevant to the fulfillment of this contract as is necessary for compliance with said Act or any amendment thereto.

PLAN ADMINISTRATOR
Anderson County Government
100 North Main Street
Suite 214
Clinton, Tennessee 37716

By: Kim Whitaker, HR Director
Authorized Representative of Plan Administrator

Kim Jeffers-Whitaker
Printed Name

Approved By
Natalie Erb 5.17.19
Natalie Erb, CPA, CTP
Anderson County Finance Director

MEDICAL BENEFITS MUTUAL LIFE INSURANCE CO.
1975 Tamarack Road
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By: _____
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Anderson County Law Director

MedBen Services

MedBen offers a wide variety of benefit services to accommodate the unique needs of employer-sponsored health plans. You can add any of the following services to your plan by informing your benefits consultant and/or your MedBen Regional Sales Manager.

Run-In Service Fees

A one-time charge based on MedBen's administrative fee (per employee per month) for the benefit products chosen and for the number of employees enrolled. Services can be provided for up to 12 months.
If run-in services are not elected but later needed, there will be a fee of $8 per claim charged for processing.

Accounting Service Fees

Internal Revenue Service Filing Services

- **Form 990 / 5500C or 5500 preparation**

  Short Form (under 100 employees)

MedBen handles banking	$660.00/Plan
Others	$770.00/Plan

  Long Form (100+ employees)

MedBen handles banking	$880.00/Plan
Others	$1,100.00/Plan

  Long Form fees do not include the cost of independent audit required for groups of 100 or more. This expense is solely the group's responsibility.

- **501(C)(9) trust qualification submission preparation and IRS fees**

(C)(9)-trust qualification submission IRS fees are on a **"passed through" basis** and may vary.

Banking and Account Reconciliation Services

MedBen offers a banking arrangement through Park National Bank. If you elect to use our arrangement, MedBen requires that it prepare the monthly bank reconciliation on the account(s). If you use another banking institution, reconciliation services are still available, but are optional.

# of Employees	Client uses Park National Bank	Client uses bank other than Park National Bank
	Cost per Employee/Month	
0-200	$ 0.60	$ 0.70
201-500	0.55	0.65
501-1,000	0.45	0.55
1,001 +	0.40	0.50

Funding Reserve Reports for Non-ERISA Groups

MedBen can prepare a report in compliance with Ohio Revised Code Section 9.833, Health Care Self-Insurance for Non-ERISA Groups.

Fee if elected	$825.00 (may vary based on actuarial costs) *Fee covers the review, preparation and related actuarial costs.*

A summary of Ohio Revised Code Section 9.833 follows.

Summary of Requirement: *This section requires Ohio individual or joint self-insurance programs providing health care benefits to reserve amounts to cover potential costs of those health care benefits. It also requires that the programs prepare a report, to be issued within 90 days after the program's fiscal year-end, reflecting those reserves, and the disbursements made from the reserved funds during the preceding fiscal year. The programs are to secure the services of an actuary to certify that the amounts reserved conform with the law, are computed in accordance with accepted loss reserving standards, and are fairly stated in accordance with sound loss reserving principles.*

Note: This report is not filed with any office, including the Ohio Auditor of State; it should be retained by the entity and be made available for the Auditor's inspection on request.

Claims Review Services

Standard Physician Medical Reviews and Recommendations	$400 per hour
Complex and Specialty Reviews and Recommendations	$600 per hour
Provider Cost Reduction Charge	35% of Provider Cost Reductions
EDI Repricing of Out-of-Network Claims	25% of savings

Each day, 100% of MedBen clients' claims are screened by an advanced surveillance system to determine an employer's potential for large loss, risk of inappropriate billing, or fraud. If savings are identified, the percentage costs shown above are applied. In addition, MedBen offer standard, complex and specialty medical reviews of claims and prior authorization requests at the hourly rates shown above.

When the surveillance system flags a claim, a multi-disciplinary medical team with over 125 specialists further evaluates the identified case to determine potential clinical problems and work with the provider to reach a proper resolution. **On average, our claims review services save 43% per selected claim** after discounts and coinsurance.

Out-of-Network Reference-based Pricing Services

Out-of-Network RBP Service Fee	16% of savings

Reference-based pricing (RBP) pays providers a fair and reasonable fee for medical services based on a percentage of Medicare. This essentially sets a pricing cap on services that can have wide variances in cost from one provider to another, and typically results in cost savings for the plan and its members.

If you select the **Out-of-Network RBP** services option, MedBen will use RBP to pay claims for any services received outside your plan's provider network. This service facilitates the prevention of balance billing through professional negotiation and attempts preemptive sign-off to ensure providers will accept the plan's payment as payment in full.

This service places no minimum threshold on claims to be repriced or potential balance billing to be negotiated.

Claims Appeal Fiduciary Services

Administrative Fee	$2.00 PEPM

To resolve outstanding claims appeal cases, MedBen has entrusted a respected legal consulting firm to serve as a fiduciary. Should you choose to utilize this service, the consultant assumes the fiduciary role, facilitating the retention of independent review organizations in accordance with applicable law, and helping to facilitate the external appeal process. The consulting firm will stand behind its directive, and defend decisions in the face of external appeal and judicial scrutiny.

Subrogation Services

Subrogation Fee	20% of amount recovered
Litigation Services Fee (associated with subrogation cases on a case by case basis)	Hourly rate in effect at the time such services are requested

MedBen outsources all plan subrogation matters to its vendor in order to provide comprehensive and accurate recovery of claims paid under the plan when such are the responsibility of another party. In addition, litigation services are available to support the plan's subrogation legal efforts, should those be necessary.

Utilization Review and Case Management

MedBen is pleased to offer clients Utilization Review and Case Management services through Hines & Associates, Inc. (Hines). **Utilization Review** provides precertification, concurrent review and discharge planning for inpatient and outpatient services. **Case Management** is provided to members with high-cost catastrophic and complex cases, ensuring that services take place at the right time, in the right setting and at the right cost.
Hines' utilization review and case management programs are URAC-accredited and available in all 50 states so your plan members are covered, regardless of where they may be located. Employers receive summaries of Utilization Review activity so trends can be monitored. Reports are distributed electronically via **MedBen Secure**.

