

Signed Resolution - May 27, 2015

- Res. #2015-165 Resolution Providing for a Meeting Not Open to the Public in Accordance with the Provisions of the New Jersey Open Public Meetings Act, N.J.S.A. 10:4-12.- **Collective Bargaining/Contract Negotiation Preparation; Insurance**
- Resolution # 2015-166 Resolution Awarding A Contract With IHC Insurance Company for Stop Loss Coverage for Insurance as an Extraordinary Unspecifiable Services Contract
- Resolution #2015-167 Resolution Awarding A Contract With Amerihealth for Medical Insurance as an Extraordinary Unspecifiable Services Contract
- Resolution #2015-168 Resolution Awarding A Contract With Health Insurance Solutions Inc. (HISI) for Prescription Insurance Extraordinary Unspecifiable Services Contract

TOWNSHIP OF LOWER, COUNTY OF CAPE MAY, STATE OF NEW JERSEY

RESOLUTION # 2015-165

TITLE:

A RESOLUTION PROVIDING FOR A MEETING NOT OPEN TO THE PUBLIC IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY OPEN PUBLIC MEETINGS ACT, N.J.S.A. 10:4-12

WHEREAS, the Township Council of the Township of Lower is subject to certain requirements of the Open Public Meetings Act, N.J.S.A 10:4-6, et seq.; and

WHEREAS, the Open Public Meetings Act, N.J.S.A. 10:4-12, provides that an Executive Session, not open to the public, may be held for certain specified purposes when authorized by Resolution; and

WHEREAS, it is necessary for the Township Council of the Township of Lower to discuss in a session not open to the public certain matters relating to the item or items authorized by N.J.S.A. 10:4-12b and designated below:

_____ (1) Matters Required by Law to be Confidential: Any matter which, by express provision of Federal law or State statute or rule of court shall be rendered confidential or excluded from the provisions of the Open Public Meetings Act.

_____ (2) Matters Where the Release of Information Would Impair the Right to Receive Funds: Any matter in which the release of information would impair a right to receive funds from the Government of the United States.

_____ (3) Matters Involving Individual Privacy: Any material the disclosure of which constitutes an unwarranted invasion of individual privacy such as any records, data, reports, recommendations, or other personal material of any educational, training, social service, medical, health, custodial, child protection, rehabilitation, legal defense, welfare, housing, relocation, insurance and similar program or institution operated by a public body pertaining to any specific individual admitted to or served by such institution or program, including but not limited to information, relative to the individual's personal and family circumstances, and any material pertaining to admission, discharge, treatment, progress or condition of any individual, unless the individual concerned (or, in the case of a minor or incompetent, his guardian) shall request in writing that the same be disclosed publicly.

 X (4) Matters Relating to Collective Bargaining Agreement: Any collective bargaining agreement, or the terms and conditions which are proposed for inclusion in any collective bargaining agreement, including the negotiation of the terms and conditions thereof with employees or representatives of employees of the public body. **Collective Bargaining/Contract Negotiation Preparation - Insurance**

_____ (5) Matters Relating to the Purchase, Lease or Acquisition of Real Property or the Investment of Public Funds: Any matter involving the purchase, lease or acquisition of real property with public funds, the setting of banking rates or investment of public funds, where it could adversely affect the public interest if discussion of such matters were disclosed.

_____ (6) Matters relating to Public Safety and Property: Any tactics and techniques utilized in protecting the safety and property of the public, provided that their disclosure could impair such protection. Any investigations of violations of possible violations of the law.

_____ (7) Matters Relating to Litigation, Negotiations and the Attorney-Client Privilege: any pending or anticipated litigation or contract negotiation in which the public body is, or may become a party. Any matters falling within the attorney-client privilege, to the extent that confidentiality is required in order for the attorney to exercise his ethical duties as a lawyer.

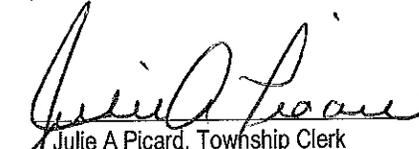
_____ (8) Matters Relating to the Employment Relationship: Any matter involving the employment, appointment, termination of employment, terms and conditions of employment, evaluation of the performance of promotion or disciplining of any specific prospective public officer or employee or current public officer or employee employed or appointed by the public body, unless all the individual employees or appointees whose rights could be adversely affected request in writing that such matter or matters be discussed at a public meeting.

_____ (9) Matters Relating to the Potential Imposition of a Penalty: Any deliberations of a public body occurring after a public hearing that may result in the imposition of a specific civil penalty upon the responding party or the suspension or loss of a license or permit belonging to the responding party bears responsibility.

NOW, THEREFORE, BE IT RESOLVED by the Township council of the Township of Lower, assembled in public session on May 27, 2015 that an Executive Session closed to the public shall be held on this date at Approximately 4:30 P.M. in the Conference Room of the Township Hall, 2600 Bayshore Road, Villas for the discussion of matters relating to the specific items designated above.

It is anticipated that the deliberations conducted in closed session may be disclosed to the public upon the determination of the Township Council that the public interest will no longer be served by such confidentiality.

I hereby certify the foregoing to be the original resolution adopted by the Township Council at a SPECIAL MEETING held on May 27, 2015.


Julie A Picard, Township Clerk

	MOTION	SECOND	AYE	NAY	ABSTAIN	ABSENT
CONRAD	X		X			
PERRY			X			
SIMONSEN		X	X			
CLARK			X			
BECK			X			

TOWNSHIP OF LOWER, COUNTY OF CAPE MAY, STATE OF NEW JERSEY

RESOLUTION #2015-166

TITLE: RESOLUTION AWARDING A CONTRACT WITH IHC INSURANCE COMPANY FOR STOP LOSS COVERAGE FOR INSURANCE AS AN EXTRAORDINARY UNSPECIFIABLE SERVICES CONTRACT

WHEREAS, there exists a need for Stop Loss coverage on the medical insurance plan beginning June 1, 2015; and

WHEREAS, the estimated annualized premium of the contract is self-funded with a total flat commission to Marsh & McLennan for Stop Loss/Health Insurance and Prescription of an amount not to exceed \$60,000.00 and funds have been certified by the Chief Financial Officer as evidenced by her signature below:

Budget Account Number: 5-01-23-220-412

CFO Signature: 

WHEREAS, the Local Public Contracts Law (N.J.S.A. 40A:11B1 et seq.) requires that the resolution authorizing the award of contracts for "Extraordinary, Unspecifiable Services" without competitive bids and the contract itself must be available for public inspection; and

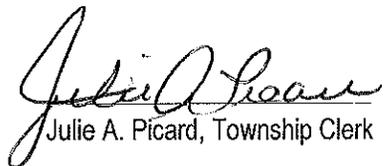
WHEREAS, the Chief Financial Officer has certified that this meets the statute and regulations governing the award of said contracts.

NOW, THEREFORE, BE IT RESOLVED, by the Township Council as follows:

1. The Township Manager is hereby authorized and directed to execute the agreement upon receipt of final contract as follows:

- A. Stop Loss Insurance – IHC Company
Effective date June 1, 2015 thru May 31, 2016

I hereby certify the foregoing to be the original resolution adopted by the Township Council at a meeting held on May 27, 2015.


Julie A. Picard, Township Clerk

	MOTION	SECOND	AYE	NAY	ABSTAIN	ABSENT
CONRAD			X			
PERRY			X			
SIMONSEN	X		X			
CLARK		X	X			
BECK			X			

Standard Security Life Insurance
Company of New York
485 Madison Ave
New York, NY 10022

APPLICATION FOR STOP LOSS INSURANCE

1. Name of Applicant: Township of Lower Policy # SSL-IHCRS-00745-15
Address (Street, City, State, Zip): 2600 Bayshore Road, Villas, NJ 08251

2. Industry/Business Type and Description: 9199: General Government

3. Name and Addresses of Subsidiaries to be covered (attach additional pages if necessary):

Name	Address (City, State, Zip)
_____	_____
_____	_____

4. Number of persons covered under the Applicant's Plan at all Locations listed above:
Single: 43 Family: 116 Composite: 159
COBRA Continuees: 0 Retirees: X On a Leave of Disability: 0

Note: If your health insurance plan does not cover individuals retired or on a leave of disability, indicate 0.

5. Name of Your Administrator: AmeriHealth Administrators, Inc.
Address (Street, City, State, Zip): 720 Blair Mill Road, Horsham, PA 19044

6. Policy Effective Date: 06/01/2015 Policy Expiration Date: 05/31/2016

All amounts and numbers shown in this application apply only to the Policy Year in effect. A new application will be completed for each new Policy Year.

COVERAGE SELECTED:
 SPECIFIC STOP LOSS INSURANCE
 AGGREGATE STOP LOSS INSURANCE

A. SPECIFIC STOP LOSS INSURANCE

1. Benefits Covered: Medical Prescription Drug Card

2. Benefit Period:
Expenses Incurred from 06/01/2014 through 05/31/2016, and
Paid from 06/01/2015 through 05/31/2016.

3. Deductible (per Covered Person) \$100,000

Aggregating Specific Deductible \$140,000

4. Specific Benefit Percentage..... 100%

5. Specific Benefit Limit per Covered Person:
Lifetime Limit: \$UNLIMITED
Annual Limit: \$UNLIMITED

6. Monthly Specific Premium Rate/Enrollment:
 RATE: COVERED UNITS/ENROLLMENT:
 Single: \$100.25 Single: 43
 Family: \$224.79 Family: 116
 Composite: N/A Composite: 159

7. Premium Payment Mode: Monthly

B. AGGREGATE STOP LOSS INSURANCE

1. Benefits Covered: Medical Prescription Drug Card
2. Benefit Period:
 Expenses Incurred from 06/01/2014 through 05/31/2016, and
 Paid from 06/01/2015 through 05/31/2016.
3. Minimum Aggregate Attachment Point..... \$4,902,444
4. Aggregate Loss Limit (per person) \$100,000
5. Aggregate Benefit Percentage 100%
6. Maximum Aggregate Benefit \$1,000,000
7. Run-In Limit: \$784,391
8. Monthly Aggregate Factors/Enrollment:
 FACTORS: COVERED UNITS/ENROLLMENT:
 Single: \$1,144.41 Single: 43
 Family: \$3,097.65 Family: 116
 Composite: N/A Composite: 159
9. Aggregate Premium ([N/A] Annual / [X] Per Person Per Month): \$12.79
10. Premium Payment Mode..... Monthly

C. OPTIONS*

- Advanced Funding for Specific Stop Loss
- Aggregating Specific Deductible
- [X - \$2.56 PEP] Aggregate Stop Loss Terminal Liability
- Retiree Expenses Included in Coverage
 Limited to: **Eligible expenses incurred by the Employer for retired individuals age 65 and older will be reimbursed under the Policy as secondary to Medicare.**

* Subject to approval.

D. NOTES

1. AmeriHealth accessing Horizon Blue Cross of NJ will be the PPO of choice. Large Case Management and Utilization Review will be done by the same.
2. The Applicant's Plan Document has not been received and reviewed by IHC Risk Solutions. No claim shall be payable until the Plan Document is received and confirmed to be the same benefits used at the time of underwriting.

E.

A deposit of \$ _____ is enclosed to apply to the first payment under the Policy, if issued. If the Application is not accepted, the deposit will be returned. **It is understood and agreed that:**

- a) **Any Stop Loss Insurance resulting from this Application shall be as described in and subject to the terms and provisions of the Policy, when issued, and shall not become effective until approved by the Company.** The Policy will become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement signed by you has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, and (4) a copy of the executed Plan is received and acceptable to Standard Security Life Insurance Company of New York (the "Company") or **IHC Risk Solutions** pursuant to paragraph b) below. If any of these requirements are not satisfied within 90 days from the proposed effective date indicated in this Application, We may refund all premiums and coverage will be null and void retroactive to the proposed effective date.
- b) The Applicant must furnish to **IHC Risk Solutions** or the Company a copy of the executed benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of **IHC Risk Solutions** or the Company. No Policy will be effective nor claim reimbursed until such time as the Plan is received and accepted by **IHC Risk Solutions** or the Company. If in the sole judgment of **IHC Risk Solutions** or the Company there is a material variance between the provisions of the Plan received by **IHC Risk Solutions** or the Company, and the Plan provisions upon which the terms and rates of the aggregate and specific stop loss coverage were based, **IHC Risk Solutions** or the Company may, at its option, notify the Applicant of such variances and decline to issue the Policy until such time as an amended Plan is received and accepted. If such amended Plan is not received and accepted by **IHC Risk Solutions** or the Company within 30 days of such notice, We may refund all premiums and coverage will be null and void retroactive to the proposed effective date.
- c) The Applicant will provide or employ supervision and claim administration facilities acceptable to **IHC Risk Solutions** or the Company to administer the Plan and to process and pay claims according to the Plan.
- d) The receipt by the Company of the deposit listed above and the deposit of any check drawn in connection with this Application shall not constitute any agreement to issue a policy or acceptance of liability. In the event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.
- e) The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and that the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application, the Policy, and the Plan shall embody all agreements existing between the Applicant and the Company, or any of their respective agents, relating to this Stop Loss Insurance for which this Application is being made.
- f) If approved, this Application: 1) supersedes and replaces prior Applications approved by the Company; and 2) will be attached to and made part of the Policy issued by the Company.

By signing below, the Applicant hereby applies for the coverage stated in this Application. The Applicant represents that it has, directly or through its authorized agent, read this Application in its entirety and has been given the opportunity to ask any questions it may have. The Applicant further understands that the insurance requested does not start unless this Application is approved and accepted by **IHC Risk Solutions** or the Company. The Applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the Applicant may experience losses that are not covered under the policy or under any prior or subsequent coverage.

The individual signing below hereby represents and warrants that he or she is duly authorized and has legal capacity to execute and deliver this Application on behalf of the Applicant and that this Application is binding on the Applicant in accordance with its terms.

Applicant: Township of Lower
Signature: [Handwritten Signature]
Print Name: JAMES R. COWAN
Title: Lower Township Manager
Date: 6/18/2015
Licensed Agent's Signature: [Handwritten Signature]
Print Name: Robert J. Cowan
Date: 6/18/2015

FRAUD WARNING NOTICES: (Please review notice that applies in your state. If your state is not listed, please review the last notice marked All Other States)

For applicants in ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents a false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

For applicants in ARIZONA: For your protection, Arizona law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

For applicants in ALASKA, DELAWARE, IDAHO, and INDIANA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For applicants in CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For applicants in ARKANSAS, LOUISIANA, RHODE ISLAND, TEXAS, and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial or insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For applicants in FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in KENTUCKY, NEW MEXICO, NORTH DAKOTA, and PENNSYLVANIA:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

For applicants in MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in MINNESOTA: A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For applicants in OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For applicants in OKLAHOMA: **WARNING**: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claims for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For applicants in OREGON: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime.

For applicants in PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For applicants in MAINE, TENNESSEE, VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For applicants in ALL OTHER STATES: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and/or confinement in prison.

Standard Security Life Ins Co of NY

Stop Loss Proposal

Name of Group	Township of Lower Villas, NJ	Proposal	04/27/2015	
Producer	Katz/Pierz	Effective	06/01/2015	Expiration 05/31/2016
Administrator				
Underwriter	Amany Zakaria (856) 267-0264			

SPECIFIC STOP LOSS Includes Medical, Rx Card Coverage(s) Advance Reimbursement: Yes

		Option 1	Option 2	Option 3
Specific Deductible	\$	100,000	110,000	125,000
Contract Type		24/12	24/12	24/12
Commission Level		10.00%	10.00%	10.00%
Aggregating Specific Deductible	\$	140,000	140,000	140,000
Quoted Rate Per Month	<u>Enrollment</u>			
Single	43	\$ 100.25	\$ 88.41	\$ 73.43
Family	116	\$ 224.79	\$ 200.03	\$ 168.93
Estimated Annual Premium		\$ 364,644	\$ 324,060	\$ 273,045
Maximum Annual Reimbursement		Unlimited	Unlimited	Unlimited
Maximum Lifetime Reimbursement		Unlimited	Unlimited	Unlimited

AGGREGATE STOP LOSS Includes Medical, Rx Card Coverage(s)

		Option 1	Option 2	Option 3
Contract Type		24/12	24/12	24/12
Aggregate Claim Factors	<u>Enrollment</u>			
<u>Medical, Rx Card</u>				
Single	43	\$ 1,144.41	\$ 1,162.16	\$ 1,188.40
Family	116	\$ 3,097.65	\$ 3,145.74	\$ 3,216.71
Est. Attachment Point		\$ 4,902,444	\$ 4,978,545	\$ 5,090,875
Rate Per Month	<u>Enrollment</u>			
Composite	159	\$ 12.79	\$ 12.95	\$ 13.18
Estimated Annual Premium		\$ 24,405	\$ 24,706	\$ 25,150
Rate(s) includes Commissions of		10.00%	10.00%	10.00%
Run-in Dollar Limit		\$ 784,391	\$ 796,567	\$ 814,540
Maximum Annual Reimbursement		\$ 1,000,000	\$ 1,000,000	\$ 1,000,000
Aggregate Corridor		125%	125%	125%
Rolling (Monthly) Aggregate Monthly Accommodation: No				
Terminal Liability Premium		\$ 4,884	\$ 4,942	\$ 5,037
Terminal Liability PEPM		\$ 2.56	\$ 2.59	\$ 2.64

OVERALL COST SUMMARY

		Option 1	Option 2	Option 3
Total Specific Premium	\$	364,644	324,060	273,045
Total Aggregate Premium	\$	24,405	24,706	25,150
Total Fixed Cost	\$	389,049	348,766	298,195
Variable Costs	\$	4,902,444	4,978,545	5,090,875
Self Funded Liability	\$	140,000	140,000	140,000
Maximum Total Liability	\$	5,431,493	5,467,311	5,529,070



MARKETING REP

Allison Brewer
 abrewer@ihcrisksolutions.com
 (877) 392-3770

Name of Group: Township of Lower
 Producer: Katz/Pierz
 Insurance Carrier: Standard Security Life Ins Co of NY
 Administrator:
 Proposed Effective Date: 06/01/2015

Case Name: Township of Lower

Quote Number: 123703

Prop ID: 1

OPTION SUMMARY

Sold Notice: Our client has selected the Option indicated below.

When this case sells with IHC Risk Solutions, we will be pleased to prepare our Sold Application Package for you. This package will contain a completed application with agreed upon rates, factors, and contingencies.

To select coverage, simply mark the box next to the option you want, date where indicated below, and email it to Amany Zakaria at azakaria@ihcrisksolutions.com (856) 267-0264 .

	Option	Specific Deductible	Specific Contract	Client's Liability	Specific Annual Premium	Aggregate Contract	Aggregate Annual Premium	Annual Attachment Point
<input checked="" type="checkbox"/>	1	\$100,000	24/12	\$140,000	\$364,644	24/12	\$24,405	\$4,902,444
<input type="checkbox"/>	2	\$110,000	24/12	\$140,000	\$324,060	24/12	\$24,706	\$4,978,545
<input type="checkbox"/>	3	\$125,000	24/12	\$140,000	\$273,045	24/12	\$25,150	\$5,090,875

Katz/Pierz

 Date



MARKETING REP

Allison Brewer
abrewer@ihcrisksolutions.com
(877) 392-3770

PROPOSAL QUALIFICATIONS AND CONTINGENCIES

This Proposal is based on standard policy provisions, limitations and exclusions contained in the issuing carrier's stop loss policy as well as the qualifications and contingencies specified in supplemental correspondence developed by IHC Risk Solutions.

The proposed rates and factors are based upon the data supplied in the request for proposal and does not constitute an offer to bind coverage. Any inaccuracy or misrepresentation in the data or any material change in the plan design or census data supplied can necessitate a recalculation of the rates and factors, or cause a claim to be reevaluated, denied or void coverage retroactive to the effective date of the policy.

Applicant, its agent and/or administrator does not have the authority to bind or modify the terms of this stop loss coverage proposal.

IHC Risk solutions and Standard Security Life Ins Co of NY may pay the selling broker or Third Party Administrator compensation for the promotion and sale of the products and services offered in this proposal. In addition to our standard compensation arrangements, we may make additional cash and/or non-cash payments or reimbursements to selling brokers in recognition of their marketing and distribution activities, persistency levels and volume of business. We encourage brokers and their clients to discuss what commissions may be paid in connection with the purchase of products and services from Standard Security Life Ins Co of NY .

Coverage ceases upon termination of the administrator, placement of an insured policy or at the end of the policy period. Specific coverage may be elected by itself. Aggregate coverage must be accompanied by Specific coverage.

This proposal is subject to review and acceptance of the employer's signed plan document (within 60 days of the effective date) confirming that all plan document provisions associated with this proposal have been met. Please review your plan document as reimbursements will be limited to the lesser of the benefit maximum reflected in the plan document or the Maximum Reimbursement amount reflected in this proposal.

This proposal assumes a minimum of 75% participation of all eligible employees as stated in the plan document. Should the 75% minimum participation or the current eligibility differ in any way, verification will be needed and this offer may be re-evaluated

This proposal assumes that Medicare is primary for retirees age 65 and over. If Medicare is not primary, we reserve the right to reevaluate the terms of this proposal.

This proposal is subject to receipt, review and approval of updated claim information to include paid, pending, denied, held and suspended reports. In addition, diagnosis, current and future treatment plan, and prognosis is required for known or expected shock claimants.

This proposal is subject to information on any individual who previously exhausted the employer benefit plan lifetime maximum who will be reinstated because the lifetime maximum cap has been eliminated. Disclosure of information must include any dependent under age 26 being added who was previously deemed not eligible under the employer benefit plan and whose claims could potentially exceed 50% of the specific deductible.

This proposal is subject to information on claims under assessment by an Independent Review Organization (IRO).

Retirees are not covered.

Organ Transplant coverage is included subject to underlying plan provisions.

TLO Option:

Terminal Liability Option (TLO) must be selected on or before inception of reinsurance coverage and cannot be added off anniversary. Premiums are due monthly and are not reimbursable if the option is not enacted. To enact TLO, the employer must notify IHC Risk Solutions of their intention not to renew, no later than 30 days before the Expiration Date.



MARKETING REP

Allison Brewer
abrewer@ihcrisksolutions.com
(877) 392-3770

TLO provides a three month run-out coverage. Claims incurred after the policy termination date are not eligible. All other coverage terms apply.

Premium rates are outlined in the proposal. If Aggregate TLO is selected, the attachment changes as follows:

Contract Basis including Run-In: Aggregate factors (attachment) increases by 30%.

Contract Basis excluding Run-In: Aggregate factors (attachment) increases by 35%.

Note: TLO is optional on the proposal and costs associated with TLO are not reflected in summary or overall totals.

Quote assumes the following plan design:

PPO: Amerihealth Administrators, Inc.

	Plan 1	
	In-Net	Out-Net
Deductible	\$200	\$200
Coinsurance	80%	80%
Max Coinsurance	\$5,000	\$5,000
Plan Description	<New>	

ADDITIONAL QUALIFICATIONS

Proposal is subject to review and acceptance of the Disclosure Statement completed by the Employer and TPA. Please refer to our Disclosure Statement form for additional stipulations and details.

Medical Review of large/ongoing claims has not been completed and will be necessary if IHC Risk Solutions' quote is being considered.

Proposal is based on the current plan design(s) using the above reference PPO networks.

The additional claims liability assumed by the employer from an Aggregating or Named Aggregating Specific Corridor will not be eligible under the aggregate.

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue
New York, New York 10022

DISCLOSURE STATEMENT

As an integral part of the application for excess loss coverage, Standard Security Life Insurance Company of New York (the Company) and **IHC Risk Solutions** require that the applicant provide information concerning the following on all known individuals no earlier than **30** days prior to the requested effective date:

- a) Individuals with ongoing or potential claims exceeding the lesser of \$30,000 or 50% of the requested specific deductible amount, during the last 12 months.
- b) Individuals currently confined to a hospital or other health care facility, or currently approved for a future hospital or other health care facility admission.
- c) Employees not actively at work on a full time basis as defined in your Plan, or dependents who are confined to a hospital, institution, or home or otherwise unable to perform the duties of a like person of the same age and sex and are in good health as of the signature date of this statement.
- d) Any other individuals with claims that may be potentially serious, regardless of current claim amount.

Please attach the following information:

- NAME
- DATE OF BIRTH
- GENDER
- Status: EMPLOYEE, DEPENDENT, RETIREE, COBRA BEN.
- DIAGNOSIS
- PROGNOSIS
- TRANSPLANT CANDIDATE
- DATE OF DISABILITY
- DATE EXPECTED RTW
- COBRA EFFECTIVE/END DATES
- PAID CLAIMS
- ADDITIONAL KNOWN CLAIMS

The Employer named below, through its authorized person, hereby represents that the attached information is true, complete and accurate to the best of its knowledge and belief after due inquiry and that of its agents, administrators, and brokers, and that nothing has been knowingly or intentionally omitted. The Employer agrees to the following: 1) if the information provided in this statement is not true, complete and accurate, the excess loss coverage may be re-rated from the effective date of coverage, 2) any individual who has incurred a serious claim may be excluded from coverage, unless disclosed by Employer and approved in writing by the Company and **IHC Risk Solutions**. The Company reserves the right to set a higher aggregate or specific deductible on, or limit the benefit eligibility period or other policy benefits for, any individual who has or should have been listed above. The Employer represents that its administrator, utilization review vendor and large claim management service organization participated in the collection of the above data.

The Company and **IHC Risk Solutions** shall use the information requested herein solely for the purpose of evaluating the acceptability of this risk and shall not disclose any nonpublic personal information collected except in evaluating the acceptability of this risk.

Employer: _____

Date of Disclosure: 5-28-2015 Authorized Representative: Jolie Picard

Title: Deputy Manager Signature: Jolie Picard

Administrator: _____

Date of Disclosure: _____

Authorized Representative: _____

Signature: _____

CHECKLIST

PROFESSIONAL SERVICE CONTRACT REQUIREMENTS

The following must be submitted to the Township Clerk 10 Days prior to award:

- _____ SIGNED CONTRACT BY PROFESSIONAL
- ✓ _____ BUSINESS REGISTRATION CERTIFICATE .
- ✓ _____ SIGNED EXHIBIT A MANDATORY EQUAL OPPORTUNITY FORM .
- ✓ _____ EEO CERTIFICATE OR AA302
- ✓ _____ BUSINESS ENTITY DISCLOSURE .
- ✓ _____ PAY TO PLAY AFFIDAVIT .

COUNCIL APPROVAL

- _____ RESOLUTION
- _____ EXECUTED CONTRACT
- _____ ADVERTISEMENT 10 DAYS AFTER AWARD

Julie Picard, RMC _____

Margaret Vitelli, QPA or PACO _____



STATE OF NEW JERSEY BUSINESS REGISTRATION CERTIFICATE

Taxpayer Name: KATZ/PIERZ INC.
Trade Name:
Address: 413 MARLTON PIKE EAST
CHERRY HILL, NJ 08034
Certificate Number: 0534372
Effective Date: December 08, 1987
Date of Issuance: May 27, 2015

For Office Use Only:
20150527112154913

EXHIBIT A

MANDATORY EQUAL EMPLOYMENT OPPORTUNITY LANGUAGE
N.J.S.A. 10:5-31 et seq. (P.L. 1975, C. 127)
N.J.A.C. 17:27

GOODS, PROFESSIONAL SERVICE AND GENERAL SERVICE CONTRACTS

During the performance of this contract, the contractor agrees as follows:

The contractor or subcontractor, where applicable, will not discriminate against any employee or applicant for employment because of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Except with respect to affectional or sexual orientation and gender identity or expression, the contractor will take affirmative action to ensure that such applicants are recruited and employed, and that employees are treated during employment, without regard to their age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Public Agency Compliance Officer setting forth provisions of this nondiscrimination clause.

The contractor or subcontractor, where applicable will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex.

The contractor or subcontractor, where applicable, will send to each labor union or representative or workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer advising the labor union or workers' representative of the contractor's commitments under this act and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

The contractor or subcontractor, where applicable, agrees to comply with any regulations promulgated by the Treasurer pursuant to N.J.S.A. 10:5-31 et seq., as amended and supplemented from time to time and the Americans with Disabilities Act.

The contractor or subcontractor agrees to make good faith efforts to employ minority and women workers consistent with the applicable county employment goals established in accordance with N.J.A.C. 17:27-5.2, or a binding determination of the applicable county employment goals determined by the Division, pursuant to N.J.A.C. 17:27-5.2.

The contractor or subcontractor agrees to inform in writing its appropriate recruitment agencies including, but not limited to, employment agencies, placement bureaus, colleges, universities, labor unions, that it does not discriminate on the basis of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, and that it will discontinue the use of any recruitment agency which engages in direct or indirect discriminatory practices.

The contractor or subcontractor agrees to revise any of its testing procedures, if necessary, to assure that all personnel testing conforms with the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.

In conforming with the applicable employment goals, the contractor or subcontractor agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

The contractor shall submit to the public agency, after notification of award but prior to execution of a goods and services contract, one of the following three documents:

Letter of Federal Affirmative Action Plan Approval

Certificate of Employee Information Report

Employee Information Report Form AA302

The contractor and its subcontractors shall furnish such reports or other documents to the Div. of Contract Compliance & EEO as may be requested by the office from time to time in order to carry out the purposes of these regulations, and public agencies shall furnish such information as may be requested by the Div. of Contract Compliance & EEO for conducting a compliance investigation pursuant to **Subchapter 10 of the Administrative Code at N.J.A.C. 17:27.**

Firm Name: Katz / Pierz

Name of Agent: Robert Snay Cowan

Title: Principal

Date: 5/27/2015

STATE OF NEW JERSEY
Division of Purchase & Property
Contract Compliance Audit Unit
EEO Monitoring Program

EMPLOYEE INFORMATION REPORT

IMPORTANT-READ INSTRUCTIONS CAREFULLY BEFORE COMPLETING FORM. FAILURE TO PROPERLY COMPLETE THE ENTIRE FORM AND TO SUBMIT THE REQUIRED \$150.00 FEE MAY DELAY ISSUANCE OF YOUR CERTIFICATE. DO NOT SUBMIT EEO-1 REPORT FOR SECTION B, ITEM 11. For instructions on completing the form, go to: http://www.state.nj.us/treasury/contract_compliance/pdf/aa302ins.pdf

SECTION A - COMPANY IDENTIFICATION

1. FID NO OR SOCIAL SECURITY 22-2879925	2. TYPE OF BUSINESS <input type="checkbox"/> 1. MFG <input type="checkbox"/> 2. SERVICE <input type="checkbox"/> 3. WHOLESALE <input type="checkbox"/> 4. RETAIL <input checked="" type="checkbox"/> 5. OTHER	3. TOTAL NO. EMPLOYEES IN THE ENTIRE COMPANY 13			
4. COMPANY NAME KATZ/PIERZ INC					
5. STREET 413 MARLTON PIKE EAST STE 100	CITY CHERRY HILL	COUNTY CAMDEN	STATE NJ	ZIP CODE 08034	
6. NAME OF PARENT OR AFFILIATED COMPANY (IF NONE, SO INDICATE) NONE		CITY	STATE	ZIP CODE	
7. CHECK ONE: IS THE COMPANY: <input checked="" type="checkbox"/> SINGLE-ESTABLISHMENT EMPLOYER <input type="checkbox"/> MULTI-ESTABLISHMENT EMPLOYER					
8. IF MULTI-ESTABLISHMENT EMPLOYER, STATE THE NUMBER OF ESTABLISHMENTS IN NJ					
9. TOTAL NUMBER OF EMPLOYEES AT ESTABLISHMENT WHICH HAS BEEN AWARDED THE CONTRACT				13	
10. PUBLIC AGENCY AWARDED CONTRACT					
LOWER TOWNSHIP OFFICIAL USE ONLY		CITY VILLAS	COUNTY CAPE MAY	STATE NJ	ZIP CODE 08251
DATE RECEIVED	NAUG DATE	ASSIGNED CERTIFICATION NUMBER			

SECTION B - EMPLOYMENT DATA

11. Report all permanent, temporary and part-time employees ON YOUR OWN PAYROLL. Enter the appropriate figures on all lines and in all columns. Where there are no employees in a particular category, enter a zero. Include ALL employees, not just those in minority/non-minority categories, in columns 1, 2, & 3. DO NOT SUBMIT AN EEO-1 REPORT.

JOB CATEGORIES	ALL EMPLOYEES			PERMANENT MINORITY/NON-MINORITY EMPLOYEE BREAKDOWN										
	COL. 1 TOTAL (Cols. 2 & 3)	COL. 2 MALE	COL. 3 FEMALE	MALE					FEMALE					
				BLACK	HISPANIC	AMER. INDIAN	ASIAN	NON MIN.	BLACK	HISPANIC	AMER. INDIAN	ASIAN	NON MIN.	
Officials/ Managers	2	1	1	0	0	0	0	1	0	0	0	0	0	1
Professionals	2	2	0	0	0	0	0	2	0	0	0	0	0	0
Technicians	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sales Workers	5	1	4	0	0	0	0	1	0	0	0	0	0	4
Office & Clerical	4	1	3	0	0	0	0	1	0	0	0	0	0	3
Craftworkers (Skilled)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Operatives (Semi-skilled)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laborers (Unskilled)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Service Workers	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	13	5	8	0	0	0	0	5	0	0	0	0	0	8
Total employment From previous Report (if any)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Temporary & Part-Time Employees	The data below shall NOT be included in the figures for the appropriate categories above.													
	0	0	0	0	0	0	0	0	0	0	0	0	0	0

12. HOW WAS INFORMATION AS TO RACE OR ETHNIC GROUP IN SECTION B OBTAINED? <input checked="" type="checkbox"/> 1. Visual Survey <input type="checkbox"/> 2. Employment Record <input type="checkbox"/> 3. Other (Specify)	14. IS THIS THE FIRST Employee Information Report Submitted? 1. YES <input checked="" type="checkbox"/> 2. NO <input type="checkbox"/>	15. IF NO, DATE LAST REPORT SUBMITTED MO. DAY YEAR
13. DATES OF PAYROLL PERIOD USED From: 05/11/2015 To: 05/22/2015		

SECTION C - SIGNATURE AND IDENTIFICATION

16. NAME OF PERSON COMPLETING FORM (Print or Type) Lenny Katz	SIGNATURE 	TITLE President	DATE MO DAY YEAR 05 27 15		
17. ADDRESS NO & STREET 413 Marlton Pike East Ste 100	CITY Cherry Hill	COUNTY Camden	STATE NJ	ZIP CODE 08034	PHONE (AREA CODE, NO., EXTENSION) 856 - 761 - 1833

BUSINESS ENTITY DISCLOSURE CERTIFICATION
FOR NON-FAIR AND OPEN CONTRACTS
 Required Pursuant To N.J.S.A. 19:44A-20.8
 TOWNSHIP OF LOWER

Part I B Contractor Affirmation

The undersigned, being authorized and knowledgeable of the circumstances, does hereby certify that the business entity by the name Robert Shay Cowan / Katz Pierz has not made and will not make any reportable contributions pursuant to N.J.S.A. 19:44A-1 et seq. that, pursuant to P.L. 2004, c. 19 would bar the award of this contract in the one year period preceding January 3, 2008 to any of the following named candidate committee, joint candidates committee; or political party committee representing the elected officials of the Township of Lower, defined pursuant to N.J.S.A. 19:44A-3(p), (q) and (r).

Michael E. Beck	
Norris Clark	Any present or future candidate committee or
Erik Simonsen	joint candidate committee or local political party
Thomas Conrad	committee formed for the election of members of
David Perry	the Lower Township governing body.

Part II B Ownership Disclosure Certification

I certify that the list below contains the names and home addresses of all owners holding 10% or more of the issued and outstanding stock of the undersigned.

Check the box that represents the type of business entity:

- Partnership Corporation Sole Proprietorship Subchapter S Corporation
 Limited Partnership Limited Liability Corporation Limited Liability Partnership

Name of Stock or Shareholder	Home Address

Part 3 B Signature and Attestation:

The undersigned is fully aware that if I have misrepresented in whole or part this affirmation and certification, I and/or the business entity, will be liable for any penalty permitted under law.

Name of Business Entity: Katz/Pierz
 Signed: Robert Shay Cowan Title: Partner
 Print Name: Robert Shay Cowan Date: 5/27/2015

Subscribed and sworn before me this 27 day of MAY, 2015.
JACQUELINE M. KATZ
 My Commission expires: **NOTARY PUBLIC OF NEW JERSEY**
 My Commission Expires **6/9/2018**

Jacqueline M. Katz
 (Affiant)
JACQUELINE M. KATZ
 (Print name & title of affiant) (Corporate Seal)

**LOWER TOWNSHIP
2600 BAYSHORE ROAD
VILLAS, NJ 08251
(609) 886-2005**

AFFIDAVIT OF PAY-TO-PLAY COMPLIANCE

The Undersigned, being duly sworn, of full age according to law, upon my oath, depose and say:

1. I am a duly authorized representative of (the "Business Entity"), which for the purposes of this Affidavit includes all entities of which the Business Entity owns, directly or indirectly, a more than 50% equity interest.

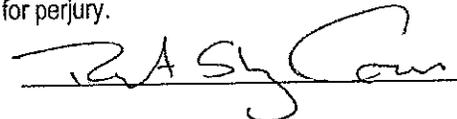
2. The Business Entity is seeking the award of a Professional Services Contract or Unspecifiable Services Contract pursuant to the exceptions from public bidding under Sections 5(1) of the Local Public Contracts Law, N.J.S.A. 40A:11-1, et seq.

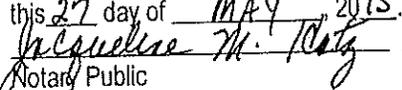
3. In accordance with Lower Township Ordinance No. 2004-10 (the "Pay-to-Play Ordinance"), I am making this Affidavit under penalties of perjury to represent to the Township of Lower that neither I nor the Business Entity have made any political contributions in violation of Section 95-2 of the Pay-to-Play Ordinance.

4. Also in accordance with the Pay-to-Play Ordinance, I am disclosing that the following represents all of the contributions that were made by the Business Entity and, to the best of my knowledge, all principals owning 10% more of the Business Entity's equity, their respective spouses, and all of the Business Entity's employees and officers and their respective spouses, to all New Jersey State and County political party committees commencing on the later of the effective date of the Pay-to-Play Ordinance (October 4, 2004) or twelve (12) months from date of this Affidavit and ending on the date of this Affidavit:

<u>Date</u>	<u>Name of Organization</u>	<u>Amount</u>
5/27/2015	Katz/Pierz	\$0

4. I represent and acknowledge that I have received, read and fully understand the Pay-to-Play Ordinance and that my violation of the Pay-to-Play Ordinance will disqualify me and the Business Entity from receiving any additional contract from the Township of Lower for a period of four (4) years and, in the event any statements made in this Affidavit are willfully false, that I and the Business Entity would be subject to criminal prosecution for perjury.



Sworn and Subscribed to before me
this 27 day of MAY, 2015.