Utilization Review

Administrative Fee	Varies according to group size; per employee per month. *See your group quote for details.*

Utilization Review fee covers inpatient medical services and behavioral health services, including skilled nursing facility and residential treatment centers, as well as outpatient surgery reviews. The utilization review fee includes:

- Precertification. Assure that plan members only receive medical care that is necessary and appropriate. Nurses monitor inpatient hospital admissions, appropriate lengths of stay, and outpatient surgeries of

plan members. Precertification for other outpatient procedures and ancillary services (i.e., home health care and hospice) can be provided for an additional fee. Precertification for the following services is performed and billed through case management (see below):

- Hospice
- Chemotherapy
- Radiation therapy
- Infusions
- Behavioral partial hospitalization programs
- Behavioral intensive outpatient programs

- Continued Stay Review. Nurses continue to monitor a patient's condition or progress during a hospital or other inpatient confinement to determine the appropriate length of continued stay.
- Discharge Planning. Determination of appropriate services for patients requiring extended care following a hospital discharge, such as home health, hospice or skilled nursing.

Case Management

Fee	**$125.00 per hour – standard medical cases** **$135.00 per hour – specialty medical cases including transplants, renal/dialysis, oncology, neonatal, high risk obstetrics, and behavioral health**

- Fee billed separately from Utilization Review service fees
- Fee covers factors that could result in a case management referral, including: diagnosis; complicated admissions; repeat admissions; client request; claims payer request; psycho/social indicators; and abnormally high length of stay request. A case manager will then contact the member to determine if case management services are in fact needed, or if the patient is coordinating health care services effectively on his or her own.

A separate hourly fee of $450.00 per hour is charged for medical peer-to-peer reviews and physician consultations (not including external review).

MedBen WellLiving

Fee for disease management and wellness services, nurse coaching, and compliance reporting	$ 6.00 PEPM

On-site biometric screenings can be arranged upon request and are charged on a cost-pass-through basis.

MedBen WellLiving focuses on your total population with the promotion of annual wellness exams and early detection testing for cancer and heart-related diseases. Plan members at higher risk of developing a chronic condition receive personalized counseling from RN Health Consultants.

Compliance reports are provided to employers on a regular basis in order for them to tie wellness incentives to these important health screenings. Additional reports provide information on the prevalence of chronic health conditions, compliance with early detection testing, overall clinical progress of members enrolled in health coaching and overall financial return on the WellLiving program.

Other key components of MedBen WellLiving include:

- Condition-specific education materials
- Plan member wellness guidelines
- Monthly WellCare newsletters

MedBen Prescription Plan

Administrative Fee	Varies according to group size; per employee per month. *See your group quote for details.*
Average Dispensing Fee by Prescription regardless of day supply (Retail and Mail Order)	$7.70 for brand and $6.70 for generic drugs. *These are average dispensing fees – actual fees will vary based on utilization and pharmacy used.*
RxEOB On-line Services	$0.10 per adjudicated electronic claim. (Ventegra remits $0.10 to RxEOB)
For processing of prescription drug card electronic claims regardless of day supply (Retail and Mail Order)	$2.95 per adjudicated electronic claim to Ventegra. (Ventegra retains $2.45 of this fee and $0.50 per adjudicated claim is retained by Pharmaceutical Horizons for Drug Program Reporting and Analysis; Plan Design Consultation; Group and Customer Service Support; and Prior Authorization Services.)

(Table continued next page)

For processing of prescription drug card program paper claims	No additional charge for the first fifty (50) DMR's each month (the $2.95 electronic claim fee above will apply). Each claim received above the 50 per month threshold shall incur an additional $5.00 processing fee per claim (for a total of $7.95 per claim).
For processing of mail order pharmacy electronic claims	$2.95 per adjudicated electronic claim to Ventegra. (Ventegra retains $2.45 of this fee and $0.50 per adjudicated claim is retained by Pharmaceutical Horizons for Drug Program Reporting and Analysis; Plan Design Consultation; Group and Customer Service Support; and Prior Authorization Services.)
Pharmacy Rebates and charges for managing and maintaining the prescription drug program pharmaceutical contracts and, if applicable, the prescription drug program formulary	Pharmacy rebates are paid by Ventegra to the Plan Administrator by remitting same to MedBen who then forwards the rebates to the Plan Administrator. 100% of the pharmacy rebates available to the Plan Administrator are paid and remitted to the Plan Administrator.
Although our drug plans offer substantial savings, these dispensing and administrative fees are not reimbursable under the stop-loss contracts.	

MedBen is pleased to offer self-funded employers a cost-effective, transparent prescription benefits option through its pharmacy services administrator, Ventegra. **100% of paid formulary rebates are returned to the plan through Ventegra's network.**

There are two primary prescription plan design options that can be used alone, or in combination with each other, for your employer-sponsored Health Plan:

- Retail Drug Card
- Mail Order Drug Program

The basic services covered by your administrative fees include:

- Integrated Mail Order Systems
- Prescription Card(s) (Prescription information is included on a traditional medical identification card if both medical and prescription benefits are being offered. If prescription benefits are being offered stand-alone, a separate prescription identification card is created.)
- Concurrent Drug Utilization Review Services at the Point of Service
- On-line Claims Administration
- Electronic Eligibility
- Annual Active/Terminated Member Listing
- Customer and Provider Service Department
- Patient and Pharmacy Audit Review
- Standard Management and Utilization Reports

MedBen Prescription Plan participants also can access information about their Rx benefits and a host of reliable drug information. Available through **MedBen Access**, this advanced online service, called RxEOB, allows participants to verify prescription information, review their personal prescription history, track Rx claims, and monitor their prescription expenses.

Medicare Part D Services

MedBen offers several services to help employers with prescription plans to meet the regulatory requirements associated with Medicare Part D.

Creditability Testing

Fee per Test	$350.00 *Includes review of employer-sponsored Rx plan to determine its creditability or non-creditability status.*

Employers who offer prescription coverage must determine whether their prescription plan is creditable or non-creditable under the federal Medicare D rules. Creditability testing is also done when an employer makes benefit changes to the prescription plan.

CMS Notice Requirements

Fee per Test	$0.60 per employee per month (PEPM) *Includes the preparation and distribution of standard notices to plan participants (including Medicare Part D eligible individuals), and the preparation and required electronic notifications to the CMS.*

Once the creditability status of the prescription plan is determined, the employer then has the responsibility to notify the Centers for Medicare and Medicaid Services (CMS). In addition, employers will need to provide ongoing notices to plan participants who are -- or who become -- eligible for Medicare Part D coverage. These notices will indicate to the individual whether or not their current prescription plan coverage is creditable or non-creditable, so they can determine whether they wish to stay on their employer's plan or enroll in a Medicare-approved plan.

Teladoc Physician Consultation Service

Fee	$3.75 per employee per month (PEPM) *Client will be required to sign a Joinder agreement with MedBen and Teladoc to obtain services.*

MedBen offers Teladoc, a national telehealth network of U.S. board-certified doctors available on-demand 24/7/365 to diagnose, treat and prescribe medication, if necessary, for many medical issues. Users can interact with a physician via online video, mobile app, or phone.

Teladoc is ideal for when non-emergency medical consultations are needed after hours or away from home, or if your schedule doesn't permit traveling to see your doctor. Participating physicians are board-certified in internal medicine, family practice, behavioral health and pediatrics.

Accessing Teladoc is easy. Users simply request a consultation and provide some background information. A physician then reviews the patient's medical history and contacts them within minutes.

Teladoc is a stand-alone service that operates separately from your health care plan. Users are charged a flat rate per consultation, and no claims data is exchanged.

24-Hour Nurseline

Fee	$1.85 per employee per month

Valuable assistance is a phone call away with MedBen's 24-Hour Nurseline. Plan participants get free medical advice around the clock, every day of the week. No matter what the time, or how big or small the question; nurses are ready to assist your employees with answers to medical questions.

(Continued next page)

Experienced Registered Nurses answer the calls, and advise callers on care options. They are there to assess symptoms during illness or injury and to help decide what the best form of care might be. Nurses are able to help through their experience and through the assistance of a patented expert system that prepares the nurses for most any condition.

Employee Assistance Program

EAP Fee	$2.20 per employee per month *Prices may vary depending on group size and composition.*

MedBen offers an Employee Assistance Program (EAP) to supplement the group's employee health benefit plan.

MedBen is guided by the philosophy that early access to professional help is the best approach to health care for employees and their families. Our EAP provider, WorkLife Solutions, gives employees confidential, 24-hour daily access to behavioral health professionals and community resources that help employees take care of their personal concerns so that they can reduce stress and focus on their work.

COBRA Administration

COBRA Administration Fee	$1.95 per employee per month
Set-up Fee	$380.00 (One time only) *From the time a signed contract is received, a two-week set-up time period is required to implement the service.*
MedBen will also retain a 2% administrative fee for insurance coverage under COBRA.	

MedBen uses a COBRA Administration System to assist employers with the complications and burdens of COBRA Administration. In addition, MedBen gives our clients access to a number of COBRA management reports and excellent customer service at a fraction of the cost, saving our clients both time and money.

MedBen's COBRA administration is an all-inclusive service, meaning the PEPM fee covers all services provided to meet your regulatory requirements. Because of the potential liability inherent in missing a COBRA occurrence, this comprehensive package is designed to alleviate the potential risk from the employer and to make sure the appropriate reporting is being completed.

Flexible Spending Account (FSA)

A Flexible Spending Account (FSA) is an excellent way to provide your employees with optimum benefits while saving your company – and your employees – significant tax dollars each year.

MedBen provides total plan administration, from FSA set-up to member reimbursements. We provide assistance:

1. Designing the plan
2. Introducing the plan to your employees
3. Providing your employees with an information packet with answers to the most commonly asked questions
4. Holding individual meetings with each employee to determine the maximum benefit to the employee
5. Providing your company with all the required forms
   - Procedures Checklist
   - Plan Document
   - Employee Election Forms
6. Claim forms and Instructions for filing
7. Providing a secure website so your participants can check their FSA benefits information, claims status and account balances 24/7.
8. Providing participants with a 1-800 # for Customer Service assistance.
9. Payment of bona-fide claim reimbursements

Premium Only Plan

Set-up Fee	$175.00 (One time only) *Includes:* • *Preparation of Plan Document only* • *Provide groups with a "SAMPLE" Election Form* • *No monthly fee* • *$75.00 Fee for plan document changes and/or updates (if applicable)*

The most basic type of FSA, a premium only plan uses funds placed in the account exclusively toward the employee's share of the employer-sponsored health, vision, dental and prescription drug plans premium.

Health FSA

Plan Start-up Fee	• $ 630.00 (1-50 participants) • $ 735.00 (51-100 participants) • $ 1,000.00 (101-300 participants) • $ 1,200.00 (301 participants and up)
Monthly Health FSA Fee	$4.85 per covered employee
Annual Renewal Fee	$210.00

Amounts placed in a health FSA are used to reimburse the employee for qualified, non-reimbursed medical expenses incurred by the participant during the plan year. Qualified expenses include, but are not limited to:

- Insurance deductibles, co-pays and coinsurance (but not insurance premiums);
- Prescription drug co-payments and prescribed over-the-counter medications;
- Eye exams, eyeglasses, contact lenses and other vision expenses (i.e., Lasik eye surgery); and
- Dental and orthodontic expenses.

Dependent Care Assistance Plan

Plan Start-up Fee	• $ 630.00 (1-50 participants) • $ 735.00 (51-100 participants) • $ 1,000.00 (101-300 participants) • $ 1,200.00 (301 participants and up)
Monthly DCAP Fee	$4.85 per participating employee
Transportation Reimbursement	$2.60 per participating employee
Annual Renewal Fee	$210.00

The dependent care assistance plan (DCAP) reimburses the employee for employment-related dependent care. This includes payments to a day care center or baby-sitter (but not a spouse or other tax dependent) for services provided while the plan participant and spouse work or look for work.