Notary Public

[APM00008056.DOC v. 1] **JACQUELINE M. KATZ**
NOTARY PUBLIC OF NEW JERSEY
My Commission Expires 08/2017

TOWNSHIP OF LOWER, COUNTY OF CAPE MAY, STATE OF NEW JERSEY

RESOLUTION #2015-167

TITLE: RESOLUTION AWARDING A CONTRACT WITH AMERIHEALTH FOR MEDICAL INSURANCE AS EXTRAORDINARY UNSPECIFIABLE SERVICES

WHEREAS, there exists a need for a medical insurance plan beginning June 1, 2015; and

WHEREAS, the estimated annualized premium of the contract is self-funded with a total flat commission to Marsh & McLennan for Stop Loss/Health Insurance and Prescription of an amount not to exceed \$60,000.00 and funds have been certified by the Chief Financial Officer as evidenced by her signature below:

Budget Account Number: 5-01-23-220-412

CFO Signature:



WHEREAS, the Local Public Contracts Law (N.J.S.A. 40A:11B1 et seq.) requires that the resolution authorizing the award of contracts for "Extraordinary, Unspecifiable Services" without competitive bids and the contract itself must be available for public inspection; and

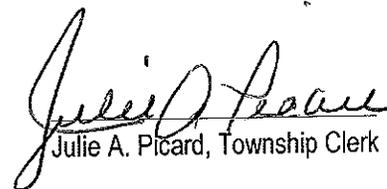
WHEREAS, the Chief Financial Officer has certified that this meets the statute and regulations governing the award of said contracts.

NOW, THEREFORE, BE IT RESOLVED, by the Township Council as follows:

1. The Township Manager is hereby authorized and directed to execute the agreement upon receipt of final contract as follows:

- A. Medical Insurance – Amerihealth
Effective date June 1, 2015 thru May 31, 2016.

I hereby certify the foregoing to be the original resolution adopted by the Township Council at a meeting held on May 27, 2015.



Julie A. Picard, Township Clerk

	MOTION	SECOND	AYE	NAY	ABSTAIN	ABSENT
CONRAD		X	X			
PERRY	X		X			
SIMONSEN			X			
CLARK			X			
BECK			X			

AMERIHEALTH ADMINISTRATORS, INC.
AMENDMENT

This Amendment amends and is made a part of the Administrative and Network Services Contract, effective June 1, 2013, between **AmeriHealth Administrators, Inc.** ("AmeriHealth Administrators") Horsham, Pennsylvania, and **Township of Lower** ("Plan Sponsor") Cape May, New Jersey. Such Contract is amended as indicated below.

I. Effective June 1, 2015, Section V. 5.1 Term of Contract is replaced by the following section 5.1.

5.1 Term of Contract. The renewal term of this Contract shall be three (3) years measured from the Effective Date. In the absence of any notice to the contrary by AmeriHealth Administrators to the Plan Sponsor or by the Plan Sponsor to AmeriHealth Administrators, this Contract shall be renewed for successive terms of one (1) year each. AmeriHealth Administrators may amend the fee schedule as of the first day of any term by providing the Plan Sponsor with at least 30 days' written notice prior to the beginning of such term.

II. Effective June 1, 2015, Exhibit D is replaced by the attached Exhibit D - Effective June 1, 2015.

III. Effective July 1, 2015, Exhibit D - Effective June 1, 2015 is replaced by the attached Exhibit D - Effective July 1, 2015.

IV. Effective June 1, 2015, Exhibit E is replaced by the attached Exhibit.

Nothing in this Amendment will change the terms of the Contract except as stated above.

IN WITNESS WHEREOF, the parties hereto have caused this Amendment to be of effect on the indicated effective date, executed in duplicate, and governed by the laws of the Commonwealth of Pennsylvania.

TOWNSHIP OF LOWER

AMERIHEALTH ADMINISTRATORS, INC.

By: James Ridgway
Name: James Ridgway
Title: Township Manager
Date: 6/16/2015

By: Richard J. Neeson
Name: Richard J. Neeson
Title: President
Date: 6/26/15

EXHIBIT D – Effective June 1, 2015

Administration and Claims Service Fee*

Administrative and Claims Service Fee Breakdown

Medical Fee**	\$ 35.80 per employee per month. (** Includes Utilization Management, HIPAA Certificates, ERISA Claims Fiduciary, Prescription Drug)
Medical Deposit	Currently estimated at \$63,500.00. The Medical Deposit must be maintained during the term of this Contract.
Prescription Drug Deposit	Currently estimated at \$26,700.00. The Prescription Drug Deposit must be maintained during the term of this Contract.
Prescription Drug Rebate Credit	4% of monthly claims
Stop-Loss Coordination Fee- if placed with another carrier.	\$ 1.50 per employee per month.
Stop-Loss Coordination Fee- if placed with IBC/HM	\$ 0.00 per employee per month.
Broker	\$ 30.00 per employee per month.
*Plus a PPO Access Fee and a Network Coordination Fee for division(s) utilizing a PPO Network.	
Network Coordination Fee*	\$ 7.25 per employee per month.
PPO Access Fee	Amount AmeriHealth Administrators pays PPO for access. PPO access fee is subject to change. Notice will be provided to the Plan Sponsor.
Network Directories	Pass through cost from network plus reasonable internal costs, if any.
COBRA/Retiree Billing Charges	\$.47 per employee per month. The 2% premium add collected from a participant will be retained by AmeriHealth Administrators. Minimum monthly COBRA charge of \$75.00 per month. Premium remittance \$50.00 per insurance carrier per month.
Run-out Claim Processing	4 months of administrative fees
Case Management Service Fee	\$115.00 per hour plus expenses.
Documentation/Underwriting/ Actuarial Services Fee	\$115.00 per hour plus expenses.
Custom Programming Services Fee	\$150.00 per hour.
Other Services	Reasonable Fee -- Cost to AmeriHealth Administrators (internal and external)

**EXHIBIT D- Effective June 1, 2015
(Continued)**

An Early Termination Charge will apply if services are terminated prior to the end of the initial Term or subsequent amendment Term. The Early Termination Charge is equal to 3 months of Administrative and Claims Service Fees.

The Plan Sponsor will reimburse AmeriHealth Administrators for any fees, services, benefits, payments, taxes, surcharges, non-compliance penalties or any other amounts imposed, increased, or adjudged due by a lawful regulatory or governmental authority or its agents.

The fees shown in this agreement do not include costs associated with new or expanded tasks that are required to be performed by AmeriHealth Administrators as a result of the requirements of The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the Health Care Reform Law). If additional administrative costs are required to conform with the Health Care Reform Law, you will be notified under separate cover. We reserve the right to adjust fees based on the additional administrative effort.

EXHIBIT D – Effective July 1, 2015

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Administrative and Claims Service Fee Breakdown

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Stop-Loss Coordination Fee- if placed with IBC/HM	\$ 0.00 per employee per month.
Broker	\$ 30.00 per employee per month.

***Plus a PPO Access Fee and a Network Coordination Fee for division(s) utilizing a PPO Network.**

If a Third-Party PBM chosen and Total Out-of-Pocket Maximum integration requested*:

Bi-directional feed to third party PBM vendor -Set-up (one-time fee)	\$15,000 (minimum).
Bi-directional feed to third-party PBM vendor (ongoing charge)	\$.29 pepm

*Not a guarantee of AmeriHealth Administrator's ability to accommodate all PBM vendors or timeliness.

Network Coordination Fee*	\$ 7.25 per employee per month.
PPO Access Fee	Amount AmeriHealth Administrators pays PPO for access. PPO access fee is subject to change. Notice will be provided to the Plan Sponsor.
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(Continued)**

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EXHIBIT E

Until amended by notice to the Plan Sponsor, the Regional Affiliate Discounts in effect for this Contract are as follows:

Regional Affiliate Discount	As of October 1, 2008
The Philadelphia five-county area Discount (Includes the following counties: Philadelphia, Montgomery, Bucks, Chester and Delaware)	67%

Regional Affiliate Discount	As of June 1, 2015
New Jersey	67%



To: Township of Lower
From: AmeriHealth Administrators
Date: June 8, 2015
RE: SBC Approval for PPO 15 and PPO 15 Retirees

AmeriHealth Administrators, Inc. ("AHA") has drafted the enclosed document(s) in response to your request for a Summary of Benefits and Coverage (SBC). In preparing the document(s), AHA is acting only as a scrivener, not as the Plan Administrator. AHA assumes no fiduciary responsibilities under the Employee Retirement Income Security Act (ERISA) and/or applicable federal and state laws/regulations. By drafting the enclosed document(s), AHA is not providing legal advice with respect to the requirements of ERISA and/or applicable federal and state laws/regulation or the requirements of the Patient Protection and Affordable Care Act (PPACA). You should carefully review all of the information in the document to ensure that it is accurate and meets the *requirements of ERISA, PPACA and/or applicable federal and state laws/regulations*. You should also have your legal counsel review the document(s).

Please check the appropriate option

- I approve the Summary of Benefits and Coverage as it appears in the enclosed draft.
- Send me another draft with the changes I noted on the enclosed draft.
- We have modified the Summary of Benefits and Coverage (SBC) provided by AHA and have made changes that may or may not comply with the requirements of PPACA. AHA will not be responsible for the form or content of this document.

Client Authorization

Client's Name: Township of Lower
Signature: James Redman
Title: Township Manager
Date: 06/16/2015

Please return the original form and the Summary of Benefits and Coverage draft with your changes, if any to:

AmeriHealth Administrators
P.O. Box 21545
Eagan, MN 55121

EXHIBIT D – Effective June 1, 2015

Administration and Claims Service Fee*

Administrative and Claims Service Fee Breakdown

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Case Management Service Fee	\$115.00 per hour plus expenses.
Documentation/Underwriting/ Actuarial Services Fee	\$115.00 per hour plus expenses.
Custom Programming Services Fee	\$150.00 per hour.
Other Services	Reasonable Fee -- Cost to AmeriHealth Administrators (internal and external)

**EXHIBIT D- Effective June 1, 2015
(Continued)**

An Early Termination Charge will apply if services are terminated prior to the end of the initial Term or subsequent amendment Term. The Early Termination Charge is equal to 3 months of Administrative and Claims Service Fees.

The Plan Sponsor will reimburse AmeriHealth Administrators for any fees, services, benefits, payments, taxes, surcharges, non-compliance penalties or any other amounts imposed, increased, or adjudged due by a lawful regulatory or governmental authority or its agents.

The fees shown in this agreement do not include costs associated with new or expanded tasks that are required to be performed by AmeriHealth Administrators as a result of the requirements of The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the Health Care Reform Law). If additional administrative costs are required to conform with the Health Care Reform Law, you will be notified under separate cover. We reserve the right to adjust fees based on the additional administrative effort.

EXHIBIT D – Effective July 1, 2015

Administration and Claims Service Fee*

Administrative and Claims Service Fee Breakdown

Medical Fee**	\$ 35.80 per employee per month. (** Includes Utilization Management, HIPAA Certificates, ERISA Claims Fiduciary)
Medical Deposit	Currently estimated at \$63,500.00. The Medical Deposit must be maintained during the term of this Contract.
Stop-Loss Coordination Fee- if placed with another carrier.	\$ 1.50 per employee per month.
Stop-Loss Coordination Fee- if placed with IBC/HM	\$ 0.00 per employee per month.
Broker	\$ 30.00 per employee per month.

***Plus a PPO Access Fee and a Network Coordination Fee for division(s) utilizing a PPO Network.**

If a Third-Party PBM chosen and Total Out-of-Pocket Maximum integration requested*:

Bi-directional feed to third party PBM vendor -Set-up (one-time fee)	\$15,000 (minimum).
Bi-directional feed to third-party PBM vendor (ongoing charge)	\$.29 pepm

*Not a guarantee of AmeriHealth Administrator's ability to accommodate all PBM vendors or timeliness.

Network Coordination Fee*	\$ 7.25 per employee per month.
PPO Access Fee	Amount AmeriHealth Administrators pays PPO for access. PPO access fee is subject to change. Notice will be provided to the Plan Sponsor.
Network Directories	Pass through cost from network plus reasonable internal costs, if any.
COBRA/Retiree Billing Charges	\$.47 per employee per month. The 2% premium add collected from a participant will be retained by AmeriHealth Administrators. Minimum monthly COBRA charge of \$75.00 per month. Premium remittance \$50.00 per insurance carrier per month.
Run-out Claim Processing	4 months of administrative fees
Case Management Service Fee	\$115.00 per hour plus expenses.
Documentation/Underwriting/ Actuarial Services Fee	\$115.00 per hour plus expenses.
Custom Programming Services Fee	\$150.00 per hour.
Other Services	Reasonable Fee -- Cost to AmeriHealth Administrators (internal and external)

**EXHIBIT D- Effective July 1, 2015
(Continued)**

An Early Termination Charge will apply if services are terminated prior to the end of the initial Term or subsequent amendment Term. The Early Termination Charge is equal to 3 months of Administrative and Claims Service Fees.

The Plan Sponsor will reimburse AmeriHealth Administrators for any fees, services, benefits, payments, taxes, surcharges, non-compliance penalties, or any other amounts imposed, increased, or adjudged due by a lawful regulatory or governmental authority or its agents.

The fees shown in this agreement do not include costs associated with new or expanded tasks that are required to be performed by AmeriHealth Administrators as a result of the requirements of The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the Health Care Reform Law). If additional administrative costs are required to conform with the Health Care Reform Law, you will be notified under separate cover. We reserve the right to adjust fees based on the additional administrative effort.

EXHIBIT E

Until amended by notice to the Plan Sponsor, the Regional Affiliate Discounts in effect for this Contract are as follows:

Regional Affiliate Discount	As of October 1, 2008
The Philadelphia five-county area Discount (Includes the following counties: Philadelphia, Montgomery, Bucks, Chester and Delaware)	67%

Regional Affiliate Discount	As of June 1, 2015
New Jersey	67%

TOWNSHIP OF LOWER, COUNTY OF CAPE MAY, STATE OF NEW JERSEY

RESOLUTION #2015-168

TITLE: RESOLUTION AWARDING A CONTRACT WITH HEALTH INSURANCE SOLUTIONS INC (HISI) FOR PRESCRIPTION INSURANCE AS EXTRAORDINARY UNSPECIFIABLE SERVICES

WHEREAS, there exists a need for a prescription insurance plan beginning July 1, 2015; and

WHEREAS, the estimated annualized premium of the contract is self-funded with a total flat commission to Marsh & McLennan for Stop Loss//Health Insurance and Prescription of an amount not to exceed \$60,000.00 and funds have been certified by the Chief Financial Officer as evidenced by her signature below:

Budget Account Number: 5-01-23-220-412

CFO Signature:



WHEREAS, the Local Public Contracts Law (N.J.S.A. 40A:11B1 et seq.) requires that the resolution authorizing the award of contracts for "Extraordinary, Unspecifiable Services" without competitive bids and the contract itself must be available for public inspection; and

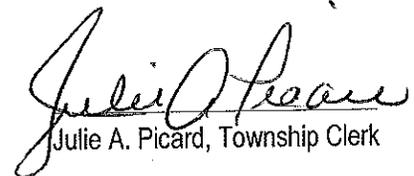
WHEREAS, the Chief Financial Officer has certified that this meets the statute and regulations governing the award of said contracts.

NOW, THEREFORE, BE IT RESOLVED, by the Township Council as follows:

1. The Township Manager is hereby authorized and directed to execute the agreement upon receipt of final contract as follows:

- A. Prescription Insurance – Health Insurance Solutions Inc
Effective date July 1, 2015 thru May 31, 2016.

I hereby certify the foregoing to be the original resolution adopted by the Township Council at a meeting held on May 27, 2015.



Julie A. Picard, Township Clerk

	MOTION	SECOND	AYE	NAY	ABSTAIN	ABSENT
CONRAD	X		X			
PERRY			X			
SIMONSEN			X			
CLARK		X	X			
BECK			X			



**HEALTH INSURANCE SOLUTIONS INCORPORATED
ADMINISTRATIVE SERVICES CONTRACT**

This Administrative Contract and any exhibits, schedules and appendices hereto. (collectively, the "Contract"), effective as of the 1st day of August, 2015 by and between Health Insurance Solutions Incorporated ("HISI"), a Pennsylvania corporation, and Township of Lower ("the Employer").

WITNESSETH

WHEREAS, the Employer has established an Employee Prescription Drug Benefit Plan (the "Plan"), incorporated herein; and

WHEREAS, the Employer desires to engage the services of Health Insurance Solutions Inc. ("HISI") for purposes of performing administrative services for the Plan as defined in this Contract; and

WHEREAS, HISI wishes to provide such services in accordance with the terms and conditions set forth in this Contract;

NOW, THEREFORE, in consideration of the premises and other good and valuable consideration, the Employer and HISI, intending to be legally bound, agree as follows:

SECTION 1. DEFINITIONS AND CONSTRUCTION.

- 1.1 Definitions. Whenever used in this Contract:
 - "Account" means the checking account established by Health Insurance Solutions Inc. for purposes of transmitting benefit payments under the plan.
 - "Claim" means any claim by a Participant for benefits under the Plan that is submitted to HISI in the time and manner and including any proof prescribed by HISI
 - "Determination" means with respect to each Claim, a decision by HISI as to whether and to what extent such Claim shall be paid, subject to the review and final determination of the Employer.

"Effective Date" means August 1, 2015.

"Participant" means any person entitled to receive benefits under the Plan as a covered employee or dependent of a covered employee.

1.2 Gender. For purposes of this Contract, the masculine gender shall include the feminine and vice versa.

SECTION 2. OBLIGATIONS, DUTIES AND COMPENSATION OF HISI

2.1 Appointment as Agent. HISI is hereby appointed administrative service agent by the Employer of the Plan for purposes of providing administrative services in connection with the Plan as set forth in this Section 2 and otherwise in this Contract and the Schedules hereto. HISI shall be referred to as, "Plan Administrator." Employer understands and acknowledges that this is the extent of HISI's appointment. Employer further understands and acknowledges that HISI shall not be acting as a fiduciary or trustee of the Plan.

2.2 The Account. HISI shall provide a checking account through which benefit payments shall be made under the Plan. HISI shall have sole authority to sign checks on the Account. Employer shall be responsible for funding the account in full to cover any and all Claims. HISI shall notify Employer as soon as practical of any amounts needed to cover Claims. Any balance in the Account shall be the property of the Plan or the Employer if the Plan is unfunded. Any interest paid on the Account shall be retained by HISI as additional compensation for services hereunder.

HISI shall not have the obligation of paying any individual pending or outstanding Claim, until sufficient funds are received from the Employer and the account is funded in full to cover all pending and outstanding Claims. HISI shall apply funding to administrative fees, any applicable charges other than administrative fees or Claim payments, and Claim payments, respectively. Because this Plan is self-funded, Employer understands and acknowledges that HISI is not liable for funding the Account, nor liable for paying Claims, and Employer is exclusively liable at all times for funding of the Account.

2.2.1 Claims funding monthly statements will be sent to the Employer. Payment of this monthly statement shall be made consistent with the selection indicated in the paragraph below. Funding of amounts due under a monthly statement that are not received within thirty (30) days of the invoice date will incur a delinquent fee as described in the paragraph below. Additional funding statements may be requested by HISI in order to cover Claim utilization ("Supplemental Statement"). Employer understands and acknowledges that fully funding the Account at all times to cover Claims is a material condition of this Agreement and that any failure to pay Supplemental Statements to cover claims will result in claims suspension until the Account has been fully-funded. Funding of amounts due under a Supplemental Statement not received within seven (7) days will be considered delinquent.

Administrative, Claim Fee Invoice (Invoice due date 1st of the month), and Supplemental Statements.