Debit Card Option

Set-up Fee	$1.00 per participating employee; one-time fee Fee includes: ☐ Procedures Checklist ☐ Plan Document ☐ Employee Election Forms ☐ Employee meetings ☐ Claim forms and Instructions for filing
Debit Card Fee	$1.75 per participating employee per month

MedBen has the ability to use a debit card service for reimbursements. We use a Visa® card that is built from a debit platform. The card is utilized to pay at point of service for qualified health care and/or dependent care expenses and is accepted nationwide wherever Visa® is accepted. It uses an auto-substantiation technique to verify the eligibility of an expense, which means significantly fewer claims your participants will have to submit for substantiation.

Health Reimbursement Arrangement (HRA)

Plan Start-up Fee	• $ 630.00 (1-50 participants) • $ 735.00 (51-100 participants) • $ 1,000.00 (101-300 participants) • $ 1,200.00 (301 participants and up)
Monthly HRA Fee	$4.85 per covered employee
Annual Renewal Fee	$210.00
HRA Analysis	$525.00 (up to 3 plans)
5500 Form Preparation	$630.00
HRA pricing assumes the HRA payments are sent directly to the plan participant.	

The Health Reimbursement Arrangement (HRA) is an employer-funded account that can be used for any substantiated Section 213 medical expense, including deductibles, coinsurance, copays, and other cost sharing as defined by the IRS. An employer presets the amount of contribution and can set it up with non-taxable dollars. This amount can be rolled over from year to year.

The HRA can be used for current employees, retirees, or both.

FSA and HRA Package Rates

Monthly Health FSA & DCAP Fee	$6.90 per covered employee
Monthly Health FSA & HRA Fee	$6.90 per covered employee
Monthly DCAP & HRA Fee	$6.90 per covered employee
Monthly Health FSA, DCAP & HRA Fee	$7.95 per covered employee
HRA pricing assumes the HRA payments are sent directly to the plan participant.	

Affordable Care Act Services Pricing

The following pricing are in effect for the Affordable Care Act (ACA) services offered by MedBen.

Stand-alone Pricing (per service, per group)

W-2 Reporting	• Single plan or single plan option – $500 per group • Multiple plans or multiple options in one plan – $800 per group
PCORI Reporting	One or more plans or plan options – $300 per group
1095-B Preparation for Small Employers	$2,000.00 per group
1095-C Preparation for Applicable Large Employers	Pass-through cost from outsourced MedBen vendor; requires separate contract with vendor

Language Translation Services

Translation Fee	Varies according to the type of translation required and the time involved. All costs are on a "pass through" basis from MedBen's translation service provider

MedBen offers* access to full service language translation through onsite, over the phone, and video remote interpreting supporting over 270 languages. Access is also provided for written translation services in over 60 languages. Whether it is simply assisting your non-English speaking employees with their benefits questions – in their own language – or providing assistance with ACA Section 1557 Non-Discrimination services, MedBen offers a meaningful translation solution. In addition, translation for the hearing-impaired is also available.

** Please note: MedBen will pass translation service fees through to its clients even if this service is not specifically elected. All calls requiring translation will be handled and answers provided when members requiring this service contact MedBen.*

General Requirements

3.1 Plan Design (Point Value: 5 Points)

A complete plan document re-write must be completed by the successful respondent and any costs associated with preparation of this document must be included in the fees quoted. Also, respondents must demonstrate the ability to administer ERISA-exempt plans and the regulations of the State because of this exemption. Please describe your ability to assist the County in these and other compliance issues, including those relating to federal health care reform legislation and associated regulations.

The initial drafting of the SPD document is at no charge. The printing and mailing costs associated with distributing these to the plan participants are a pass-through cost to the plan. Once the client executes the plan document, the SPD and bids for its printing can be obtained in approximately seven working days.

MedBen's Compliance Department gets daily updates from multiple federal and state websites with both pending and enacted legislation and regulation pertaining to Health Care Reform. These sources include direct links to the Federal Register and daily emails from the Department of Health and Human Services and Department of Labor. We also actively search multiple websites and print resources for new and proposed laws and regulations. To ensure proper interpretation of both state and federal law, we have contacts at the applicable state Departments of insurance, the International Foundation of Employee Benefit Plans (IFEBP), and the Society of Professional Benefit Administrators (SPBA) all of which provide access to additional information, insight and guidance.

As with state regulatory matters, MedBen has taken a proactive approach to understanding and implementing federal laws and regulations related to Health Care Reform. Our Compliance staff actually reads all laws, regulations, bulletins and guidance promulgated regarding the Affordable Care Act. All of this is summarized for our clients. We also act as liaisons for our clients regarding new and proposed laws, writing comment letters and advocating for clearer guidance as provisions are promulgated.

This regulatory experience and insight directs the Compliance Department as it prepares the plan document and other required documentation for our self-funded clients. Information is gathered through regulation research, seminars and webinars; it is used to train Compliance Department personnel on the new material. Then new plan language is crafted and proposed to our self-funded clients along with plan language recommendations. In addition, documents and filings required by the ACA are created and shared with our clients, including information, checklists and templates for requirements like W-2 reporting, Summary of Benefits Coverage, and PCORI and Transitional Reinsurance tax filings. If the law allows, MedBen will prepare the required documents and make the required filings.

3.2 Pharmacy Program (Point Value: 15 Points)

The County is seeking a pharmacy benefit manager (PBM) to administer its prescription drug program. **Pharmacy pricing must be stated on a fully transparent and pass-through basis. Proposals must include 100% of rebates retained by the County.** Please complete the attached Pharmacy Benefit Manager Questionnaire for each PBM option submitted. Points will be given for employee on- line access to the participating pharmacy list, formulary lists, and personal pharmacy information. Points will also be given for access to a pharmaceutical consultant, preferably a licensed pharmacist, who can analyze the County's pharmacy program and make recommendations. The County may also negotiate PBM services outside of the scope of this RFP or directly with pharmacy benefit vendors.

Our preferred PBM, Ventegra, pricing is based on a fully transparent and pass-through basis and 100% of rebates are passed through to the County.

Your prescription plan participants can access information about their Rx benefits and a host of reliable drug information through RxEOB. This advanced online service allows participants to verify prescription information, review their personal prescription history, track Rx claims, and monitor their prescription expenses. This secure website provides plan members with personalized information about the drugs they are taking, out-of-pocket costs associated with those drugs, availability of lower-cost therapeutic alternatives, and out-of-pocket cost savings resulting from migration to a lower-cost therapeutic alternative.

MedBen also has access to a pharmaceutical consultant that can analyze the County's pharmacy program and make recommendations.

3.3 PPO Network (Point Value: 20 Points)

The County currently utilizes the BlueCross BlueShield provider network. The top facilities currently utilized by the County are Methodist Medical Center, Parkwest Medical Center, University of Tennessee Medical Center, Fort Sanders Regional Medical Center, East Tennessee Children's Hospital and NHC Healthcare. The

TPA/ASO must either be able to continue the present network arrangements, or provide other network options.

TPA/ASO respondents proposing other network options should provide average discounts for the top five hospitals in the proposed network on both an inpatient and outpatient basis, and should also provide average provider discounts for the proposed network for providers in the 37716 zip code. Respondents proposing other network options should also submit a GeoAccess report with the following minimal parameters: 2 primary care physicians within a 5-mile radius; 2 specialists within a IO-mile radius; 2 pediatricians within a 10-mile radius; 2 OB/GYNs within a IO-mile radius, and 1 hospital within a 10-mile radius. A disruption report may be required of finalists.

MedBen has proposed two different network options for this group. We've quoted an option using the PHCS/Multiplan Wrap Network and an option using Cigna. Please see section 8 of the formal proposal for the requested Geo Access Reports and discount information.

3.4 Stop Loss (Point Value: 10 Points)

The County is requesting illustrative stop loss proposals at this time. The County's current stop loss contract is with Optum. Respondents must indicate if they are an approved TPA with Optum. The specific deductible is $100,000. The County also purchases aggregate coverage. The County will entertain proposals with higher specific stop loss deductibles, but a $100,000 specific deductible option must be quoted. The County currently has a 24/12 contract for both specific and aggregate. Only 24/12 or Paid Contracts will be considered. Currently, medical and prescription drug claims are covered under the specific and aggregate and The County is requesting that this remain the same with the new stop loss coverage.

Current specific rates are: Single $58.60; Family $144.21

Current aggregate rate is: $4.48

Current aggregate factors are: Single $617.77; Family $1,486.31

The group currently has and requires a no new laser with a rate cap.

If necessary, further negotiation with successful respondents regarding stop loss will be permitted after the deadline. Stop loss should be quoted net of commissions.

Stop Loss proposals are included in Section 8 of the formal proposal.

3.5 Utilization Review/Medical Management (Point Value: 5 Points)

Please identify if your utilization review is a part of your services and whether it is an in-house service or provided by an outside vendor, and whether you're UR/medical management is URAC-accredited. Also, please describe how individuals are reported to UR/medical management and the procedures involved.

MedBen has proposed two different network scenarios for this group, utilizing two separate UR vendors. Please see descriptions below.

Hines & Associates, Inc. (Hines)

Utilization Review provides precertification, concurrent review and discharge planning for inpatient and outpatient services. **Case Management** is provided to members with high-cost catastrophic and complex cases, ensuring that services take place at the right time, in the right setting and at the right cost.

Hines' utilization review and case management programs are URAC-accredited and available in all 50 states so your plan members are covered, regardless of where they may be located. Employers receive summaries of Utilization Review activity so trends can be monitored. Reports are distributed electronically via MedBen Secure.

Utilization Review

Administrative Fee: Varies according to group size; per employee per month. See your group quote for details.

Utilization Review fee covers inpatient medical services and behavioral health services, including skilled nursing facility and residential treatment centers, as well as outpatient surgery reviews. The utilization review fee includes:

- Precertification. Assure that plan members only receive medical care that is necessary and appropriate. Nurses monitor inpatient hospital admissions, appropriate lengths of stay, and outpatient surgeries of plan members. Precertification for other outpatient procedures and ancillary services (i.e., home health care and hospice) can be provided for an additional fee. Precertification for the following services is performed and billed through case management (see below):
- Hospice
- Chemotherapy
- Radiation therapy
- Infusions
- Behavioral partial hospitalization programs
- Behavioral intensive outpatient programs
- Continued Stay Review. Nurses continue to monitor a patient's condition or progress during a hospital or other inpatient confinement to determine the appropriate length of continued stay.
- Discharge Planning. Determination of appropriate services for patients requiring extended care following a hospital discharge, such as home health, hospice or skilled nursing.

Case Management

Fee $125.00 per hour – standard medical cases

$135.00 per hour – specialty medical cases including transplants, renal/dialysis, oncology, neonatal, high risk obstetrics, and behavioral health

- Fee billed separately from Utilization Review service fees
- Fee covers factors that could result in a case management referral, including: diagnosis; complicated admissions; repeat admissions; client request; claims payer request; psycho/social indicators; and abnormally high length of stay request. A case manager will then contact the member to determine if case management services are in fact needed, or if the patient is coordinating health care services effectively on his or her own.

A separate hourly fee of $450.00 per hour is charged for medical peer-to-peer reviews and physician consultations (not including external review).

Cigna Utilization Review

The Cigna Utilization Management program can help lower costs and help customers avoid unnecessary procedures. Their program is Utilization Review Accreditation Commission (URAC) accredited. They focus on facilitating medically appropriate care.

Inpatient/outpatient precertification

- Precertification is the process of determining in advance whether a procedure, treatment or service is medically necessary.
- This helps customers to get the right care in the right setting – saving them from costly and unnecessary services.
- Cigna looks for ways to save customers money by reviewing inpatient and outpatient services.
- Cigna can help to lower out-of-pocket costs by recommending one of our preferred facilities, transitioning inpatient care to outpatient treatment, or helping to identify treatments or procedures that may be avoidable or unnecessary.
- Inpatient services include procedures, treatments and services received in a hospital or related facility that require an overnight stay.