Administrative and claim fee invoice (entitled: MONTHLY INVOICE) will be mailed to the Employer on the first business day of each month. Funding is due by the 1st of the following month. Payment not received by the due date will be considered delinquent. Any Supplemental Statement not paid within seven (7) days of invoicing will be considered delinquent. Past due amounts not received by the 1st of each month will incur a delinquent fee as described below:

Past Due Claims Funding	1% of Claims per month
Past Due Administrative Fees	1% of outstanding fees per month

Past due Claims Funding and/or past due Administrative Fees not received by the last day of the current month will result in claims suspension until the Account has been properly funded. Past due Supplemental Statement invoicing not received within seven (7) days will result in claims suspension until the Account has been properly funded.

Repeated delinquencies will require advanced deposits equal to the average monthly claim amount (prescription drug) and may result in the termination of the Contract.

2.2.2 Responsibility of HISI. HISI shall be responsible for amounts paid or withdrawn from the Account by reason of the willful misconduct or negligence of any of its officers or employees and each of the officers and employees of HISI who handle funds held in the Account shall be bonded in an amount not less than \$100,000.00.

HISI shall be entitled to rely on representations made to it with respect to the Plan and any Participants thereunder by the President or Board of Directors of the Employer and any other officer or employee authorized by the President or Board of Directors of the Employer in writing to make such representations to HISI.

HISI shall not be responsible for investigating whether a Claim is payable, primarily or otherwise, under any plan or program other than the Plan except for any plan or program identified as covering the Participant making such Claim in information provided to HISI by the Employer and the Participant's own statements.

2.3 Advice. HISI shall, where it deems appropriate or upon the reasonable request of the Employer, provide the Employer with advice and information concerning matters listed below.

HISI shall provide advice to the Employer in accordance with Section 2.3 on the following matters:

- (1). Disputed claims.

- (2). Design features, funding alternatives, administrative procedures and cost savings mechanisms pertinent to the operation of the Plan.

HISI compensation for Administration, Claims Services, Materials, and Advice to the Employer shall be as shown under the listing "Administration and Claims Service Fee" as set forth in Schedule 3 attached hereto.

2.4. **ADMINISTRATIVE SERVICES.** HISI shall provide administrative services to the Employer as follows:

- (1) Eligibility maintenance.
- (2) Monthly eligibility listings.
- (3) Monthly billing services.
- (4) Pharmacy Benefits Manager (PBM) calculations and payment.
- (5) HISI shall make available a Point Of Contact to the Employer for questions about administration and claims services.

2.5 **CLAIM SERVICES.** HISI shall be the point-of-contact to coordinate eligible claims in accordance with the following procedures:

2.5.1 HISI shall make a Determination with respect to each Claim as soon as practicable following receipt of such Claim. HISI shall make such Determination on the basis of the provisions of the Plan. HISI shall conduct an investigation into the validity of the Claim as it deems reasonable and shall observe any appropriate utilization review procedures.

2.5.2 HISI shall, through its periodic reporting procedures, notify the Employer of its Determination with respect to each Claim submitted by a Participant and shall provide the Employer with additional information regarding such Claim or Determination as the Employer may reasonably request.

2.5.3 If HISI makes a Determination that a Claim has been denied it shall so notify the Employer through reporting procedures. If Employer determines that a Claim shall be paid despite HISI's Determination, Employer shall authorize payment of the denied Claim in writing from the Plan's named fiduciary or trustee.

2.6 **MATERIALS.** HISI shall provide to, or on behalf of, the Employer the following materials:

- (1) Identification cards for employees and their dependents who are eligible to receive coverage and benefits under the Plan.
- (2) HISI checks for payment of eligible claims made by Participants and eligible Plan pharmacies.
- (3) Participant claim forms.

2.7 COBRA PLAN & DOCUMENTATION. (TO ELECT, PLEASE CHECK BOX AND INITIAL ON LINE AFTER)

COBRA COMPLIANCE _____
(initial here)

2.7.1 HISI shall assist the Employer with respect to compliance with the requirements of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

2.7.2 HISI compensation for its services under this section shall be as shown under the listing, "COBRA Charges".

2.8 PLAN DOCUMENTATION / UNDERWRITING / ACTUARIAL SERVICES

2.8.1 HISI shall furnish for review by Employer's counsel a sample plan document or other documentation necessary for the establishment and maintenance of the Plan. The Employer shall review and, upon advice of legal counsel, adopt such documents or take such other action as it deems appropriate.

2.8.2 HISI shall also provide other Underwriting/Actuarial services to the Employer that the Employer reasonably requests. HISI compensation for these services shall be as shown under the listing "Underwriting/Actuarial Services Fee".

SECTION 3. EMPLOYER'S OBLIGATIONS AND DUTIES

3.1 Prior Plan Documents. In the event that the Employer has a prior Plan in place, the Employer shall timely furnish HISI with a detailed description of the Plan and any and all amendments thereto, including all materials as shall be necessary to maintain the Plan. The Employer shall provide notice of any change in benefits provided under the Plan prior to the date on which such change becomes effective.

3.2 Plan Administrator and Named Fiduciary. The Employer or its delegate as identified to HISI on Schedule 1 hereto (hereinafter the "Delegate") shall be the Plan's named Fiduciary. HISI shall be the Plan Administrator.

3.3 Review of Determinations. The Employer or its Delegate may review all Determinations made by HISI. If Employer determines that a Claim shall be paid despite HISI's Determination, Employer shall authorize payment of the denied Claim in writing from the Plan's named fiduciary or trustee.

3.4 Information to HISI The Employer shall provide HISI with all of the information required by HISI regarding the eligibility of Participants in the Plan and shall notify HISI on at least a monthly basis of all changes in participation in the Plan, whether by reason of termination, change in job classification, or otherwise.

The Employer shall promptly furnish HISI with any other information that HISI reasonably requests for purposes of performing its claims processing and other administrative functions.

3.5 Deposits to Account. Employer shall take all steps reasonably necessary to ensure that checks / wire transfers payable to HISI on the Account will be honored and/or will further resolve, to the best of its ability, any returned funds so as to ensure payment to HISI.

3.6 Fees and Expenses. The Employer shall pay HISI for the services rendered pursuant to this Contract in accordance with the terms set forth. HISI reserves the authority to adjust the fee set forth as of the effective date of any amendment to or change in benefits provided under the Plan as mutually agreed upon by both parties.

The Employer shall reimburse HISI for any expenses occurred in the performance of HISI's duties under this Contract, including but not limited to the retention of administrative or professional services necessary and appropriate to the performance of such duties provided, however, that HISI shall provide a reasonable estimate of such expenses and fees in advance of the incurrence of the same. Amounts due HISI shall be charged against the Plan, and to the extent not paid by the Employer, shall be paid by the Plan.

3.7 Plan Responsibility. The Employer shall have full/all responsibility for the Plan. HISI will act solely as an administrator, not in any fiduciary capacity, to process and pay Claims with reasonable accuracy and utilizing due diligence as may be expected from an experienced benefit plan administrator. If it is determined that any benefit payment has been made to or in behalf of an ineligible individual, or if it is determined that more than the correct amount has been paid by HISI, HISI will make a diligent attempt to recover the payment made to such ineligible person or overpayment, but HISI will not be required to initiate litigation for purposes of payment recovery.

HISI shall, however, notify the Employer of such overpayment or payment to an ineligible person as soon as reasonably possible following discovery of any such improper payment. Except for a situation governed under Section 3.8, the defense of any legal action involving a claim for benefits under the Plan shall not be the obligation of HISI under this Contract, but of the Employer and Employer agrees to indemnify, defend, and hold HISI harmless from same. HISI shall, however, reasonably cooperate with the Employer in the defense of any action arising out of the matter related to this Contract.

3.8 Indemnification. HISI will indemnify and hold the Employer harmless from and against any loss, cost, damage, expense, or other liability, including, without limitation, reasonable costs and attorneys' fees incurred in connection with any and all third party claims, suits, investigations, or enforcement actions which may be asserted against, imposed upon or incurred by the Employer and arising as a result of HISI's negligent acts or omissions or willful misconduct, HISI material breach of this Administrative Services Contract. The foregoing indemnification shall not apply if Employer has modified or altered the applications without the prior written consent of HISI.

The Employer will indemnify and hold HISI harmless from and against any costs for claims which may be asserted against, imposed upon or incurred by HISI and arising as a result of Employer's negligent acts or omissions or willful misconduct, adopted benefit design, and coverage decisions by HISI in accordance with such benefit design, or breach of this Administrative Services Contract.

The indemnified party shall notify the indemnifying party in writing promptly upon learning of any Claim for which indemnification may be sought.

SECTION 4. TERMINATION OF THE CONTRACT.

4.1 Employer's Right to Terminate. The Employer may terminate this Contract at the end of any Term of Contract by giving not less than 60 days' written notice of intention to terminate delivered to HISI prior to the end of such Term. The Employer may terminate this Contract during the sixty (60) day notice period if any rate increase has been given. Employer has the option to terminate at any time if, as a condition precedent, HISI increases the fees set forth in Schedule 3 during the Term of the Contract. Employer shall exercise this option within ten (10) business days upon receipt of written notice from HISI of a fee increase. If not exercised before the expiration of ten (10) business days, this option shall expire and become null and void.

4.2 HISI Right to Terminate. HISI may terminate this Contract at the end of any Term of Contract by giving not less than 60 days' written notice of intention to terminate delivered to the Employer prior to the end of such Term. HISI may also terminate this Contract at any time for reason of repeated delinquencies of fees.

4.3 Rights and Obligations of Parties upon Termination of Contract. Upon termination of this Contract, HISI shall deliver to the Plan, or to the Employer if there is no trust under the Plan, any amounts held in the Account (other than interest due and an amount sufficient to cover uncashed checks).

SECTION 5. TERMS AND AMENDMENT OF CONTRACT.

5.1 Term of Contract. The initial term of this Contract shall be for one year ending on May 31, 2016. A new Contract will be provided to the client and negotiated for one (1) year measured from each renewal date.

5.2 Amendment of Contract. Except as provided elsewhere in this Contract and the Schedules, the Employer and HISI may amend the Contract only by their mutual written agreement.

SECTION 6. PROVIDER NETWORKS AND DISCOUNT ARRANGEMENTS.

6.1 Prescription Drug Card. The Prescription Drug Card program is an arrangement between HISI and a national prescription drug provider ("Pharmacy Benefits Manager") to secure discounted prescriptions for its clients. The Prescription Drug Card program includes a formulary program pursuant to which the prescriber of a drug (doctor or pharmacist) selects from a list of preferred medications. Medications are included on the list based on cost and efficacy.

6.2 Rebates. Manufacturers of the preferred drugs pay a rebate with respect to their drugs that are included in the formulary program. HISI will pass through 100% of all rebate shares received from the Pharmacy Benefits Manager (PBM) on behalf of the Plan's claim utilization.

SECTION 7. USE OF RECORDS; HIPAA AND EMPLOYER.

7.1 Use of Prescription Drug Records. Employer and HISI shall maintain the confidentiality of any Personal Health Information ("PHI") in accordance with any applicable laws and regulations. Employer hereby represents and warrants to HISI that, as a sponsor of a health plan, Employer is legally entitled to provide PHI to HISI, either directly or indirectly, and to receive PHI relating to a Member's prescription drug utilization from HISI. All PHI, records, reports and other data provided by HISI to Employer under this Employer Contract are solely for the treatment, payment and/or health care functions associated with Employer's health plan, and HISI disclaims all liability arising out of Employer's receipt, use or dissemination of such information, records, reports or data.

7.2 HIPAA and Employer Contract Terms. As required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, HISI and Employer agree to comply with the terms and conditions set forth in the Act.

7.3 Claims Retention Data. Except as otherwise provided, HISI will maintain claims data supporting invoices for Covered Drugs adjudicated by HISI during the term of this Employer Contract for a period of twenty-four (24) months in their original forms and thereafter for an additional five (5) years. HISI shall use reasonable efforts to cooperate with Employer for purposes of meeting Employer's Prescription Drug Program retention obligations under applicable law. After expiration of the retention period, HISI shall archive and then dispose of such data in accordance with applicable state and federal law.

SECTION 8. PROPRIETARY INFORMATION.

8.1 Each party agrees that information of the other party, including, but not limited to, the following, shall constitute confidential and proprietary information unless otherwise public:

(a) With respect to HISI: reporting and web-based applications, Pharmacy Benefits Manager (PBM), system formats, data banks, clinical or formulary management operations or programs, information concerning Rebates, prescription drug evaluation criteria, drug choice management, drug pricing information, and Participating Pharmacies Agreements; and

(b) With respect to Employer: Employer and Member information files, business operations and strategies, are confidential and proprietary. Neither party shall use a party's Proprietary Information, or disclose it to any third party, at any time during or after termination of this agreement, except as specifically agreed by this Contract or upon prior written

consent or as otherwise required by law. Upon termination of this Contract, each party shall cease using the other's Proprietary Information, and all such information shall be returned or destroyed at the Employer's direction. HISI shall retain full ownership rights over all compilations, analyses and reports prepared by same specifically for Employer.

SECTION 9. MISCELLANEOUS.

9.1 Successors. This Contract shall be binding upon and to the benefit of the parties hereto and their respective heirs, personal representative, successors and assigns, provided that this Contract may not be assigned by either party without the prior written consent of the other party.

9.2 Entire Contract. This Contract contains the entire Agreement among the parties relating to the subject matter hereof, and may not be altered, amended, modified or supplemented except by a writing signed by the parties hereto, provided that HISI reserves the authority to amend the fee schedule as provided herein.

9.3 Notices. Any notice, material or information that HISI is required to provide to the Employer under this Contract shall be deemed to have been given to the Employer three (3) days after mailing by regular or certified mail, postage prepaid, to the employer address on file with HISI.

9.4 No Contract of Insurance. Nothing in this Contract shall be construed as a Contract of insurance. HISI shall be under no obligation to pay from its own funds or insure any benefits payable under the Plan. Any reference to an obligation of HISI to "pay" an amount hereunder shall refer to its obligation to pay on behalf of the Plan from the Account, and shall not imply any liability on HISI with respect to its own funds.

9.5 Governing Law. This Contract shall be governed by and construed and enforced in accordance with the internal laws of the State of Pennsylvania without regard to the conflicts of laws provisions thereof.

9.6 Severability. If any provision of this Contract is held to be invalid or unenforceable for any reason, such provision shall be ineffective to the extent of such invalidity or unenforceability without invalidating the remaining portions hereof.

The undersigned hereby acknowledges this Contract for Administrative Services and Fees and authorizes Health Insurance Solutions Inc. to begin installation.

EMPLOYER:
Township of Lower

HEALTH INSURANCE
SOLUTIONS INC.

By: James Ridgway
Title: Township Manager

By: Michelle Perrine
Title: President

Date: 7/2/2015

Date: 7/6/2015

Tax ID #:

SCHEDULE 1

PARTICIPANT'S INFORMATION

Plan Administrator: Health Insurance Solutions, Inc.
177 North Main Street
Souderton, PA 18954
1-877-939-HISI
(215) 721-2220

Contact: Kathy Dunnum

Name of the Plan: Township of Lower Prescription Drug Plan

Plan Number:

Contract Year for the Plan: 08/01/2015 - 05/31/2016

**Company,
Participating Employer:** Township of Lower

Plan Fiduciary: Township of Lower

Participating Employer Identification Number:

Agent for Service of Legal Process: Plan Administrator

Benefit Types Offered under Plans and Funding: Prescription Drug benefit funded by the Participating Employer, Employee and his/her Dependents.

SCHEDULE 2
SUMMARY BENEFIT DESCRIPTION.

PRESCRIPTION DRUG COVERAGE BENEFITS FOR PARTICIPANT & DEPENDENTS

1.1 If you (or any of your eligible dependents), incurs expenses for charges made by a pharmacy for covered prescription drugs for a non-work related injury or a sickness, payment for these drugs will be provided based on the following schedule:

1.2 Deductibles & Co-Payments

COVERAGE SCHEDULE

Deductible: \$0	
<p><u>Participants Co-payments (retail)</u></p> <p>Generic Drugs \$ 3.00 P Brand Drugs \$10.00 NP Brand Drugs \$10.00</p> <p>Retail Order: 0-34 Days = 1 Copay 35-60 Days = 2 Copays 61-90 Days = 3 Copays</p>	<p><u>Participants Co-payments (mail order)</u></p> <p>Generic Drugs \$ 5.00 P Brand Drugs \$15.00 NP Brand Drugs \$15.00</p> <p>Mail Order Supply: 0-90 day</p>
<p>Calendar Year Maximum Paid by the Plan: Per Individual: No Maximum Per Family: No maximum</p> <p>Calendar Year MOOP \$200 Single \$400 Non-Single</p>	

PRESCRIPTION DRUG PURCHASES

- 1.3 This prescription drug coverage applies only to legend drugs and medications that may be sold with a prescription from a physician.
- 1.4 Your drug coverage pertains only to drugs and medicine sold to you by a pharmacy because drugs and medicine furnished to you during a hospital stay are covered under a medical/health plan.

BENEFITS LIMITATIONS

- 1.5 No payments will be made for expenses incurred for the following items unless pre-authorized.

<ul style="list-style-type: none"> • Immunization agents, biological sera, blood or blood plasma • Experimental drugs, or drugs labeled: "Caution – Limited by federal law to investigational use" • Medication which is taken or administered, in whole or in part, at the place where it is dispensed, or while a person is a patient in an institution which operates, or allows to be operated, on its premises, a facility for dispensing pharmaceuticals • Any refill dispensed more than one year from the date of a physician's order • Any medication that may be obtained without charge through any public program. 	<ul style="list-style-type: none"> • Charges for covered Prescription Drugs used for treatment of an occupational injury or illness. • Any drug that can be legally dispensed without a written prescription by a physician • Steroids for body building • Any cosmetic or other health and beauty aids • Therapeutic devices, bandages and support garments • Non-medicinal substances
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GENERAL INFORMATION

1.6 Eligibility: Individuals who are full-time employees (determined by Employer), age 18 or older and their eligible dependents. An eligible dependent is a spouse or a domestic partner and unmarried children from birth to age 26; extended to age 31 pursuant to state and federal rules and guidelines.

1.7 Deductible amount: The Deductible is shown in the Coverage Schedule. The Deductible is an amount of covered charges incurred by a covered individual for which no benefits will be paid. The deductible amount will apply to each covered individual each Calendar Year.

1.8 Calendar Year Maximum: The maximum amount payable for all eligible expenses in any Calendar Year is shown in the Coverage Schedule. The Calendar Year Maximum will apply to each covered person and/or each covered family.

1.9 Coordination of Benefits: This Plan will be coordinated with any other group insurance, blanket or franchise insurance plan under which an individual will receive benefits to avoid duplication of benefits.

1.10 Termination of Coverage: Coverage terminates for you or your dependent, as the case may be, on the earliest of the following dates:

- (1) The last day of the month in which you cease to be eligible for coverage,
- (2) The last day of the month in which you're dependent is no longer an eligible dependent,
- (3) The last day of the month for which funding for this Plan has been paid by your Participating Employer on your behalf; or
- (4) The date the Contract Plan ends.

ADDITIONAL DEFINITIONS

Definitions. Whenever used in this Contract Plan:

"Pharmacy" A licensed establishment where prescription drugs are dispensed.

"Pharmacist" A person licensed to dispense prescription drugs.

"Prescription Drug Legend" Any medical substance requiring under the Federal Food, Drug and Cosmetic Act a label that reads: "Caution: Federal Law prohibits dispensing without a prescription".

"Prescription Order" The request for each separate drug or medication by a physician or each authorized refill of such request.

"Generic Drug" Any drug identified by its official or chemical name rather than by a brand name.

"Brand Name Drug" Any drug given a name by the discovering company, which has an exclusive manufacturing patent for 17 years for the drug.