Concurrent review (inpatient case management)

- Review inpatient stay to encourage appropriate care.
- Work with an individual during his or her hospital stay to help ensure the right care and services are in place for a strong recovery process following discharge.

Discharge planning

- Focuses on identifying and removing any barriers to a smooth, safe and timely discharge to home or to a less intense inpatient setting.
- Helps ensure that individuals can quickly and safely transition to home or a lower level of care without unnecessary delay.

Reporting

Payers can access the medical management Hyperion portal to view the following reports: Closed and Open Cases, Shock Loss Trigger Report, Open and Closed Inpatient Events, Open and Closed Outpatient Events, Readmissions, Confinements Greater than Seven Days, and CareEnhance Clinical Management Software (CCMS) Documented Savings.

3.6 Disease Management/Wellness Programs (Point Value: 5 Points)

Respondents should provide information on disease management and wellness programs they offer. Discuss ability to provide a Gaps in Care component to wellness programs offered.

Worksite Wellness and Disease Management Program

Base Fee $ 6.00 PEPM

The program focuses on your total population with the promotion of early detection testing for cancer and heart-related diseases. It also emphasizes the importance of members having an annual wellness exam by their primary care physician. Claims-based reports on testing compliance are provided to employers on a regular basis in order for them to tie wellness incentives to these important health screenings. Reports can be produced in a format that allows the employer to know who qualifies for incentives while protecting the personal health information of the individual member.

Other key components of the program include:

- **Nurse health coaching for Diabetes, Hypertension, Asthma, High Cholesterol, and Coronary Artery Disease**. A nurse will place a confidential call to individuals who are at risk for, or may be currently managing, one of these conditions based on a historical review of your claims.
- **Condition-specific education** materials may be sent to a member's home to provide information to a member on how to access relevant education sources, including self-help activities and websites.
- **Wellness Guidelines** will be mailed each year to members' homes that outline recommended tests for good health, along with immunization guidelines and suggested prevention screenings for the most common cancer types (colon, breast, prostate and lung), based on an individual's specific age and gender.

An extensive employer reporting package provides information on the prevalence of chronic health conditions, compliance with early detection testing, overall clinical progress of members enrolled in health coaching and overall financial return on the program. Our standard reporting package also includes information on individuals with Gaps in Care and the financial risk associated with those members. Please refer to our sample reporting package in the Section 6 of our Formal Proposal.

The program is an opt-out service, meaning that all employees and their dependents on the health plan are considered participants in the wellness program unless they indicate otherwise. This approach allows for maximum outreach and program involvement.

Program Consultation and Additional Services

MedBen works with employers to develop custom enrollment strategies, effective employee incentives, best practice approaches, and ways to tie their wellness initiatives to the health plan.

On-site biometric screenings can be arranged upon request and are charged on a cost-pass-through basis.

3.7 COBRA (Point Value: 5 Points)

The chosen TPA/ASO must be able to provide COBRA services on behalf of the County. Please indicate whether COBRA administration is provided in-house or through an outside vendor.

The fee to administer these services is a fee of $1.95 PEPM.

MedBen uses a proprietary COBRA Administration System to assist employers with the COBRA Administration, this turnkey administration gives our clients access to a number of COBRA management reports and excellent customer service at a fraction of the cost, saving our clients both time and money.

3.8 Online Capabilities (Point Value: 10 Points)

The County would like as much on-line access as possible to the plan information for management purposes as well as, but not limited to, the ability to monitor claims, run reports and make enrollment changes online. Consideration will be given to whether vendors allow employees to check personal information on-line. Any additional cost for this service should be quoted separately.

MedBen offers employee self-serve (ESS) technology, called **MedBen Access**, for both employer and employee convenience and is provided free of charge. MedBen Access is unique in that it offers real-time information as opposed to some ESS systems, which update information on a scheduled basis. The information is protected by an individual's password via a secured server.

From the employer perspective, you can perform a number of basic management functions 24/7, including, but not limited to:

- Reviewing change of information requests
- Updating eligibility data
- Ordering I.D. cards
- Reviewing Plan Documents
- Checking deductible and coinsurance accumulations
- Monitoring real-time claims activity
- Downloading forms
- Reviewing provider information through website links

From the employee perspective, a number of basic benefits functions are available 24/7, including, but not limited to

- Requesting a change of information
- Notifying of an eligibility change
- Requesting an I.D. card
- Reviewing coverage in the Plan Document
- Checking individual deductible and coinsurance accumulations
- Checking on a claim's status
- Downloading a form
- Linking to provider websites for search and information

3.9 Section 125 (Point Value: 5 Points)

The County offers a Flexible Spending Account and Dependent Care Account. The County would like members to be able to use a debit card in conjunction with these accounts and to view their detailed account information online.

MedBen has the ability to administer complete FSA services for the County, including expense reconciliation, check issuance, account tracking, participant account activity reports and employer summary reports. We can provide the FSA account in conjunction with the administration of the County's medical plans.

MedBen also provides the latest FSA features to make administration easy. These include an online tax savings calculator, IRS eligible expense table and other self-service technology for real time benefits management as well as a debit card option.

3.10 Dental/Vision Administration (Point Value: 5 Points)

The County's current dental plan is with Delta Dental and the vision plan is with VisionBlue. The County may consider increasing the dental and vision benefits in the future. Respondents should indicate whether they can administer The County's current dental and vision plan designs. Points will be allotted for dental/vision administration, on-line capabilities, and for providing a dental network. Respondents wishing to bid only on dental or vision coverage may do so.

MedBen would be able to administer the dental plan on a self-funded basis for $2.00 PEPM. MedBen would also be able to administer the vision plan on a self-funded basis for $1.25 PEPM. All online capabilities available for medical are available for dental and vision. MedBen is willing to work with leased dental and/or vision networks at the group's request.

5.11 References (Point Value: 5 Points)

At least five references in total should be provided, and one of the five must be a former client. Representation of government agencies, especially those in Tennessee, will receive significant regard.