SUBROGATION

1.11 If you incur a claim for which a third party is deemed to be liable the Plan retains the right to recover any benefits for which it has paid. You shall reimburse and/or cooperate fully with the Plan Administrator in obtaining reimbursement, whether a recovery is reached by settlement, judgment or otherwise. Furthermore, the Plan Administrator has the right to pursue any legal action necessary to obtain reimbursement. Recovery shall not exceed the amount of money paid in benefits by the Plan.

PARTICIPATION RIGHTS

1.12 As a participant in the Plan you are entitled to:

- (1). Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents and copies of all documents filed by the Employer with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- (2). Obtain copies of all Plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- (3). Receive a summary of the plan's financial report. The Plan Administrator is required by law to furnish each participant with a copy of the Summary Annual Report.

(4). You can file suit in a federal court of law. If any materials requested are not received within 30 days of an appropriate request, the court may require the Plan Administrator to pay daily fines until the materials are delivered, unless the materials are not sent due to circumstances beyond the control of the Plan Administrator.

1.13 Certain people who operate the Plan are referred to as "fiduciaries", and act solely in the interest of the Plan Participants and their beneficiaries by exercising prudence in the performance of their Plan duties. If a Participant is improperly denied a benefit in full or in part, they have the right to file suit in federal or state court.

1.14 If any fiduciary misuses the Plan's funds, a participant can file suit in federal court or ask for assistance from the U.S. Department of Labor. The court may require the other party to pay the participant's legal costs, including attorney's fees. However, the court may require the Participant to pay such costs and fees should the participant lose the suit.

1.15 If a Participant has any questions regarding benefits described in this booklet, he/she should contact their local Human Resources Department or the Plan Administrator. If a Participant has any questions regarding any right described in this section, or any legal rights that may relate to the Plan, he/she should contact the Plan Administrator or the nearest area office of the U.S. Labor-Management Service Administration, Department of Labor.

1.16 The Employer may not discharge or discriminate against a Participant to prevent them from obtaining any benefits or exercising his/her rights under ERISA.

OTHER PRESCRIPTION DRUG INFORMATION

1.17 The Employer, Plan Administrator, or the Stop-Loss Insurer if applicable will not be legally liable for any injury or illness caused by the manufacture or use of any prescription drugs, medicine or insulin covered by this Plan.

**SCHEDULE 3
FEE SCHEDULE***

Installation Fee	WAIVED
Administration and Claims Service Fees *	
Administrative Fee	\$3.75 per employee per month
Estimated Premium Equivalent Rates, including Administrative Fee	An amount equal to an estimate of one (1) months' worth of prescription drug claims, adjusted from time to time. EE Only: \$227.95 EE/Child(ren):\$337.30 EE/Spouse: \$429.19 EE/Family: \$550.66 HISI will periodically review claims history and may make adjustments to this Schedule based on such review.
COBRA Charges (If ELECTED)	\$ 1.25 per employee per month; <i>and</i> 2 % premium add-on collected from COBRA participant. \$ 50.00 minimum monthly COBRA charge per month. \$ 50.00 premium remittance per insurance carrier per month. \$ 20.00 per notification.
Run-in/Run-out Claim Processing	6 % of charges
Underwriting / Actuarial Services Fee	\$ 105.00 per hour
Custom reporting	\$ 100.00 per report

**PERFORMANCE PHARMACY SOLUTIONS
CLIENT AGREEMENT**

(For Express Scripts Internal Use)

DIV# _____
BPL _____
GROUP #: _____
SALES DIRECTOR: _____
INDUSTRY TYPE: _____

Client Name: Township of Lower
Client Tax ID Number: _____
Producer Name: Health Insurance Solutions, Inc.
Effective Date: 7/1/15
Initial Term of Client Agreement: 36 Months

Contact Information:	Client Information	Broker Information	Producer/Third Party Administrator Information
Contact Person: (Name & Title)	Lauren Read, CFO	Jerry Campanaro	Kathy Dunnum Account Manager
Company Name:	Township of Lower	Marsh & McLennan Agency	Health Insurance Solutions, Inc.
Street Address:	2600 Bayshore Road	510 Bank St Commons Ste 200	177 North Main St.
City/State/Zip Code:	Villas, NJ 08251	Cape May NJ 08204	Souderton, PA 18964
Phone Number:	609-886-2005 ext. 125	609-884-8431	215-721-2220
Fax Number:		866-795-1233	215-721-2260

Management Reporting: Party to receive Management Reports? PPS Client TPA - Person's Name: Kathy Dunnum

Percentage of Rebates to be retained by PPS: 0 %

Payor: The party that will be responsible for payments to ESI under the Prescription Drug Program will be: Client Payor
If no party is selected, Client shall be deemed "Payor" by default

Provide Payor Name: TPA

Payor shall pay all Fees as outlined in the Agreement, depending on the form of payment selected below:

- Payor wire transfer to a bank account designated by ESI within 5 calendar days of receipt of ESI's bill (First Chicago NBD, A Bank One Company, One First National Plaza, Chicago, IL 60670-0196, Bank ABA#071000013, Account Name: Express Scripts, Inc., Account No. 10-16856).
- Payor ACH transfer based on its written authorization, initiated by ESI within 5 calendar days of receipt of ESI's bill.

Medium on which invoice is to be sent (check one or two): Hard Copy (and) Magnetic Tape (or) Email

Do you want Member names to appear on Billing Statement? Yes No

Pricing Option to be implemented? Open Managed

Included Producer Commissions? No;
 Yes, on Per Member per Month basis in the Amount of : \$ _____ PMPM, OR
 Yes, on Per Rx in the Amount of : \$ 2.25 per Rx

ESI and PPS have entered into that certain Prescription Drug Program Agreement ("PBM Agreement"), which sets forth certain terms and conditions associated with ESI's, either directly or through its subsidiaries or affiliates, provision of pharmacy benefit management services (which, under this Client Agreement shall be exclusive for all of Client's self-funded welfare benefit plans that offer a prescription benefit, including, but not limited to, pharmacy network contracting; pharmacy claims processing; mail and specialty drug pharmacy; cost containment, clinical, safety, adherence and other like programs; and formulary and rebate administration ("PBM Services"). A summary of various pricing components, including ingredient cost guarantees, dispensing fee guarantees, Rebate guarantees, and Administrative Service Fees is attached to this Client Agreement as Attachment 2 to Client Agreement. The PBM Agreement is incorporated herein for all purposes. To the extent not defined herein, capitalized terms shall have the meaning ascribed to them in the PBM Agreement.

1. Plan Design; Commencement of Services. Client agrees that the PBM Services should be provided in accordance with the PBM Agreement, this Client Agreement, and the specific benefit design reflected on the ESI Set-Up Forms adopted by Client (if ESI assists Client with completion of the Set-Up Forms, it will send Client the completed Set-Up Forms for review and Client agrees that such documentation will constitute the governing Set-Up Forms for Client unless Client notifies ESI in writing within thirty days of receipt of the completed documentation of any discrepancies therein, in which case the parties shall work together in an expeditious manner to correct such discrepancies and issue a revised Set-Up Forms). If Client already has on file

with ESI any Set-Up Forms or similar set-up documentation as of the date Client executes this Client Agreement, Client adopts and directs ESI to use such Set-Up Forms until ESI is otherwise directed in writing by Client.

2. Eligibility of Members. Client shall provide ESI with an initial Eligibility File under a mutually agreeable time frame prior to the effective date of Client's Prescription Drug Program, and updates thereto shall be provided to ESI on a mutually determined basis. All Eligibility Files shall be submitted on-line, or on tape or disk in a format that is acceptable to ESI. Eligibility performed manually by ESI for Client, or material changes to the Eligibility File processes requested by Client

during the term may be subject to additional charges as set forth in Exhibit B of the PBM Agreement. Client will be responsible for all Prescription Claims during the period of the Member's eligibility as indicated on the Eligibility File including for retroactively termed Members, except in the event of ESI's negligence.

3. Pharmacy Network.

(a) Mail Service Pharmacy. Members may have prescriptions filled through the Mail Service Pharmacy. Subject to applicable law and unless Client requests otherwise, ESI may communicate with Members regarding benefit design, cost savings, availability and use of the Mail Service Pharmacy, as well as provide supporting services. ESI may suspend Mail Service Pharmacy services to a Member who is in default of any Copayment amount due ESI. Client will be responsible for any unpaid Member Copayment amounts if payment has not been received from the Member within one hundred twenty (120) days following dispensing. Client will be billed following the one hundred twenty (120) day collection period, with payment due in accordance with the payment terms set forth in Section 8 of this Agreement.

(b) Specialty Products and ASES. As elected by Client on the Set-Up Forms, Members may have prescriptions filled through ESI Specialty Pharmacy on an exclusive basis (i.e., "ESI Specialty Pharmacy – Exclusive Care") or at Participating Pharmacies and through ESI Specialty Pharmacy (i.e., "ESI Specialty Pharmacy – Open Care"). Subject to applicable law and unless Client requests otherwise, ESI and ESI Specialty Pharmacy may communicate with Members and physicians to advise Members filling Specialty Products at Participating Pharmacies of the availability of filling prescriptions through ESI Specialty Pharmacy. Specialty Products will be excluded from any non-Specialty price guarantees set forth in the PBM Agreement. In no event will the Mail Service Pharmacy or Participating Pharmacy pricing specified in the PBM Agreement apply to Specialty Products.

(i) ESI will notify Client of all new Specialty Products that are introduced to the market on or after the Effective Date of this Agreement with their applicable reimbursement rates, but not more frequently than monthly ("Notice"). The parties agree as follows:

(A) If Client has expressly excluded a specific therapy class or product on a Set-Up Form, Specialty Products in such excluded classes will automatically be deemed excluded from coverage and will reject as "NDC Not Covered" through Participating Pharmacies, Mail Service Pharmacy and ESI Specialty Pharmacy; otherwise, subject to (B) below, all other Specialty Products will be implemented as Covered Drugs at the rate specified in the applicable Specialty Product list or Notice. If Client desires to cover otherwise excluded Specialty Products, Client must notify ESI in writing that it desires to cover the Specialty Product before ESI will adjudicate as a Covered Drug, and if ESI receives such confirmation of coverage from Client such Specialty Product will be loaded thereafter as a Covered Drug at the applicable reimbursement rate set forth in the Notice.

(B) Client must notify ESI in writing if it wants to exclude the Specialty Product from coverage. The exclusion will be implemented within seven (7) business days after the date of ESI's receipt of such notification. There will not be any retroactive denials for Prescription Claims processed prior to ESI's receipt of the rejection notice and implementation of the exclusion as provided above and Client will be responsible for the payment of such Prescription Claims processed prior to the rejection of coverage.

(ii) For Specialty Products filled through ESI Specialty Pharmacy only, Members may receive the following services from ESI Specialty Pharmacy, depending on the particular therapy class or disease state: ASES; patient intake services; pharmacy dispensing services and/or social services (patient advocacy, hardship reimbursement support, and indigent and patient assistance programs).

(iii) Subject to Client's prior authorization requirements, if applicable, at the rates set forth in Exhibit B, ESI will provide or coordinate ASES for Members through ESI Specialty Pharmacy or through other specialty pharmacies or other independent third party providers of ASES when ASES is required. If ESI or ESI Specialty Pharmacy engages a third party provider of ASES, ESI or ESI Specialty Pharmacy shall contractually obligate such third party provider of ASES to comply with all applicable laws, including, without limitation, all applicable laws relating to professional licensure. ESI does not direct or

exercise any control over any third party provider of ASES in administering Specialty Products or otherwise providing ASES.

(iv) If Client elects the ESI Specialty Pharmacy - Open Care option, then any ancillary supplies, equipment, and services provided or coordinated in connection with the dispensing of Specialty Products at Participating Pharmacies (for example, limited distribution products not then available through ESI Specialty Pharmacy or overrides) will be billed to Payor at the cost charged to ESI for such ancillary supplies, equipment, and services provided or coordinated, unless such ancillary supplies, equipment, and services provided or coordinated are included in the ingredient cost of the Specialty Product.

(c) Participating Pharmacies. Members may obtain prescriptions for Covered Drugs through the Participating Pharmacy network selected by Client. ESI shall direct Participating Pharmacies to charge and collect the applicable Copayment from Members for each Covered Drug dispensed; provided, a Member's Copayment charged for a Covered Drug will be the lesser of the applicable Copayment, AWP discount or U&C. ESI will maintain a network(s) of Participating Pharmacies as identified in Exhibit B, and will make available an updated list of Participating Pharmacies on-line. ESI maintains multiple networks and subnetworks, and periodically consolidates networks or migrates clients to other networks and subnetworks. If, due to an access concern, PPS or Client requests that ESI attempt to add a particular retail pharmacy to the network of Participating Pharmacies serving Client and its Members hereunder, ESI will make commercially reasonable efforts to add any such pharmacy to the Participating Pharmacy network for PPS or Client, provided that such pharmacy meets ESI's network participation requirements and agrees to ESI's standard terms and conditions. If any such Participating Pharmacy meets ESI's network participation requirements and agrees to ESI's standard terms and conditions except for ESI's standard network rates (i.e., the particular pharmacy will only agree to higher than standard reimbursement rates), and PPS or Client nevertheless requests that ESI add such pharmacy, the rate charged to Payor for Prescription Claims processed through such pharmacy (assuming ESI agrees to contract with such pharmacy) will be the net ingredient cost plus the dispensing fee paid by ESI to such Participating Pharmacy (plus applicable sales or excise tax or other governmental surcharge, if any). All such Prescription Claims will be excluded from the pricing guarantees set forth in Exhibit B.

(i) ESI will require each Participating Pharmacy to meet ESI's network participation requirements, including but not limited to licensure, insurance and provider agreement requirements. ESI also performs audits (i.e., electronic or on-site) of Participating Pharmacies to determine compliance with their provider agreement billing requirements. ESI will attempt recovery of identified overpayments through offset, demand or other reasonable means; provided that ESI will not be required to institute litigation. Recovered overpayments are credited to Payor. To compensate ESI for the cost of conducting audits and audit-related services, ESI charges a standard fee in the amount set forth in Exhibit B upon recovery of overpayments. Copies of participation requirements and auditing processes are available upon request.

(ii) ESI does not direct or exercise any control over the Participating Pharmacies or the professional judgment exercised by any pharmacist in dispensing prescriptions or otherwise providing pharmaceutical related services at a Participating Pharmacy. ESI shall have no liability to PPS or Client, any Member or any other person or entity for any act or omission of any Participating Pharmacy or its agents or employees.

4. Claims Processing.

(a) Claims Processing.

(i) ESI will perform claims processing services for Covered Drugs dispensed by Participating Pharmacies, Mail Service and ESI Specialty Pharmacy.

(ii) In connection with each prescription submitted for processing on-line by a Participating Pharmacy, ESI will perform standard drug utilization review ("DUR") in order to assist the dispensing pharmacist and prescribing physician in identifying potential drug interactions, incorrect prescriptions or dosages, and certain other circumstances that may be indicative of inappropriate prescription drug usage. ESI's DUR processes are not intended to substitute for the professional judgment of the prescriber, the dispensing pharmacist or any other health care professional providing services to the Member.

(iii) If elected by Client, ESI will process Member Submitted Claims in accordance with the rules in the Set-Up Forms and ESI's standard procedures.

(iv) If authorized by Client on the Set-Up Forms, ESI will process Subrogation Claims in accordance with applicable federal and state laws, in which case Payor will pay such Subrogation Claims in accordance with

Article IV of the PBM Agreement, Section 8 of this Client Agreement and Exhibit B. If Client does not authorize ESI to process Subrogation Claims, ESI will reject the claim and refer claimants to Client regarding such claims, in accordance with applicable federal and state laws. ESI is not legally responsible to pay Subrogation Claims to the extent Payor is not timely paying ESI with respect to such Subrogation Claims.

(v) Client will have the final responsibility for all decisions with respect to coverage of a Prescription Claim and the benefits allowable under the Plan, including determining whether any rejected or disputed claim will be allowed.

(b) Prior Authorization. For the fees set forth in the Clinical Addendum described in Exhibit B of the PBM Agreement (if applicable), ESI shall provide prior authorization ("PA") services as specified by Client on the Set-Up Form. PA drugs must meet Client-approved guidelines ("Guidelines") before they are deemed to be Covered Drugs. Unless Client otherwise directs, Client hereby authorizes coverage for an otherwise excluded use in the event of co-morbidities, complications and other factors not otherwise expressly set forth in the Guidelines. In determining whether to authorize coverage of such drug under the PA Program, ESI shall apply only the Guidelines and may rely entirely upon information about the Member and the diagnosis of the Member's condition provided to it from sources deemed reliable to ESI. ESI shall not undertake to determine medical necessity, to make diagnoses or substitute ESI's judgment for the professional judgment and responsibility of the prescriber.

(c) Claims for Benefits. ESI will process initial "claims for benefits" for Member Submitted Claims and PA requests consistent with the ERISA claims rules set forth in 29 CFR Part 2560 (or applicable state law if a non-ERISA plan) ("Claims Rules"). ESI may elect to have ESI perform appeals services in connection with denied "claims for benefits" for the fees set forth in Exhibit B, or facilitate such services through Client or a third party of Client's choice. If Client elects to conduct its own appeals or facilitate through a third party of Client's choice, ESI will route Member appeals to Client or other Client designated entity. If Client elects to have ESI perform appeals services, Client agrees that ESI may perform such services through the UM Company. Through its contract with ESI, the UM Company has agreed to be, and will serve as, the named fiduciary for its performance of such appeals. ESI also agrees to accept fiduciary status solely with respect to its performance of any appeal.

(d) UM Company. In the event ESI performs appeals services, or facilitates the performance of appeals services through the UM Company, ESI or the UM Company, as applicable, will be responsible for conducting the appeal on behalf of Client in accordance with the Claims Rules. ESI represents to Client that UM Company has contractually agreed that: (A) UM Company will conduct appeals in accordance with the Claims Rules and Client's plan, (B) Client is a third party beneficiary of UM Company's agreement with ESI (a copy of which is available upon request) and the remedies set forth therein, and (C) UM Company will indemnify Client for third party claims caused by the UM Company's negligence or willful misconduct in providing the appeal services.

(e) External Review Services.

(i) ESI will not conduct any external review services (as defined in the Patient Protection and Affordable Care Act of 2010 and its implementing regulations ("PPACA")); provided, however, Client may elect to have UM Company facilitate the provision of external review services through UM Company contracted IROs (as such term is defined in PPACA), for the fees set forth on Exhibit B below (if applicable). Client must execute a standard ESI "External Appeals Services" Set-Up Form, which may be requested through ESI Account Management, in order to receive such services from UM Company.

(ii) In the event that Client elects to utilize UM Company to facilitate the provision of external review services through UM Company contracted IROs, UM Company will be responsible for facilitating all such appeals (and the IROs will be responsible for providing all such appeals) in accordance with PPACA and all other applicable federal and state laws, and Client hereby acknowledges and agrees that:

(A) UM Company (with respect to facilitating the external reviews) and the IROs (with respect to performing the external reviews), and not ESI, will be providing external review services; UM Company is an independent contractor of ESI; the IROs are independent contractors of UM Company and not ESI; and ESI does not in any way control or direct either UM Company or the

IROs with respect to facilitation or performance of external review services provided by each respectively.

(B) ESI represents to Client that UM Company has contractually agreed that: (1) UM Company will facilitate all external review services in accordance with PPACA and all other applicable federal and state laws; (2) UM Company will contractually require its contracted IROs to perform all external reviews in accordance with PPACA and all other applicable federal and state laws; (3) to the extent not prohibited by law, UM Company will indemnify, defend and hold Client harmless from and against any and all losses, damages, injuries, causes of action, claims, demands and expenses (including reasonable attorney's fees, costs and expenses), arising out of, resulting from, or related to any act, omission or default by the IROs in their performance of the external reviews; and (4) Client has third party beneficiary rights to enforce the preceding indemnification and hold harmless provision.