Licking County Government
Gina Lewis, Human Resources Director
(740) 670-5150

City of Zanesville
Jeff Tilton, Mayor
(740) 455-0601

Boone County Fiscal Court
Lori Zombek, Treasurer
(859) 334-3261

City of Covington
Jo Ann Simpson, Human Resources Director
(859) 292-2176

Terminated Reference:

Madison Precision
Cari Morrison-Bear, Human Resources Manager
(812) 265-6629

3.12 Run-in/Run-out

Run-in claims may be negotiated with successful respondents, and services for run-in should be quoted.

If elected, there will be a one-time charge for run-in services based on MedBen's administrative fee (PEPM) for products chosen and for the number of employees enrolled. Services can be provided for up to twelve months. If run-in services are not elected, but later needed, there will be a fee of $8.00 per claim charged for processing.

3.13 Additional Criteria (Point Value: 10 Points)

All proposals must be submitted in writing. Criteria that will be used to determine award of the contract will include but will not be limited to the following:

a. The cost per employee per month for all services. Cost quoted must be guaranteed for at least one year period following acceptance.

All applicable fees are listed in the Fees Section below. MedBen's fees are guaranteed for TWO years.

b. References provided.

c. The qualifications and experience of the Respondent's staff and associated vendors. **Please describe.**

Please refer to the Contact Directories located in the Section 5 of our Formal Proposal.

d. The scope and degree of services provided.

e. Thoroughness and usefulness of reports provided to the County on a monthly basis. **Please describe your reporting package and provide examples.**

MedBen's standard reporting package has been designed to meet virtually every client's needs. Report schedules are set with our client during their implementation process; however, if a client determines they need to request a report off schedule, MedBen is able to generate the report on an AD/HOC basis to fulfill our clients' requests.

Please refer to the Section 6 of our Formal Proposal for a sample reporting package.

f. On-line services not already described above. **Please describe.**

Please refer to item 3.8 above for a full description of our online services.

g. The ability to work with related vendors. **Please describe.**

MedBen maintains a comprehensive portfolio of vendors covering a wide variety of services in order to accommodate individual employer needs. These firms range from worksite wellness to claims auditing firms. We have a Vendor Review Group that selects and monitors the quality of any third party vendor MedBen utilizes.

h. Demonstrated customer service. **Please describe.**

MedBen offers two levels of customer service to our clients. These units reside next to each other in our facility to enable quick communication between the servicing areas.

- *Customer Service Representatives* who handle inquiries from your plan participants and their providers.
- *Group Service Representatives* who are your direct contacts into MedBen. They provide assistance with claims, benefits, eligibility, reports, billing, and plan document questions.

i. Claims turnaround time. **Please state your average clean claim turnaround time.**

MedBen's goal is to have 95% of clean claims processed within 15 calendar days. Our average for 2018 was 91.54%.

k. Size/scope of the PPO network.

l. Thoroughness of the response to the RFP.

Pharmacy Benefit Manager Questionnaire

Please complete for each PBM offered as part of this proposal

The County requests that each Pharmacy Benefit Manager confirm its stance on the following contractual and administrative issues.

Pricing must be stated on a fully transparent and pass-through basis. Proposals must include 100% of rebates retained by the County.

Name of PBM: Ventegra

7.1 Pricing

a. Affirmatively state whether the proposed PBM's pricing is quoted on a fully transparent and pass-through basis, and whether 100% of rebates will be passed through to the County.

Yes, pricing is quoted on a fully transparent and pass-through basis, and 100% of rebates will be passed through to the client. Since their start, Ventegra has only adhered to 100% transparent, pass-through models.

b. Does the proposed PBM own its pharmacy network? If not, please identify the network it uses and state whether the network passes through all discounts to the PBM.

Yes, Ventegra owns the pharmacy network, which is based on a cost-plus model that utilizes their (patent pending) Acquisition Cost Index.

c. Does the proposed PBM own its claims processor? If not, please identify the claims processor it uses and state whether the processor passes through all discounts to the PBM.

They partner with New Tech Systems, which is owned by Morris & Dickson, for claims processing; however, they own the source code and are able to make any programming changes as necessary. The processor passes through all discounts.

d. Does the proposed PBM own its mail order vendor? If not, please identify the mail order vendor it uses and state whether the mail order vendor passes through all discounts to the PBM. Please also state whether the County may use a mail order vendor other than the one used by the PBM.

They do not take title to drug (i.e. own a Mail Order or Specialty Pharmacy) as it creates a potential conflict-of-interest. They partner with Drug Source, Inc., which is a family-owned mail order pharmacy based in Chicago. They submit to Ventegra their acquisition costs to use for adjudication. The County may use a mail order vendor other than our preferred vendor. Additionally, the County is able to customize the pharmacy network as desired.

e. Does the proposed PBM own its specialty drug network? If not, please identify the specialty drug network it uses (if any) and state whether the specialty drug network passes through all discounts to the PBM. Please also state whether the County may use a specialty drug network other than the one used by the PBM.

Ventegra does not take title to drug (i.e. own a Mail Order or Specialty Pharmacy) as it creates a potential conflict-of-interest. They partner with Costco Specialty, Drug Source, and have contracts in place for Limited Distribution medications. The Specialty pharmacies pass through the discounts, and the County may use a Specialty pharmacy vendor other than our preferred vendors.

7.2 Corporate Capabilities

a. Identify the staff that would be directly involved with the County's contract, along with their titles and responsibilities with respect to the group.

Our Group Service Representatives (GSRs) act as intermediary for you and our PBM (Pharmacy Data Management). The GSRs are able to assist with enrolling newly eligible plan participants to expedite their prescription needs, answering benefit questions, or managing any necessary drug overrides.

b. Identify three references of clients similar to the County.

City of Zanesville
Jeff Tilton, Mayor
(740) 455-0601

Licking County
Gina Lewis, Director of Human Resources
(740) 670-5154

City of Covington
Jo Ann Simpson, Human Resources Director
(859) 292-2176

7.3 Maximum Allowable Costs

Describe your MAC program including discounts and maintenance procedures.