5. Formulary Adherence and Clinical Programs. Provided Client's prior written approval, ESI may provide clinical, safety, adherence and other like programs as appropriate. The Clinical Addendum described in Exhibit B-2 sets forth certain available adherence, clinical, safety and/or trend programs that require additional fees hereunder.

6. Rebates. PPS may have negotiated Rebate sharing with ESI, and PPS may be retaining such Rebates. Client acknowledges and consents to the same. Information regarding such Rebate sharing, if any, is set forth in the PBM Agreement or the related pricing exhibit.

7. Medicare (QRPDP) Services. If Client establishes a qualified retiree prescription drug plan ("QRPDP") under Medicare for the purpose of applying for subsidy payments as defined under 42 CFR §423.886 it may request ESI to provide the supporting services to such QRPDP under the terms and conditions of such services by executing ESI's standard subsidy election form and agreeing to the fees set forth in Exhibit B of the PBM Agreement.

8. Billing and Payments.

(a) Payor shall be responsible to ESI for timely payment of all Fees under one of the payment methods below specified. ESI will bill Payor weekly for all applicable claims reimbursement amounts ("Claims Reimbursements") and other administrative fees ("Administrative Fees") pursuant to the terms specified in the PBM Agreement relating to the program selected by Client (as communicated to ESI by Client or PPS) ("Claims Reimbursements," "Administrative Fees" and any other charge or fee that is the responsibility of Payor as may be described elsewhere in the PBM Agreement or this Client Agreement are hereinafter referred to collectively as "Fees").

(b) Payor shall pay all Fees within the time period depending on the form of payment as outlined on the first page of this Client Agreement.

(c) Any Fees not paid by Payor on the due date set forth above shall bear interest at the rate of 1.5% per month or, if lower, the highest interest rate permitted by law, and the Payor shall be liable for payment of the interest to ESI. The Payor shall promptly reimburse ESI for all collection costs and expenses incurred by ESI, including but not limited to attorneys' fees, in connection with attempting to recover overdue Fee payments.

(d) In the event Payor is delinquent in payment of Fees for two consecutive billing cycles, or ESI has reasonable grounds (as determined in good faith) for insecurity as to the ability of Client to meet its financial commitments hereunder, ESI shall have the option to require that Payor provide ESI with a deposit in an amount equal to the average monthly invoice amount for the previous three (3) months, or if there is less than three (3) months billing history, then such deposit shall be based on the average monthly invoice of the actual billing history. ESI shall retain the deposit until the earlier of: (i) termination of the Client Agreement (following any run-off period), or (ii) six consecutive months of timely payments of all Fees following submission of the deposit, and may apply the deposit to unpaid balances of Fees until return of the deposit. Upon 48 hours written notice to Client and PPS, ESI (and its wholly owned subsidiaries) shall be entitled to immediately suspend performance under this Client Agreement if Payor fails to pay ESI in accordance with the terms of this Client Agreement or fails to promptly provide a deposit required by this Section (or such deposit becomes insufficient to cover delinquent Fees and the responsible party does not promptly replenish such deposit upon notice).

(e) Client shall be responsible for and Payor shall pay ESI in accordance with this Agreement for all claims for Covered Drugs dispensed and services provided to Clients and Members on or before the effective date of termination ("Termination Date"). Claims submitted by Participating Pharmacies or

Member Submitted Claims filed with ESI after the Termination Date shall be processed and adjudicated in accordance with a mutually determined run-off plan. Upon termination of this Agreement, ESI agrees to remit to PPS (or Client, if applicable) after the Termination Date all outstanding Rebate amounts earned and collected as a result of prescriptions utilized by Members on or before the Termination Date. Rebates will be paid to the PPS (or Client, if applicable) under the regularly established payment process outlined in Exhibit B of the PBM Agreement. Notwithstanding the preceding, ESI may (i) delay payment of any final Rebates or other amounts due PPS (or Client, if applicable), if any, to allow for final reconciliation of any outstanding amounts owed by PPS or Client to ESI, or (ii) request that Client pay a reasonable deposit in the event ESI is requested to process after the Termination Date claims incurred on or prior to such date. Upon request of Client, ESI shall provide at no cost open refill files and standard claims data for transition to the successor pharmacy vendor in accordance with current industry protocol. Notwithstanding anything in this Agreement to the contrary, ESI shall not be obligated to provide post-transition services following the transition to the successor pharmacy benefit manager and conclusion of the run-off period, including, but not limited to, the provision of continued data reporting, reporting, consultation, or analysis.

9. Use of Records; HIPAA and Business Associate Agreement Terms. Subject to applicable law, ESI may communicate with Members regarding benefit design cost savings, availability, use of the Mail Service and ESI Specialty Pharmacies, and related items as necessary to conduct applicable clinical and/or trend programs. ESI or its affiliates may use and disclose both during and after the term of this Agreement the anonymized claims data (de-identified in accordance with HIPAA) including drug and related medical data collected by ESI or provided to ESI by Client or PPS for research; provider profiling; benchmarking, drug trend, and cost and other internal analyses and comparisons; clinical, safety and/or trend programs; ASES; or other business purposes of ESI or its affiliates, in all cases subject to applicable law. ESI agrees to comply with the business associate provisions of HIPAA, and the Business Associate Agreement posted at <http://www.express-scripts.com/hipaa/baa/>, the terms and conditions of which are incorporated herein by reference. Notwithstanding the foregoing, the parties acknowledge that in providing services to Members, ESI Specialty Pharmacy and the Mail Service Pharmacy are acting as separate health care provider covered entities under HIPAA and not as business associates to the Plan covered by the Business Associate Agreement. In providing services, ESI Specialty Pharmacy and the Mail Services Pharmacy shall abide by all HIPAA requirements applicable to covered entities and shall safeguard, use and disclose Member PHI accordingly.

10. Client Audits. Provided that this Client Agreement has been duly executed by Client and Payor is current in the payment of invoices under this Client Agreement, Client may, upon no less than thirty (30) days prior written request, audit ESI's provision of services hereunder, the scope of which shall be to verify regulatory compliance and/or compliance with the financial terms of this Client Agreement and ESI's accurate administration of the Plan pursuant to Set-Up Forms, on an annual basis consistent with the Audit Protocol set forth in Exhibit C of the PBM Agreement. Client may use an independent third party auditor ("Auditor"), so long as such Auditor is not engaged in providing services for Client or otherwise that conflict with the scope or independent nature of the audit (as determined by ESI acting reasonably and in good faith), and provided that Client's Auditor executes a mutually acceptable confidentiality agreement. Any request by Client to permit an Auditor to perform an audit will constitute Client's direction and authorization to ESI to disclose PHI to the Auditor. If PPS has audited the prescription drug program on behalf of its clients, Client may not audit ESI for the same time frame or claims.

11. Compliance with Law; Change in Law.

(a) Each party shall be responsible for ensuring its compliance with any laws and regulations applicable to its business, including maintaining any necessary licenses and permits. Payor shall be responsible for any governmental or regulatory charges and taxes imposed upon or related to the services provided under the PBM Agreement or this Client Agreement. If there is a new or change in federal, state or local law, court decisions, or regulations or the interpretation thereof, or any government, judicial or legal action that, among other things, materially burdens ESI, requires ESI to increase payments or shorten payment times for Covered Drugs to Participating Pharmacies, or materially changes the scope of services hereunder (a "Change in Law"), then there shall be an appropriate modification

of the services, reimbursement rates, Administrative Fees and/or Rebates hereunder. If the parties cannot agree on an adjusted fee, then either party may terminate this Client Agreement upon thirty (30) days prior written notice to the non-terminating party.

(b) Client shall be responsible for disclosing, or shall direct PPS to disclose, to Members any and all information relating to the Prescription Drug Program to the extent required by law. It shall be Client's obligation to communicate the terms of the Prescription Drug Program to Members and to provide Members with any documents required under ERISA (e.g., SPD) or other applicable law. Client agrees that, except for the limited purpose set forth in Section 4, ESI is not a fiduciary and Client will not name ESI or any of ESI's wholly-owned subsidiaries or affiliates as a fiduciary (as defined under ERISA or state law) of its plan. Client agrees that neither ESI nor any of ESI's wholly-owned subsidiaries or affiliates have any power to make any decisions as to plan policy, interpretations, practices or procedures, but rather provides administrative services within a framework of policies, guidelines, rules, practices and procedures chosen by Client or PPS. Neither ESI nor any of ESI's wholly-owned subsidiaries or affiliates have discretionary authority or control respecting management of Client's plan except as set forth in Section 4 and do not exercise any authority or control respecting the management or disposition of the assets of Client's plan, if any exist.

12. Third Party Fees. As authorized by Client for services rendered to Client by PPS or Producer, ESI will facilitate the payment of Third Party Fees as follows:

Third Party Program Management ("TPPM") Fees to PPS: Client hereby directs and authorizes ESI to facilitate the payment of monthly TPPM fees in the amount of 1% of Total AWP (excluding any Medicare Part D EGWP utilization) plus a one-time data analytics fee of \$12.00 per Member implemented on Client's Effective Date.

Client further acknowledges that ESI has agreed to pay a percentage of Rebates as set forth on Exhibit B-2 of the PBM Agreement. To the extent that the Percentage of Rebates Retained by PPS (as set forth on page 1 of this Client Agreement) is greater than 0.00%, client acknowledges and directs ESI to pay to PPS such percentage as additional compensation to PPS for services provided by PPS to Client.

Commissions to Producer: As indicated on page 1 of this Client Agreement, Client hereby directs and authorizes ESI to facilitate the payment of monthly commissions in the amount indicated on page 1. Client understands that ESI will invoice a separate Administrative Fee in an amount equal to the Commissions to Producer (PMPM or per Rx) as set forth on Page 1 of this Client Agreement.

ESI agrees to facilitate the foregoing fees and commissions on behalf of Client subject to the following: (a) Client has executed this Client Agreement, and Client is current in its payment obligations to ESI. ESI understands that Client may direct ESI to cease paying fees and commissions, and Client shall hold ESI harmless with respect to any dispute between Client and PPS regarding the commissions if ESI has paid such fees and commission in accordance with the terms above; (b) Client hereby confirms that the above fees and commissions are fair and reasonable, commensurate with other standard fees and commissions in the industry and not in violation of any law or regulation; and (c) ESI agrees, in event Client so directs ESI to cease facilitating the payment of such commissions to PPS, that ESI will require Client to execute a new Client Agreement between ESI and Client. Such new agreement will contain different terms, conditions and pricing than those in the then-current Client Agreement. Such terms, conditions and pricing will reflect the purchasing power of the individual Client in the open market and not of PPS's aggregate leverage.

Client represents that the commissions represent fair and reasonable compensation for actual services rendered or to be rendered to Client. Commissions shall be paid from ESI's general assets and client agrees that commissions do not constitute "plan assets" of the Client. If the commission amount changes following an amendment of Exhibit B of the PBM Agreement, PPS and Client agree that PPS shall notify Client of such change in writing without the need to amend this Client agreement, and that unless client objects to the change, ESI may rely on PPS's confirmation of notice as Client approval. Commissions for any QR-PDP (Part D subsidy) Prescription Claims shall be a PMPM amount. To the extent additional commission information necessary for Client to satisfy its duties under ERISA or other applicable law cannot be obtained by client from PPS, ESI will provide such information to Client upon written request.

ESI will provide up to \$5.00 per Member implemented as of the Effective Date ("PMF"), to reimburse Client the actual, fair market value of: (i) expense items and services related to transitioning, administering, and implementing the pharmacy benefit initially and throughout the term, such as, custom ID Cards, IT programming, custom formulary letters, member communications, and benefit set-up quality assurance; and/or (ii) mutually agreed upon expense items and services related to implementation of additional clinical or other similar programs provided by ESI throughout the Term; in either case subject to submission of adequate documentation to support reimbursement within 180 days of incurring the applicable expense. Both Client and ESI (upon agreement from Client) may use the PMF to cover the fair market value of expenses for projects requiring joint resources. All reimbursement under the PMF is subject to ESI's standard PMF business practices for all clients.

Client represents and warrants that: (i) it will only request reimbursement under the PMF for its actual expenses incurred in transitioning, administering, and implementing the pharmacy benefit managed by ESI hereunder, and/or the additional clinical or other similar program provided by ESI throughout the Term; (ii) that the applicable service, item or program was actually performed or provided; (iii) the amount of the reimbursement is equal to or less than the reasonable fair market value of the actual expenses incurred by Client; (iv) it will notify and disclose the amount and the terms of any PMF reimbursements to Members and other third parties to the extent required by applicable laws and regulations. In addition, if the Client and the Plan are subject to ERISA, Client represents and warrants that it will only request reimbursement under the PMF for items or services for which Client, in the absence of the PMF, would be allowed reimbursement from the Plan (i.e., not "setoff functions").

Client shall comply with all applicable federal and state requirements, including, but not limited to, all applicable federal and state reporting requirements with respect to any expense, item or service reimbursed under this Section 12. ESI reserves the right to periodically audit the books and records of Client on-site, during normal business hours and after giving reasonable advance notice, for the purposes of verifying Client's compliance with the PMF requirements set forth in this Client Agreement.

ESI intends to amortize the PMF over the Initial Term of the Client Agreement on a straight-line basis. In the event of a termination of this Client Agreement for any reason other than ESI's uncured material breach prior to the expiration of the Initial Term, Client will reimburse ESI an amount equal to any paid but unamortized portion of the PMF. Reimbursement to ESI by Client pursuant to this Section will not be in lieu of any other rights or remedies ESI may have in connection with the termination of this Client Agreement, including monetary or other damages. PMF reimbursements shall not be paid prior to the Effective Date of this Client Agreement and are not payable until this Client Agreement is executed. Client will have no right to interest on, or the time value of, any PMF, and unused funds shall be retained by ESI.

Third Party Fees, Commissions, PMF and Rebates are not payable until this Client Agreement is executed.

13. Disclosure of Certain Financial Matters. In addition to the Administrative Fees paid to ESI by Client, ESI and ESI's wholly-owned subsidiaries or affiliates derive revenue in one or more of the ways described in the ESI Financial Disclosure to PBM Clients set forth in Attachment 1 hereto ("Financial Disclosure"), as updated by ESI from time to time. Unlike the Administrative Fees, the revenues described in the Financial Disclosure are not direct or indirect compensation to ESI from Client for services rendered to Client or the Plan under this Client Agreement. In negotiating any of the fees and revenues described in the Financial Disclosure or in this Agreement, ESI and ESI's wholly-owned subsidiaries and affiliates act on their own behalf, and not for the benefit of or as agents for PPS, Client, Members or the Plan. ESI and ESI's wholly-owned subsidiaries and affiliates retain all proprietary rights and beneficial interest in such fees and revenues described in the Financial Disclosure and, accordingly, Client acknowledges that neither it, nor the PPS, nor any Member, nor the Plan, has a right to receive, or possesses any beneficial interest in, any such fees or revenues.

14. Term; Termination. The initial term of this Client Agreement shall commence on the Effective Date and shall continue for the duration of the initial term as specified on the first page of this Client Agreement (the "Initial Term"). Thereafter, this Client Agreement shall automatically renew for successive 12 month renewal terms unless either ESI or Client gives notice to

the other of its intention not to renew this Client Agreement at least thirty (30) days prior to the end of the then current term of this Client Agreement, with such termination of this Client Agreement upon notice effective the last day of such then current term. Notwithstanding the foregoing, a party hereto may terminate this Client Agreement at any time in the event the other party materially breaches this Client Agreement and the breaching party does not reasonably cure such breach within thirty days following receipt of written notice from the non-breaching party sufficiently describing and evidencing the actual breach and the non-breaching party's intention to terminate as a result thereof. A party's right to terminate this Client Agreement shall not be exclusive of any other remedy available to the terminating party under this Client Agreement or otherwise. ESI shall have the right to immediately terminate PBM Services to Client (or, if applicable, Members) located in a state requiring a pharmacy benefit manager to be a fiduciary to PPS, Client, a Member or other third party relating to this Agreement.

15. Force Majeure. Neither party shall lose any rights under this Agreement or be liable in any manner for any delay to perform its obligations under this Client Agreement that are beyond a party's reasonable control, including, without limitation, any delay or failure due to labor disputes, riots, earthquakes, storms, floods or other extreme weather conditions, fires, explosions, acts of terrorism, epidemics, embargoes, war or other outbreak of hostilities, government acts or regulations, the failure or inability of carriers, suppliers, delivery services, or telecommunications providers to provide services necessary to enable a party to perform its obligations hereunder, or any other reason where failure to perform is beyond the party's reasonable control, and is not caused by the negligence, intentional conduct or misconduct of the defaulting party; *provided, however*, that this clause may not be invoked to excuse a party's payment obligations hereunder.

16. Notice. Any notice or document required or permitted to be delivered pursuant to this Client Agreement must be in writing and shall be deemed to be effective upon mailing and must be either (a) deposited in the United States Mail, postage prepaid, certified or registered mail, return receipt requested, or (b) sent by recognized overnight delivery service with tracing capability, in either case properly addressed to the other party at the address set forth below, or at such other address as such party shall specify from time to time by written notice delivered in accordance herewith:

Express Scripts, Inc.	Client
Attn: President	Attn: President
One Express Way	Address on Client Agreement
St. Louis, MO 63121	
With copy to Legal Department	
Fax No. (800) 417-8163	

17. Assignment and Subcontracting. Client may assign this Agreement upon first obtaining ESI's written consent, which consent will not be unreasonably withheld following a standard credit review of the proposed assignee. Client acknowledges and agrees that ESI may perform certain services hereunder (e.g., mail service pharmacy and specialty pharmacy services) through one or more ESI subsidiaries, affiliates or designees. ESI is responsible and liable for the performance of its subsidiaries and affiliates in the course of their performance of any such service. To the extent that ESI subcontracts any PBM Service under this Agreement to a third party, ESI is responsible and liable for the performance of any such third party. In addition, ESI may contract with third party vendors to provide information technology support services and other ancillary services, which services are not PBM Services hereunder, but rather are services that support ESI's conduct of its business operations. This Agreement will be binding upon, and inure to the benefit of and be enforceable by, the respective successors and permitted assigns of the parties hereto.

18. Proprietary Information. Information of the other party, including, but not limited to, the following, shall constitute confidential and proprietary information ("Proprietary Information") unless otherwise public: (a) with respect to ESI: ESI's reporting and other web-based applications, eligibility and adjudication systems, system formats and databanks (collectively, "ESI's Systems"), clinical or formulary management operations or programs, fraud, waste and abuse tools and programs, anonymized claims data (de-identified in accordance with HIPAA); ESI Specialty Pharmacy and Mail Service Pharmacy data; information concerning Rebates, prescription drug evaluation criteria, drug pricing information, and Participating Pharmacy agreements; and (b) with respect to Client: Participating Pharmacy Client and Member identifiable health information and data, Eligibility Files, Set-Up Form information, business operations and strategies, are confidential and proprietary. Neither party shall use a party's Proprietary Information, or disclose it or this Client

Agreement to any third party, at any time during or after termination of this Client Agreement, except as specifically contemplated by this Client Agreement, upon prior written consent or as otherwise required by law. Upon termination of this Client Agreement, each party shall cease using the other's Proprietary Information, and all such information shall be returned or destroyed at the owner's direction.

be the partner, agent, fiduciary, employee, or representative of the other and neither party shall have the right to make any representations concerning the duties, obligations or services of the other except as consistent with the express terms of this Client Agreement or as otherwise authorized in writing by the party about which such representation is asserted.

Notwithstanding the foregoing, ESI acknowledges that the Client has the right to use their information, which includes but not limited to: Member ID, NDC, Drug Name, Days Supply, Units Dispensed, Ingredient Cost, U&C Price, Dispensing Fee, Member Copayment, Net Cost, Fill Date, Pharmacy Type, Pharmacy ID (NABP, NCPDP, and NPI), DAW Code, Specialty Indicator, and Formulary Indicator.