Ventegra does not use traditional "AWP minus" (brands) or MAC lists (generics), but instead has a cost-plus model that utilizes a (patent pending) Acquisition Cost Index, which is updated automatically every 24-hours. Ventegra receives electronic feeds from pharmacies (retail, mail order, and specialty) and wholesalers on a nightly basis of the price and quantity of drug in supply that creates a market-weighted price of nearly all medications available in the marketplace. The same price for each individual NDC is used across our entire book of business (network pharmacies and clients). Furthermore, unlike traditional PBMs, they have no restrictions in place that prevent payers from discussing reimbursement with our network pharmacies, which eliminates the potential for (Bill-Pay differential) spread pricing.

7.4 Rebate Management

a. The County requests the access and right to audit all records regarding rebates with drug manufacturers as it pertains to the County. Please describe your current policy and scope for outside audit procedures.

   Ventegra has the most transparent rebate program in the country. Our clients have access to individual contract terms as needed. They can allow in-person audits as necessary; however, because they pay all rebates on the last day of the month for every rebate that is received and reconciled by the 25th of every month, and because the rebate disbursement reports disclose down to the NDC-level of each drug (i.e. what manufacturer, paid what amount, for how many units of what drug) our clients find that outside audits are unnecessary.

b. Do you utilize a rebate processor? If so, does your rebate processor pass through 100% of rebates to you?

   Ventegra is one of the few remaining independent rebate processors in the county, and all contracts have been 100% pass-through since their start.

c. Describe the process for recommending formulary changes in conjunction with rebate contracts in order to obtain the most cost effective net per member per month costs.

   Their CAC (Clinical Advisory Committee; P&T) meets on a quarterly basis to review new medications to add to the formulary. The most current evidence and net cost information is used when making their decisions so that the cost-effective medications are recommended. Furthermore, because clients have access to individual drug ingredient costs and contracted rebate rates, our clients are able to make custom formulary decisions as necessary.

7.5 Price Proposal

a. Identify the administrative services fee per employee per month (PEPM). Identify all of the administrative services included in this fee. If there are any other charges that will be assigned to other services, please identify these services and the associated fee. Any fees not identified will be assumed to be part of the administrative services included in the PEPM service fee.

The Administrative Fee for RX Card/Mail Order is $2.50 PEPM. Please refer to the MedBen Services in Section 3 of the Formal Proposal for additional fees associated with the PBM.

b. Identify retail dispensing fees.

Since Ventegra utilizes a cost-plus network based on an Acquisition Cost Index, their model has a professional fee vs. the traditional dispense fee used by traditional PBMs. Therefore, their professional fee, which is higher because our ingredient costs start lower, cannot be compared "apples-to-apples" to the traditional dispense fees. Our retail professional fees average $7.83 across our book of business.

c. Identify mail order dispensing fees.

We advocate "Mail at Retail" (i.e. 90-days at retail), but we do have mail order available for those health plans that are interested and we can use your preferred mail order vendor should one exist. The professional fee for mail order is $7.50.

d. Identify proposed specialty pharmacy services reimbursement fees and/or current product list as applicable.

Similar to the answers above related to mail order pharmacy, Ventegra does not own a specialty pharmacy (potential conflict of interest), but partners with Costco Specialty and the Limited Distribution pharmacies. We also advocate specialty medications be filled through the retail pharmacy channel when available as it is oftentimes the most cost-effective.

e. Identify drug ingredient cost discounts for your block of business for:

Converted our professional fees to $0.75 for ease in comparison.

- All retail brand claims for the period January 1, 2017-December 31, 2017
  AWP-20.0%
- All mail order brand claims for the period January 1, 2017-December 31, 2017
  AWP-20.1%
- All retail generic claims for the period January 1, 2017-December 31, 2017
  AWP-86.9%
- All mail order generic claims for the period January 1, 2017-December 31, 2017
  AWP-95.2%
- All retail brand claims for the period January 1, 2018-December 31, 2018

AWP-18%

- All mail order brand claims for the period January 1, 2018-December 31, 2018
  AWP-83.5%
- All retail generic claims for the period January 1, 2018-December 31, 2018
  AWP-19.4%
- All mail order generic claims for the period January 1, 2018-December 31, 2018
  AWP-88.1%

ATTACHMENT TO BID FORM: ADMINISTRATIVE SERVICES

Third Party Administrator or ASO Provider: MedBen Administrators

Contact Information: Brooke Hupp, bhupp@medben.com, 800-423-3151 x348

This form must be completed according to how administrative fees are applicable to your organization.

*All rates should be provided as a PEPM (per employee per month) charge unless otherwise Indicated.

Base Administration	$22.05 PEPM
COBRA Administration	$1.95 PEPM
HIPAA Administration	N/A – Certificates of Creditable Coverage available upon request
Utilization Review/Medical Management	$3.05 PEPM (Hines) OR $1.40 (Cigna)
Name of UR/Case Management Organization:	Hines OR Cigna depending on Network
Disease Management Fee	$6.00 PEPM - MedBen WellLiving
PPO Administration/Coordination Fee	$0.75 PEPM
PPO Access Fee	$4.90 PEPM – PHCS; 16% of savings for Multiplan Wrap OR $19.43 – Cigna (includes their fee for UR & Case Mgmt)
Rx Administration/Coordination Fee	$2.50 PEPM
Medicare Part D Notices & Testing	$0.60 PEPM Notices / $350 per Test
HRA Administration	$4.85 PEPM
Other Fee FSA Services	$4.85 PEPM – FSA, $4.85 PEPM Dep Care, $1.75 PEPM FSA Debit Card
TOTAL MONTHLY FEES	The total monthly fee will depend on services chosen
Other Annual Fees (if applicable)	HRA/FSA- $210 Annual Renewal Fee
Setup (One-Time fee)	$2,050 Set-up Fee / $380 COBRA Set-up / $1,200 FSA/HRA Set-up / $7,210 Run-In / $1.00 per participant FSA Debit Card
Are on-line administrative services available?	Yes, included in the Base Admin Fee
Is a copy of your EOB included?	Yes
Rate guarantees (please specify)	MBA's Fees are guaranteed for TWO Years through 6/31/21. We cannot guarantee any outside vendor and/or PPO fees.