21. Taxes and Assessments. Any applicable sales, use, excise, or other similarly assessed and administered tax, surcharge, or fee imposed on items dispensed, or services provided hereunder, or the fees or revenues generated by the items dispensed or services provided hereunder, or any other amounts ESI or one or more of its subsidiaries or affiliates may incur or be required to pay arising from or relating to ESI's or its subsidiaries' or affiliates' performance of services as a pharmacy benefit manager, third-party administrator, or otherwise in any jurisdiction, will be the sole responsibility of Payor or the Member. If ESI is legally obligated to collect and remit, or to incur or pay, any such sales, use, excise, or other similarly assessed and administered tax, surcharge, or fee in a particular jurisdiction, such amount will be reflected on the applicable invoice or subsequently invoiced at such time as ESI becomes aware of such obligation or as such obligation becomes due. ESI reserves the right to charge a reasonable administrative fee for collection and remittance services provided on behalf of Client.

19. Indemnification. Each party agrees to indemnify and hold the other party, and its officers, directors, and employees, harmless from and against any and all third party claims, actions, demands, liabilities, losses, damages, judgments, costs or expenses (including reasonable attorneys' fees) incurred by the indemnified party and arising from any negligent act, negligent omission, or breach of this Agreement by the indemnifying party. Indemnification is conditioned upon the indemnified party notifying the indemnifying party in writing promptly upon learning of any claim for which indemnification may be sought hereunder, and tendering of the defense of such claim to the indemnifying party. Neither party will be obligated to indemnify the other party with respect to any claim settled without the mutual written consent of both parties hereto, which consent will not be unreasonably withheld.

22. Miscellaneous. ESI may amend the Terms and Conditions (the "T&C") of this Client Agreement at any time upon written notice to Client (the "Notice"). If, however, Client objects to such amendment, Client shall have the right to object to such amendment by submitting a written objection within thirty (30) days of Client's receipt of ESI's Notice. In such event, the parties agree to negotiate in good faith a mutually acceptable amendment to the T&C and, if the parties cannot agree on such an amendment, then either party may terminate this Client Agreement upon sixty (60) days prior written notice to the other party. This Client Agreement shall be governed by and construed in accordance with the internal laws of the State of Missouri. This Client Agreement supersedes any agreements between the parties hereto. Sections 2, 7 (last sentence), 8, 9, 11, 15, 17, 16, 18, 19, 20 and 22 of this Client Agreement shall survive termination for any reason.

20. Independent Parties. No provision of this Client Agreement is intended to create or shall be construed to create any relationship between ESI and Client other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Client Agreement. Neither party, nor any of their respective representatives, shall be construed to

THE UNDERSIGNED AGREE THAT THIS CLIENT AGREEMENT ACCURATELY DESCRIBES THE PRESCRIPTION DRUG PROGRAM TO BE PROVIDED TO CLIENT. CLIENT FURTHER EXPRESSLY AGREES TO THE TERMS AND CONDITIONS SET FORTH IN THIS CLIENT AGREEMENT AND THE PBM AGREEMENT. CLIENT SHALL RECEIVE A COPY OF THE PBM AGREEMENT BETWEEN PPS AND ESI UPON REQUEST.

NAME OF CLIENT (PRINT): Township of Lower Date: _____

By: _____ Name: _____ Title: _____
SIGNATURE (PRINT NAME)

EXPRESS SCRIPTS, INC.

By: _____ Name: _____ Title: _____
SIGNATURE (PRINTED NAME)

IMPLEMENTATION OF THE PRESCRIPTION DRUG PROGRAM DETAILED HEREIN INCLUDING PAYMENT OF REBATES AND/OR COMMISSIONS, IF ANY, SHALL NOT BE INITIATED UNTIL THIS CLIENT AGREEMENT IS EXECUTED BY CLIENT AND ESI.

ATTACHMENT 1 TO CLIENT AGREEMENT

FINANCIAL DISCLOSURE TO ESI PBM CLIENTS

This disclosure provides an overview of the principal revenue sources of Express Scripts, Inc. and Medco Health Solutions, Inc. (individually and collectively referred to herein as "ESI"), as well as ESI's affiliates. In addition to administrative and dispensing fees paid to ESI by our clients for pharmaceutical benefit management ("PBM") services, ESI and its affiliates derive revenue from other sources, including arrangements with pharmaceutical manufacturers, wholesale distributors, and retail pharmacies. Some of this revenue relates to utilization of prescription drugs by members of the clients receiving PBM services. ESI may pass through certain manufacturer payments to its clients or may retain those payments for itself, depending on the contract terms between ESI and the client.

Network Pharmacies – ESI contracts for its own account with retail pharmacies to dispense prescription drugs to client members. Rates paid by ESI to these pharmacies may differ among networks (e.g., Medicare, Worker's Comp, open and limited), and among pharmacies within a network, and by client arrangements. PBM agreements generally provide that a client pays ESI an ingredient cost, plus dispensing fee, for drug claims. If the rate paid by a client exceeds the rate contracted with a particular pharmacy, ESI will realize a positive margin on the applicable claim. The reverse also may be true, resulting in negative margin for ESI. ESI also enters into pass-through arrangements where the client pays ESI the actual ingredient cost and dispensing fee amount paid by ESI for the particular claim when the claim is adjudicated to the pharmacy. In addition, when ESI receives payment from a client before payment to a pharmacy, ESI retains the benefit of the use of the funds between these payments. ESI may maintain non-client specific aggregate guarantees with pharmacies and may realize positive margin. ESI may charge pharmacies standard transaction fees to access ESI's pharmacy claims systems and for other related administrative purposes.

Brand/Generic Classifications – Prescription drugs may be classified as either a "brand" or "generic;" however, the reference to a drug by its chemical name does not necessarily mean that the product is recognized as a generic for adjudication, pricing or copay purposes. Associated with pharmacy reimbursement, ESI distinguishes brands and generics through a proprietary algorithm ("BGA") that uses certain published elements provided by First DataBank (FDB) including price indicators, Generic Indicator, Generic Manufacturer Indicator, Generic Name Drug Indicator, Innovator, Drug Class and ANDA. The BGA uses these data elements in a hierarchical process to categorize the products as brand or generic. The BGA also has processes to resolve discrepancies and prevent "flipping" between brand and generic status due to price fluctuations and marketplace availability changes. The elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the BGA are available upon request. Brand or generic classification for client reimbursement purposes is either based on the BGA or specific code indicators from Medi-Span or a combination of the two as reflected in the client's specific contract terms. Application of an alternative methodology based on specific client contract terms does not affect ESI's application of its BGA for ESI's other contracts.

Maximum Allowable Cost ("MAC")/Maximum Reimbursement Amount ("MRA") – As part of the administration of the PBM services, ESI maintains a MAC List of drug products identified as requiring pricing management due to the number of manufacturers, utilization and/or pricing volatility. The criteria for inclusion on the MAC List are based on whether the drug has readily available generic product(s), is generally equivalent to a brand drug, is cleared of any negative clinical implications, and has a cost basis that will allow for pricing below brand rates. ESI also maintains MRA price lists for drug products on the MAC List based on current price reference data provided by MediSpan or other nationally recognized pricing source, market pricing and availability information from generic manufacturers and on-line research of national wholesale drug company files, and client arrangements. Similar to the BGA, the elements listed above and sources are subject to change based on the availability of the specific fields. Updated summaries of the MAC methodology are available upon request.

Manufacturer Formulary Rebates, Associated Administrative Fees, and PBM Service Fees – ESI contracts for its own account to obtain formulary rebates attributable to the utilization of certain brand drugs and supplies (and possibly certain authorized generics marketed under a brand manufacturer's new drug application). Formulary rebate amounts received vary based on client specific utilization, the volume of utilization as well as formulary position applicable to the drug or supplies, and adherence to various formulary management controls, benefit design requirements, claims volume, and other similar factors, and in certain instances also may vary based on the product's market-share. ESI often pays an amount equal to all or a portion of the formulary rebates it receives to a client based on the client's PBM agreement terms. ESI retains the financial benefit of the use of any funds held until payment of formulary rebate amounts is made to the client. ESI or its affiliates may maintain non-client specific aggregate guarantees and may realize positive margin. In addition, ESI provides administrative services to contracted manufacturers, which include, for example, maintenance and operation of systems and other infrastructure necessary for invoicing and processing rebates, pharmacy discount programs, access to drug utilization data, as allowed by law, for purposes of verifying and evaluating applicable payments, and for other purposes related to the manufacturer's

products. ESI receives administrative fees from the participating manufacturers for these services. These administrative fees are calculated based on the price of the drug or supplies along with the volume of utilization and do not exceed the greater of (i) 4.58% of the average wholesale price, or (ii) 5.5% of the wholesale acquisition cost of the products. In its capacity as a PBM company, ESI also may receive other compensation from manufacturers for the performance of various services, including, for example, formulary compliance initiatives, clinical services, therapy management services, education services, medical benefit management services, and the sale of non-patient identifiable claim information. This compensation is not part of the formulary rebates or associated administrative fees.

Copies of ESI's standard formularies may be reviewed at www.express-scripts.com/wps/portal/. In addition to formulary considerations, other plan design elements are described in ESI's Plan Design Review Guide, which may be reviewed at www.express-scripts.com/wps/portal/.

ESI Subsidiary Pharmacies – ESI has several licensed pharmacy subsidiaries, including our specialty pharmacies. These entities may maintain product purchase discount arrangements and/or fee-for-service arrangements with pharmaceutical manufacturers and wholesale distributors. These subsidiary pharmacies contract for these arrangements on their own account in support of their various pharmacy operations. Many of these subsidiary arrangements relate to services provided outside of PBM arrangements, and may be entered into irrespective of whether the particular drug is on one of ESI's national formularies. Discounts and fee-for-service payments received by ESI's subsidiary pharmacies are not part of the PBM formulary rebates or associated administrative fees paid to ESI in connection with ESI's PBM formulary rebate programs. However, certain purchase discounts received by ESI's subsidiary pharmacies, whether directly or through ESI may be considered for formulary purposes if the value of such purchase discounts is used by ESI to supplement the discount on the ingredient cost of the drug to the client based on the client's PBM agreement terms. From time to time, ESI and its affiliates also may pursue and maintain for its own account other supply chain sourcing relationships not described below as beneficial to maximize ESI's drug purchasing capabilities and efficiencies, and ESI or affiliates may realize an overall positive margin with regard to these initiatives.

The following provides additional information regarding examples of ESI subsidiary discount arrangements and fee-for-service arrangements with pharmaceutical manufacturers, and wholesale distributors:

ESI Subsidiary Pharmacy Discount Arrangements – ESI subsidiary pharmacies purchase prescription drug inventories, either from manufacturers or wholesalers, for dispensing to patients. Often, purchase discounts off the acquisition cost of these products are made available by manufacturers and wholesalers in the form of either up-front discounts or retrospective discounts. These purchase discounts, obtained through separate purchase contracts, are not formulary rebates paid in connection with our PBM formulary rebate programs. Drug purchase discounts are based on a pharmacy's inventory needs and, at times, the performance of related patient care services and other performance requirements. When a subsidiary pharmacy dispenses a product from its inventory, the purchase price paid for the dispensed product, including applicable dispensing fees, may be greater or less than that pharmacy's acquisition cost for the product net of purchase discounts. In general, our pharmacies realize an overall positive margin between the net acquisition cost and the amounts paid for the dispensed drugs.

ESI Subsidiary Fee-For-Service Arrangements – One or more of ESI's subsidiaries, including, but not limited to, its subsidiary pharmacies also may receive fee-for-service payments from manufacturers or wholesalers in conjunction with various programs or services, including, for example, patient assistance programs for indigent patients, dispensing prescription medications to patients enrolled in clinical trials, various therapy adherence and fertility programs, administering FDA compliance requirements related to the drug, product reimbursement support services, and various other clinical or pharmacy programs or services. As a condition to having access to certain products, and sometimes related to certain therapy adherence criteria or FDA requirements, a pharmaceutical manufacturer may require a pharmacy to report selected information to the manufacturer regarding the pharmacy's service levels and other dispensing-related data with respect to patients who receive that manufacturer's product. A portion of the discounts or other fee-for-service payments made available to our pharmacies may represent compensation for such reporting.

Other Manufacturer Arrangements – ESI also maintains other lines of business that may involve discount and service fee relationships with pharmaceutical manufacturers and wholesale distributors. Examples of these businesses include a wholesale distribution business, group purchasing organizations (and related group purchasing organization fees), a medical benefit management company, and United BioSource Corporation ("UBC"). Compensation derived through these business arrangements is not considered for PBM formulary placement, and is in addition to other amounts described herein. Of particular note, UBC partners with life sciences and pharmaceutical companies to develop, commercialize, and support safe, effective use and access to pharmaceutical products. UBC maintains a team of research scientists, biomedical experts, research operations professionals, technologists and clinicians who work with clients to conduct and support clinical trials, create, and validate and administer pre and post product safety and risk management programs.

UBC also works on behalf of pharmaceutical manufacturers to provide product and disease state education programs, reimbursement assistance, and other support services to the public at large. These service fees are not part of the formulary rebates or associated administrative fees.

Third Party Data Sales – Consistent with any client contract limitations, ESI or its affiliates may sell HIPAA compliant information maintained in their capacity as a PBM, pharmacy, or otherwise to data aggregators, manufacturers, or other third parties on a fee-for-service basis or as a condition of discount eligibility. All such activities are conducted in compliance with applicable patient and pharmacy privacy laws and client contract restrictions.

December 1, 2014

THIS EXHIBIT REPRESENTS ESI'S FINANCIAL POLICIES. ESI MAY PERIODICALLY UPDATE THIS EXHIBIT AND THE FINANCIAL DISCLOSURES CONTAINED HEREIN TO REFLECT CHANGES IN ITS BUSINESS PROCESSES; THE CURRENT FINANCIAL DISCLOSURE IS AVAILABLE UPON REQUEST AND ACCESSIBLE ON EXPRESS-SCRIPTS.COM AT WWW.EXPRESS-SCRIPTS.COM/WPS/PORTAL/.

ATTACHMENT 2 TO CLIENT AGREEMENT

Open Channel Discount Guarantees

Type of Guarantee	National Plus Network	Mail Service Pharmacy	Claims Excluded
Generic Claims	AWP – 77.00%	AWP – 81.00%	OTC, compounds, Member Submitted Claims, Subrogation Claims, vaccines, Specialty Products, biosimilar products, and products filled through 340b pharmacies (if applicable)
Brand Claims	AWP – 17.25%	AWP – 25.00%	OTC, compounds, Member Submitted Claims, Subrogation Claims, vaccines, Specialty Products, biosimilar products, and products filled through 340b pharmacies (if applicable)

Managed Channel Discount Guarantees: Requires Exclusive Home Delivery

Type of Guarantee	National Plus Network	Mail Service Pharmacy	Claims Excluded
Generic Claims	AWP – 77.00%	AWP – 82.00%	OTC, compounds, Member Submitted Claims, Subrogation Claims, vaccines, Specialty Products, biosimilar products, and products filled through 340b pharmacies (if applicable)
Brand Claims	AWP – 17.25%	Year 1: AWP – 25.00% Year 2: AWP – 25.50% Year 3: AWP – 25.75%	OTC, compounds, Member Submitted Claims, Subrogation Claims, vaccines, Specialty Products, biosimilar products, and products filled through 340b pharmacies (if applicable)

Open and Managed Channel Dispensing Fee Guarantees

Type of Guarantee	National Plus Network	Mail Service Pharmacy	Claims Excluded
Generic Claims	\$0.90	\$0.00	OTC, compounds, Specialty Products, and biosimilar products
Brand Claims	\$0.90	\$0.00	OTC, compounds, Specialty Products, and biosimilar products

Specialty Net Effective Discount Guarantee

Type of Pricing Guarantee	ESI Specialty Pharmacy – Exclusive Care	Claims Excluded
<u>Average Aggregate Annual Ingredient Cost Discount Guarantee</u>	<u>AWP – 15.00%</u>	<u>All Specialty Product Claims not dispensed through ESI Specialty Pharmacy and limited distribution Specialty Products dispensed through ESI Specialty Pharmacy</u>

Rebate Guarantees – (ESI will pay an amount equal to the greater of 85% of Rebates received by ESI or the guaranteed amounts below)

Formulary:	ESI National Preferred <u>Formulary</u>					
	<u>Minimum \$15 Copayment differential</u>			<u>Less than \$15 Copayment differential</u>		
	<u>Participating Pharmacies</u>	<u>ESI Specialty Pharmacy</u>	<u>Mail Service Pharmacy</u>	<u>Participating Pharmacies</u>	<u>ESI Specialty Pharmacy</u>	<u>Mail Service Pharmacy</u>
Per Brand Claim	Year 1: \$35.79 Year 2: \$40.54 Year 3: \$40.83	\$150.00	Year 1: \$107.38 Year 2: \$121.62 Year 3: \$122.49	Year 1: \$33.79 Year 2: \$38.54 Year 3: \$38.83	\$150.00	Year 1: \$101.38 Year 2: \$115.62 Year 3: \$116.49

For all HDHP starting at 20% of the Client's overall claims, ESI will charge a per-claim administrative fee \$0.15 to cover the cost of processing high deductible health plan claims. For every additional increase of 5% of total claims, the per-claim administrative fee will increase by \$0.15.

This pricing summary is a summary of the high level guarantees negotiated by PPS with ESI. Complete pricing, Rebate and Administrative Fee details including but not limited to program requirements, assumptions, administrative & clinical Program fees, definitions, and calculation methodologies are included in Exhibits B through B-4 of the Agreement between PPS and ESI and will be provided upon request and execution of a confidentiality agreement with PPS.

PBM Services

Customer service for members
Electronic/online eligibility submission
Standard coordination of benefits (COB)
(reject for primary carrier)
Electronic claims processing
Plan setup
Software training for access to our online system(s)
FSA eligibility needs

Network Pharmacy Services

Pharmacy help desk
Pharmacy network management
Pharmacy reimbursement
Network development (upon request)
Network Pharmacy Reporting
Network Pharmacy Audit Program

Home Delivery Services

Benefit education
Prescription delivery — standard

Reporting Services

Web-based client reporting — produced by Express Scripts
Web-based client reporting — produced by client
Ad hoc desktop parametric reports
Claims detail extract file electronic (NCPDP)
Load 12 months claims history for clinical reports and reporting
Annual Strategic Account Plan report
Billing reports
Inquiry access to claims processing system

Website Services

Client Website — Eservice Delivery (Eligibility, Claims, and Benefit Administration), Coverage Management and Appeals, Eligibility File Transfer, Reporting Solutions and Resources Area.
My Rx Choices – helps members make informed medication choices based on cost, health and safety. Member website portion only.
Express-Scripts.com for Members — access to benefit, drug, health, and wellness information; prescription ordering capability; and customer service.
Online Benefit Management – eService web-based application with Claims History, Eligibility Maintenance, and Prior Authorization Add.
Mobile App for Members – includes My Rx Choices, My Medicine Cabinet, Pharmacy Care Alerts, Refills and Renewals, and virtual prescription ID card.

Implementation Package and Member Communications

Member replacement cards printed via web
Implementation support
New member packets (includes two standard resin ID cards)

Clinical

PBM Services
Concurrent Drug Utilization Review (DUR) Prior Authorization — Administrative <ul style="list-style-type: none"> • Non-clinical Prior Authorization • Lost/stolen overrides • Vacation supplies • Pharmacogenomics Prior Authorization List

Administrative Service Fees

PBM Services	Fees
Manual Submissions	
Manual/hardcopy eligibility submission Member Submit Fee (includes Medicaid subrogation claims)	\$10.00/update (includes initial entry) \$2.50/claim
Electronic Prescribing	
Electronic Prescribing	Pass through charge for ePrescribing Eligibility and Formulary transaction fees charged to PPS Client at Express Scripts' preferred rate with data switch such as Surescripts.
Reporting Services	
Custom ad hoc reporting – applies for reporting outside of self services reporting tool	\$150/hour, with a minimum of \$500
Replacement Member Communication Packets	
Member-requested replacement packets Client-requested re-carding	\$1.50 + postage per packet \$1.50 + postage per packet
Communication Fee	
Smart90 and Select Home Delivery Programs	\$2.50 per employee upon implementation of program (one-time charge)
Reviews and Appeals Management	
<u>Initial Determinations (i.e. coverage reviews) and Level One Appeals for the Coverage Authorization Program, consisting of:</u> <ul style="list-style-type: none"> • Prior Authorization • Step Therapy • Drug Quantity Management 	Included in the existing UM PMPM charge

PBM Services	Fees
<p><u>Initial Determinations and Level One Appeals</u> for the <u>Benefit Review Program</u>, consisting of reviews known as:</p> <ul style="list-style-type: none"> • Plan Design Related Requests • Plan Exclusion Reviews (clinical or administrative reviews of non-covered drugs) • Copay Reviews • Plan Limit Reviews (e.g. age, gender, days' supply limits) • Plan Rule/Administrative Reviews/Non-clinical Reviews • Clinical Benefit Reviews • Direct Claim Reject Reviews 	\$55 per review
<p><u>Final and Binding Appeals</u> – Level Two Appeals * and/or Urgent Appeals**</p> <p>*Level One for clients with only one level of appeal ** Appeals can be urgent at Level One or Level Two and decisions are final and binding.</p>	<p>\$10.00 per review* (incremental to PMPM fees or per the review fees above)</p> <p>* This additional fee is applied to each initial determination.</p>
<p><u>External Reviews by Independent Review Organizations</u> - for non-grandfathered plans</p>	\$800 per review
Retiree Drug Subsidy (RDS)	
<p>RDS enhanced service (Express Scripts sends reports to CMS on behalf of client)</p> <ul style="list-style-type: none"> • Notice of Creditable Coverage <p>RDS standard service (Express Scripts sends reports to client)</p> <ul style="list-style-type: none"> • Notice of Creditable Coverage 	<p>\$1.12 PMPM for Medicare-qualified members with a minimum annual fee of \$7,500</p> <p>\$1.35/letter + postage</p> <p>\$0.62 PMPM for Medicare-qualified members with a minimum annual fee of \$5,000</p> <p>\$1.35/letter + postage</p>
Required Services and Fee for all CDH Enrollees	
<p>Foundational Services</p> <ul style="list-style-type: none"> • Technical <p>Bi-directional data exchange; dedicated operations; 24-hour a day, seven-days a week monitoring and quality control; performance reporting; and analytics</p> <ul style="list-style-type: none"> • Member Advocacy <p>Dedicated CDH member services, open enrollment tools and member communications library, robust online features, and preventive care</p>	<p>Technical and Member Advocacy: \$0.35 PMPM</p> <p><i>Additional services will be quoted upon request. Postage charges are not included and will be billed to Client.</i></p>
Optional Service and Fee for all non-CDH Enrollees	

PBM Services	Fees
<p>Comprehensive Member Engagement Services</p> <ul style="list-style-type: none"> • Health Choices <p>Medication Adherence Monitoring and Outreach and proactive, personalized member communications</p> <ul style="list-style-type: none"> • Drug Choices <p>Benefit Coaching, Prescription Benefit Review Statements, proactive, personalized member communications</p>	<p>Comprehensive Services: \$0.30 PMPM</p> <p>All Services (Foundational & Comprehensive): \$0.65 PMPM</p> <p><i>Additional services will be quoted upon request.</i></p> <p><i>Postage charges are not included and will be billed to Client.</i></p>
<p><i>If Sharing Data Only - Required Service and Fee for all Non-CDH Enrollees</i></p>	
<p>Combined Benefit Management</p> <p>Services to manage combined medical-pharmacy benefits that are not a consumer-directed health (CDH) plan.</p> <p>Services include ongoing management of the data exchange platform with the medical vendor/PPS, production monitoring and quality control, and dedicated operations team. Combined benefit types may include deductible, out of pocket, spending account, and lifetime maximum.</p>	<p>\$0.10 PMPM per combined accumulator up to maximum of \$0.20 PMPM for existing connection with medical carrier or PPS.</p> <p>Fees to establish connection with new medical carrier or PPS are quoted upon request.</p> <p><i>Additional services will be quoted upon request.</i></p> <p><i>Postage charges are not included and will be billed to Client.</i></p>

CHECKLIST

PROFESSIONAL SERVICE CONTRACT REQUIREMENTS

The following must be submitted to the Township Clerk 10 Days prior to award:

- _____ SIGNED CONTRACT BY PROFESSIONAL
- _____ BUSINESS REGISTRATION CERTIFICATE
- _____ SIGNED EXHIBIT A MANDATORY EQUAL OPPORTUNITY FORM
- _____ EEO CERTIFICATE OR AA302
- _____ BUSINESS ENTITY DISCLOSURE
- _____ PAY TO PLAY AFFIDAVIT

COUNCIL APPROVAL

- _____ RESOLUTION
- _____ EXECUTED CONTRACT
- _____ ADVERTISEMENT 10 DAYS AFTER AWARD

Julie Picard, RMC _____

Margaret Vitelli, QPA or PACO _____

The contractor or subcontractor agrees to revise any of its testing procedures, if necessary, to assure that all personnel testing conforms with the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.

In conforming with the applicable employment goals, the contractor or subcontractor agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

The contractor shall submit to the public agency, after notification of award but prior to execution of a goods and services contract, one of the following three documents:

Letter of Federal Affirmative Action Plan Approval

Certificate of Employee Information Report

Employee Information Report Form AA302

The contractor and its subcontractors shall furnish such reports or other documents to the Div. of Contract Compliance & EEO as may be requested by the office from time to time in order to carry out the purposes of these regulations, and public agencies shall furnish such information as may be requested by the Div. of Contract Compliance & EEO for conducting a compliance investigation pursuant to **Subchapter 10 of the Administrative Code at N.J.A.C. 17:27.**

Firm Name: Health Insurance Solutions, INC.

Name of Agent: Nanette Poserina

Title: President

Date: 5/27/2015

BUSINESS ENTITY DISCLOSURE CERTIFICATION

FOR NON-FAIR AND OPEN CONTRACTS
Required Pursuant To N.J.S.A. 19:44A-20.8
TOWNSHIP OF LOWER

Part I B Contractor Affirmation

The undersigned, being authorized and knowledgeable of the circumstances, does hereby certify that the business entity by the name Health Ins. Solutions, Inc. has not made and will not make any reportable contributions pursuant to N.J.S.A. 19:44A-1 et seq. that, pursuant to P.L. 2004, c. 19 would bar the award of this contract in the one year period preceding January 3, 2008 to any of the following named candidate committee, joint candidates committee; or political party committee representing the elected officials of the Township of Lower, defined pursuant to N.J.S.A. 19:44A-3(p), (q) and (r).

Michael E. Beck	
Norris Clark	Any present or future candidate committee or
Erik Simonsen	joint candidate committee or local political party
Thomas Conrad	committee formed for the election of members of
David Perry	the Lower Township governing body.

Part II B Ownership Disclosure Certification

I certify that the list below contains the names and home addresses of all owners holding 10% or more of the issued and outstanding stock of the undersigned.

Check the box that represents the type of business entity:

- Partnership
 Corporation
 Sole Proprietorship
 Subchapter S Corporation
 Limited Partnership
 Limited Liability Corporation
 Limited Liability Partnership

Name of Stock or Shareholder	Home Address
Nanette Poserina	980 Gallery Drive, Schwenksville, Pa. 19473
Thomas E. Poserina	980 Gallery Drive, Schwenksville, Pa. 19473

Part 3 B Signature and Attestation:

The undersigned is fully aware that if I have misrepresented in whole or part this affirmation and certification, I and/or the business entity, will be liable for any penalty permitted under law.

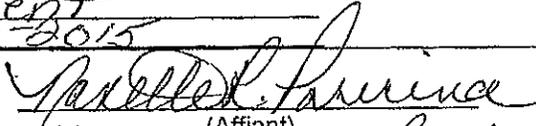
Name of Business Entity: Health Insurance Solutions, Inc.

Signed: Nanette Poserina Title: President

Print Name: NANETTE POSERINA Date: 5-27-2015

Subscribed and sworn before me this 27 day of May, 2015.

My Commission expires: 3/22/2018


 (Affiant)
NANETTE POSERINA - President
 (Print name & title of affiant) (Corporate Seal)

COMMONWEALTH OF PENNSYLVANIA
 NOTARIAL SEAL
 KAREN WATSON, Notary Public
 Souderton Boro., Montgomery County
 My Commission Expires March 22, 2018

**LOWER TOWNSHIP
2600 BAYSHORE ROAD
VILLAS, NJ 08251
(609) 886-2005**

AFFIDAVIT OF PAY-TO-PLAY COMPLIANCE

The Undersigned, being duly sworn, of full age according to law, upon my oath, depose and say:

1. I am a duly authorized representative of (the "Business Entity"), which for the purposes of this Affidavit includes all entities of which the Business Entity owns, directly or indirectly, a more than 50% equity interest.

2. The Business Entity is seeking the award of a Professional Services Contract or Unspecifiable Services Contract pursuant to the exceptions from public bidding under Sections 5(1) of the Local Public Contracts Law, N.J.S.A. 40A:11-1, et seq.

3. In accordance with Lower Township Ordinance No. 2004-10 (the "Pay-to-Play Ordinance"), I am making this Affidavit under penalties of perjury to represent to the Township of Lower that neither I nor the Business Entity have made any political contributions in violation of Section 95-2 of the Pay-to-Play Ordinance.

4. Also in accordance with the Pay-to-Play Ordinance, I am disclosing that the following represents all of the contributions that were made by the Business Entity and, to the best of my knowledge, all principals owning 10% more of the Business Entity's equity, their respective spouses, and all of the Business Entity's employees and officers and their respective spouses, to all New Jersey State and County political party committees commencing on the later of the effective date of the Pay-to-Play Ordinance (October 4, 2004) or twelve (12) months from date of this Affidavit and ending on the date of this Affidavit:

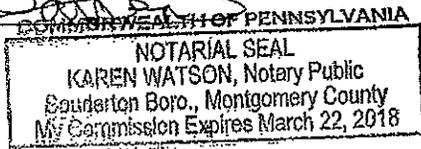
Date	Name of Organization	Amount
5/27/2015	Health Insurance Solutions, Inc.	\$ 0

4. I represent and acknowledge that I have received, read and fully understand the Pay-to-Play Ordinance and that my violation of the Pay-to-Play Ordinance will disqualify me and the Business Entity from receiving any additional contract from the Township of Lower for a period of four (4) years and, in the event any statements made in this Affidavit are willfully false, that I and the Business Entity would be subject to criminal prosecution for perjury.

[Handwritten Signature]

Sworn and Subscribed to before me
this 27 day of May, 2015
[Handwritten Signature]

Notary Public



Chapter 95, PROFESSIONAL SERVICE CONTRACTS, REGULATION OF

[HISTORY: Adopted by the Township Council of the Township of Lower 10-4-2004 by Ord. No. 2004-10. Amendments noted where applicable.]

§ 95-1. Definitions.

As used in this chapter, the following terms shall have the meanings indicated:

BUSINESS ENTITY SEEKING A PUBLIC CONTRACT -- An individual, including the individual's spouse, if any, and any child living at home, person, firm, corporation, professional corporation, partnership, organization or association. The definition of a business entity includes all principals who own 10% or more of the equity in the corporation or business trust, partners, and officers in aggregate employed by the entity as well as any subsidiaries directly controlled by the business entity.

PROFESSIONAL BUSINESS ENTITY -- A business entity as defined in this section which provides services by individuals who are required to be professionally licensed under the laws or regulations of this State or which provides "extraordinary unspecifiable services" pursuant to N.J.S.A. 40A:11-5(1)(a)(ii).

§ 95-2. Prohibition of awarding public contract to certain contributors.

A. Any other provision of law to the contrary notwithstanding, the Township of Lower or any of its purchasing agents or agencies or those of its independent authorities, boards or commissions, as the case may be, shall not enter into an agreement or otherwise contract to procure services from any professional business entity if that entity has solicited or made any contribution of money or pledge of a contribution, including in-kind contributions, to a campaign committee of any candidate for or holder of the office of Mayor or Council of the Township of Lower or to any Township of Lower political party committee in excess of the thresholds specified in Subsection C of this section within one calendar year immediately preceding the date of the contract or agreement.

B. No professional business entity which enters into negotiations for or agrees to any contract or agreement with the Township of Lower or any department or agency thereof or of its independent authorities, boards or commissions for the provision of professional services shall knowingly solicit or make any contribution of money or pledge of a contribution including in-kind contributions in excess of the thresholds specified in Subsection C of this section to a campaign committee of any candidate for or holder of the office of Mayor or Council of the Township of Lower or to any Township of Lower political party committee between the time of first communications between that business entity and the Township of Lower regarding a specific professional services agreement and the later of the termination of negotiations or the completion of the contract or agreement.

C. Notwithstanding Subsections A and B above, any individual who is a professional business entity may annually contribute a maximum of \$250 each for any purpose to any candidate for or holder of the offices of Mayor or Council of the Township of Lower, or \$500 to any Township of Lower political party committee, without violating this § 95-2; provided, however, that no group of individuals meeting the definition of a professional business entity may, in the aggregate, contribute annually for any purpose in excess of \$2,500 to all Township of Lower candidates for or holders of the offices of Mayor or Council and all Township of Lower political party committees combined without violating § 95-2.

§ 95-3. Contributions made prior to the effective date.

No contribution of money or any other thing of value, including in-kind contributions, made by a professional business entity to any candidate for or holder of the office of Mayor or Council of the Township of Lower or Township of Lower political party committee shall be deemed a

violation of this chapter, nor shall an agreement for services be disqualified thereby, if that contribution or agreement was made by the professional business entity prior to the effective date of this chapter.

§ 95-4. Contribution statement required by professional business entity.

A. Prior to awarding any contract or agreement to procure services with any professional business entity, the Township or any of its purchasing agents or agencies or independent authorities, boards or commissions, as the case may be, shall receive a sworn statement from the professional business entity made under penalty of perjury that the professional business entity has not made a contribution in violation of § 95-2.

B. Prior to awarding any contract or agreement to procure services with any professional business entity, the Township or any of its purchasing agents or agencies or independent authorities, boards or commissions, as the case may be, shall also receive a sworn statement from the professional business entity made under penalty of perjury disclosing all contributions made by the professional business entity during the immediately preceding 12 months to any New Jersey state and/or county political party committees which contributions, when added to any contributions made to any Township of Lower political party committees during the same time period, exceed the sum of \$500.

C. The professional business entity shall have a continuing duty to report any violations of this Chapter that may occur and to report any additional contributions to New Jersey state and/or county political party committees above the amounts set forth in Subsection B of this section during the negotiation or duration of a contract.

D. The sworn statement required under this section shall be made prior to entry into the contract or agreement with the Township and shall be in addition to any other certifications that may be required by any other provision of law.

§ 95-5. Penalty.

A. All Township of Lower professional service agreements shall provide that it shall be a breach of the terms of the government contract for a professional business entity to violate § 95-2 or to knowingly conceal or misrepresent contributions given or received or to make or solicit contributions through intermediaries for the purpose of concealing or misrepresenting the source of the contribution.

B. Any professional business entity who knowingly fails to reveal a contribution made in violation of § 95-2 or who knowingly makes or solicits contributions through intermediaries for the purpose of concealing or misrepresenting the source of the contribution shall be disqualified from eligibility for future Township contracts for a period of four calendar years from the date of the violation.

C. Nothing herein shall be deemed to apply to contributions made to any county or state campaign committee, candidate or officeholder, or to any county or state political party committee, however, such contributions are subject to the disclosure provision that may apply as set out in § 95-4C.

§ 95-6. Procedures to ensure compliance with regulation.

A. Neither the Chief Financial Officer nor his or her designee shall issue a certification of availability of funds without first receiving a certification from the Township Manager that the disclosures required by this chapter have occurred and that such disclosures do not violate the contribution limits set forth herein.

B. No contract or agreement for professional services shall be signed and delivered to any professional business entity without full compliance with this chapter.



HEALT-4

OP ID: NC

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

03/26/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Dawson of Florida, Sarasota 9031 Town Center Parkway Lakewood Ranch, FL 34202 Jason Nestferode	Phone: 941-907-3828 Fax: 941-757-0028	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS:	FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE		NAIC #
INSURED Health Insurance Solutions Inc 177 N Main St Souderton, PA 18964	INSURER A: Maxum Indemnity Company		26743
	INSURER B:		
	INSURER C:		
	INSURER D:		
	INSURER E:		
	INSURER F:		

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input checked="" type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR <input checked="" type="checkbox"/> E&O GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC			PFP-6026335-01	03/25/2015	03/25/2016	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ 1,000,000 PRODUCTS - COMP/OP AGG \$ \$
	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	<input type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY <input type="checkbox"/> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below			N/A			<input type="checkbox"/> WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Insurance Agent E&O
 Deductible: \$5,000 per claim

CERTIFICATE HOLDER**CANCELLATION**

Health Insurance Solutions Inc
 177 N Main St
 Souderton, PA 18964

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Matthew D. Lewis

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State of New Jersey
 Department of Banking and Insurance
 20 West State Street
 Trenton, NJ 08625-0327

LICENSE NUMBER
 1191710

THIS CERTIFIES THAT **HEALTH INS SOLUTIONS INC**

AT BUSINESS ADDRESS 177 NORTH MAIN STREET
 SOUDERTON, PA 18964

This insurance license is valid and shall remain in effect unless revoked or suspended provided that the fee set forth in N.J.A.C. 11:17-2.12 is paid and renewal requirements set forth in N.J.A.C. 11:17-2.5, including continuing education requirements for resident individuals, are met by the license expiration date. A renewal notice will be mailed to the licensee mailing address approximately 30 days prior to the license expiration date.

IS DULY LICENSED WITH THE FOLLOWING LICENSE TYPE(S) AND AUTHORITIES

LICENSE TYPE	LINES OF AUTHORITY	EFFECTIVE DATE	EXPIRATION DATE
PRODUCER	LIFE INSURANCE; ACCIDENT, HEALTH OR SICKNESS	06/01/2014	05/31/2016

printed: 04/22/2014

K. S. K...
 Commissioner of Banking and Insurance

The Department maintains an informative website at www.dobi.nj.gov. Please visit this web page for valuable information and forms necessary to maintain compliance with licensing requirements.

Department Contact Information
 web site: www.dobi.nj.gov
 phone: (609) 292-4337
 fax: (609) 984-5263

The request for any change of license information must be sent to the Department within 30 days of the change.

Make any checks and/or money orders payable to: **STATE OF NEW JERSEY, GENERAL TREASURY**

Mailing Address: Department of Banking and Insurance
 20 West State Street
 P.O. Box 327
 Trenton, NJ. 08625-0327



STATE OF NEW JERSEY BUSINESS REGISTRATION CERTIFICATE

Taxpayer Name:	HEALTH INSURANCE SOLUTIONS INC
Trade Name:	
Address:	177 N MAIN ST SOUDERTON, PA 18964-1715
Certificate Number:	1300495
Effective Date:	February 07, 2007
Date of Issuance:	June 25, 2014

For Office Use Only:
20140625161319174